Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT

BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Monday, February 7, 2011

6:00 p.m. (Closed)

7:30 p.m. (Open)

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

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

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

II. Roll Call — Kristen Thorson

VIII. Closed Session Agenda

A. Call to Order

B. Approval of Closed Session Minutes – January 10, 2011

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

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

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

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

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

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

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

I. Adjourn into Open Session

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

A. Announcements from Closed Session — Jordan Battani

III. Regular Agenda

A. President's Report — Jordan Battani

1) Compensation Survey Process

INFORMATIONAL [ENCLOSURE] (PAGES 4-19)

- Bill Hopkins, Senior Consultant, Integrated Health Strategies

B. Consent Agenda

1) Approval of January 10, 2011 Regular Meeting Minutes

ACTION ITEM [enclosure] (PAGES 20-27)

2) Approval of Finance and Management Committee Structure and Purpose

ACTION ITEM [enclosure] (PAGES 28-29)

3) Acceptance of November 2011 Financial Statements

ACTION ITEM [enclosure] (PAGES 30-49)

4) Acceptance of December 2011 Financial Statements

ACTION ITEM [enclosure] (PAGES 50-69)

C. Action Items

1) Approval to Purchase Nihon Kohden ECG Monitoring System — Kerry Easthope

ACTION ITEM [ENCLOSURE] (PAGES70-71)

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

1) Stroke Certification Update

INFORMATIONAL

2) Monthly Statistics

INFORMATIONAL

3) IT Projects Update

INFORMATIONAL [ENCLOSURE] (PAGES 72-74)

4) Hospital Updates / Events

INFORMATIONAL

E. Facilities Report — Kerry Easthope

1) SB 1953 Seismic Compliance Update

INFORMATIONAL [ENCLOSURE] (PAGES 75-82)

2) Marina Village / Wound Care Update

INFORMATIONAL

F. Medical Staff President Report — James Yeh, DO

INFORMATIONAL

G. Community Relations and Outreach Committee Report

1) January 25, 2011 Committee Meeting Report — Stewart Chen, DC

INFORMATIONAL

H. Finance and Management Committee Report

1) January 26, 2011 Committee Meeting Report — J. Michael McCormick

INFORMATIONAL

X. General Public Comments

XI. Board Comments

XIII. Adjournment

INTEGRATED HEALTHCARE STRATEGIES™

WHO WE ARE, GOVERNANCE BEST PRACTICES, & TOTAL COMPENSATION REVIEW PROCESS

Prepared for
ALAMEDA HOSPITAL

Prepared by
Bill Hopkins, Senior Consultant

February 7, 2011

Integrated Healthcare Strategies

Integrated Healthcare Strategies - Who We Are

The leading specialist in human capital consulting for not-for-profit healthcare organizations

- **Founded in 1973**
- **Offices in Minneapolis and Kansas City**
- **Nearly 200 associates**
- **Clients include over 900 major healthcare providers**
  - Large, integrated provider networks and systems
  - Academic medical centers
  - Large, multi-specialty group practices
  - Children's hospitals
  - National and state healthcare associations

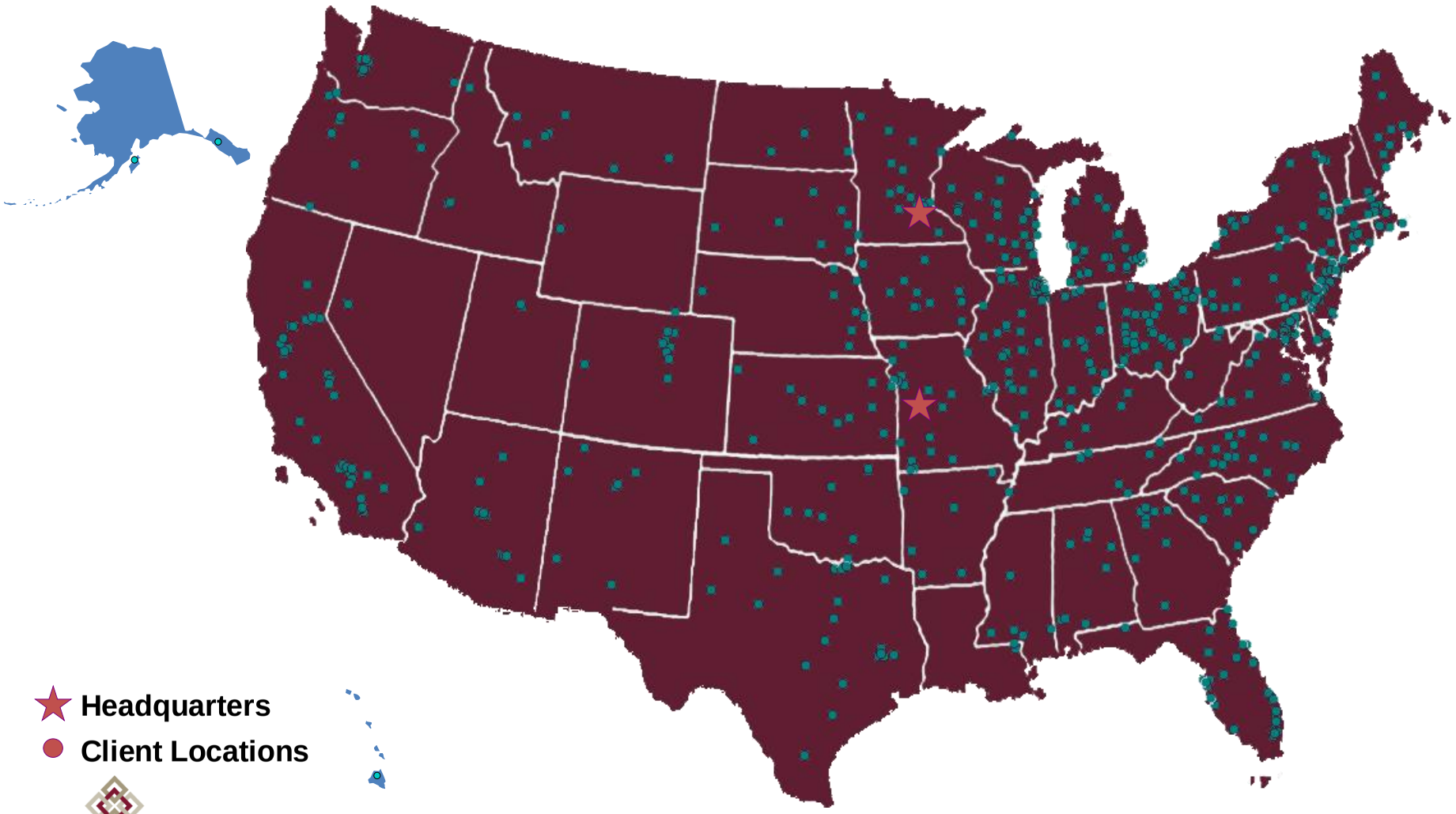
What We Do

We provide a full suite of strategic human capital consulting services to hospitals and health systems

- **Assess and develop total compensation programs**
  - Leadership
  - Staff
  - Physicians
- **Provide independent advisory services to boards and committees**
  - Governance and best practices
  - Reasonableness opinions
  - Performance appraisal
- **Design of compensation and benefit plans that:**
  - Enhance the ability to attract and retain quality talent
  - Align leadership, staff, and physicians with the organization's mission and strategic priorities
  - Help manage performance at all levels of the organization

Who We Serve

IHStrategies serves over 900 leading healthcare organizations across the country



Some of Our Regional Clients

El Camino Hospital	Mountain View, CA
Washington Hospital Healthcare System	Fremont, CA
Sutter Health	Sacramento, CA
Scripps Health	San Diego, CA
Adventist Health	Roseville, CA
Huntington Memorial Hospital	Pasadena, CA
Cottage Health System	Santa Barbara, CA
Alameda County Medical Center	Oakland, CA
Community Hospital of the Monterey Peninsula	Monterey, CA
Kaweah Delta Health Care	Visalia, CA
Eisenhower Medical Center	Rancho Mirage, CA

What Distinguishes Us

- Exclusive focus on tax-exempt health care organizations
- Make it easy for boards/committees to make well-informed decisions
  - Protect them from intermediate sanctions
  - Help them respond to critics
- Expertise of our leaders, principals, and consultants
  - First-hand knowledge of practices in every region and segment of health care industry
- Breadth and depth of human capital services
- Largest database on compensation and benefits in health care
  - Ability to meet IRS specifications for accurate total compensation data from custom peer groups

Governance Best Practices

Taxpayers Bill Of Rights 2 (TBOR 2)

- TBOR 2 authorizes the IRS to apply intermediate sanctions to any excess benefit transaction in not-for-profit 501(c)(3) organizations
- Intermediate sanctions include taxes and penalties on individuals receiving the excess benefits and on anyone who knowingly approves any excess benefit transaction
  - An excess benefit transaction arises when a tax-exempt organization provides an economic benefit to a "disqualified person" which exceeds the value of the consideration the tax-exempt organization receives in return
  - A "disqualified person" is any person who is (or was in the preceding five years) in a position to exercise substantial influence over the affairs of the organization (similar to 990 reporting)
    - "Disqualified persons" are likely to include directors, trustees, top management, and even key physicians without any management status
- Not-for-profit organizations can create a "rebuttable presumption of reasonableness" and shift the burden of proof of unreasonable compensation to the IRS

Establishing A Rebuttable Presumption Of Reasonableness

- Boards should take steps to ensure compliance with TBOR 2
  - Shift the burden of proof of unreasonable compensation to the IRS
- Have compensation arrangements for any "disqualified individual" approved by the Board or committee made up entirely of independent directors
- Committee must obtain and rely upon appropriate comparability data in making its decisions
  - Data should be collected by reputable consulting firm
  - Data should represent like jobs and like organizations
  - Data must represent total compensation (salary + incentives + benefits + perquisites)
- Committee should meet in executive session for debate, deliberation, and vote
  - Should exclude any executive whose pay is being determined

Establishing A Rebuttable Presumption Of Reasonableness

- Decisions, rationale, and process must be documented in minutes
  - Minutes must document people present during debate, deliberation, and vote
  - Should explicitly indicate lack of conflict of interest for all present
  - Should explicitly indicate that executives left room prior to debate on their own compensation
  - Must document source of comparability data and indicate how it was collected and obtained
  - Should state that data represents total compensation for like jobs in like organizations

Best Practices In Governing Executive Compensation

- Independence
  - Separate compensation committee, entirely independent
    - Committee members should be independent and have no potential conflict of interest
    - Charged to oversee all of executive compensation
    - Required to report periodically to the whole Board
- Charter
  - Written charter for committee
    - Set qualifications for membership
    - Require clear, thorough documentation of process and decisions
    - Require annual disclosure to full board
- Compensation Philosophy
  - Focus on total compensation
    - Guides decision-making
    - Get quantitative data on total compensation (including salaries, incentives, benefits and perquisites) and use it in making all decisions
    - Rely upon appropriate comparability data from like organizations
    - Evaluate every enhancement in terms of impact on total compensation

Best Practices In Governing Executive Compensation

- Review Process
  - Require a thorough review of all aspects of the executive compensation program every few years
  - Committee should hire and supervise consultant directly
  - Committee should meet regularly in executive session
    - Staff should be excused from deliberations affecting their compensation
  - Establish a “rebuttable presumption of reasonableness” for all disqualified individuals (executives and employed physician leaders)
    - Minimize risk of intermediate sanctions
  - Periodically look at total value of retirement benefits and severance
  - Get “reasonableness opinions” on any executives or physicians who are paid exceptionally high
- Communications Plan
  - Be prepared to explain process, philosophy, and anomalies
  - Point person identified to respond to requests (should not be management)

Best Practices In Governing Executive Compensation

- Documentation
  - Make sure minutes include enough information to establish “rebuttable presumption”
    - Statement of intent to establish presumption of reasonableness
    - People present during debate, deliberation and vote
    - Lack of conflict of interest for all present or indication of how conflict was dealt with
    - Source of comparability data and how it was collected
    - Assertion that comparability data is for like jobs, like organizations
    - Terms of compensation approved
    - Assertion that board/committee relied on comparability data in making decision
    - Statement of directors’ belief that pay approved represents fair market value
    - Rationale for approval of any compensation above comparability data

Total Compensation Review Process

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Our Methodology for Total Compensation Consulting

Process Step	Timing	Activities
Comprehensive Data Collection Process	January	• Financial and organizational data review • Strategic and operating plans review • Job content calls • Incentive plan review • Benefit plan review
Focused Interviews & Compensation Philosophy Development	January/ February	• Board interviews • CEO interview • On-site meeting to discuss findings
Competitive Analysis & Draft Recommendations	February	• Identify peer group • Analyze salaries, incentives and benefits • Compare total compensation to peer group • Identify issues/problems needing attention
Recommendation & Final Report	March	• Meet with Board to present report • Discuss issues/recommendations/opportunities • Help comply with best practices
Ongoing Support	As needed	• Board support and education • Annual updates

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DRAFT

Minutes of the Board of Directors

January 10, 2011

Directors Present:		**Management Present:**	**Legal Counsel Present:**	**Medical Staff Present:**	**Excused:**
Jordan Battani	Elliott Gorelick	Deborah E. Stebbins	Thomas Driscoll, Esq.	James Yeh, DO	
Stewart Chen, DC	J. Michael McCormick	Kerry J. Easthope			
Robert Deutsch, MD					

Submitted by: Kristen Thorson

Topic	Discussion	Action / Follow-Up
I. Call to Order	Jordan Battani called the Closed Session of the Board of Directors of the City of Alameda Health Care District to order at 6:10 p.m.	
II. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
III. Closed Session Agenda	The meeting was adjourned into Executive Closed Session at 6:11 p.m.	
IV. Reconvene to Public Session	The meeting was reconvened into public session at 7:45 p.m. Director Battani reported that the following actions were taken in Closed Session. A. Announcements from Closed Session 1. Closed Session Minutes – December 13, 2010 (Regular) 2. Board Quality Committee (BQC) Report – October 2010	 The Closed Session Minutes were approved. The BQC report was accepted as presented.
V. Consent Agenda	A. Approval of December 13, 2010 Regular Meeting Minutes. B. Approval of Administrative Policies and Procedures C. Approval of Human Resources Policy – Performance Evaluation D. Approval of Board Quality Committee Structure and Purpose	Director McCormick made a motion to approve the Consent Agenda as presented. Director Chen seconded the motion. The motion carried unanimously.

	E. Approval of Union Bank Signing Authorization / Resolution	
VI. Regular Agenda	A. Action Items	
	1. Approval of Election of District Officers In preparation for the election of officers, Ms. Thorson, District Clerk queried each Board member as to their preference for office. Based on the response, the following slate of officers was presented for approval. President – Jordan Battani First Vice President – Robert Deutsch, MD Second Vice President – Stewart Chen, DC Treasurer – J. Michael McCormick Secretary – Elliott Gorelick	Director McCormick made a motion to approve the slate of District Officers as presented Director Chen seconded the motion. The motion carried unanimously.
	2. Approval of 2011 District Board Meeting Dates Ms. Stebbins presented the 2011 District Board Meeting Dates for approval. Board Members were asked in prior meetings to indicate whether there were any conflicts with the meeting schedule. No conflicts were indicated to Management regarding the schedule.	Director Deutsch made a motion to approve the 2011 District Board Meeting Dates. Director McCormick seconded the motion. The motion carried unanimously.
	3. Approval of 2011 Appointment to Board Committees Director Battani presented the slate of committee assignments (listed below) noting that Ms. Thorson queried each Board member as to the preference of committee assignments. Director Chen asked if Board Members are able to attend Committees that they are not assigned. Director Battani stated that Board Members are welcome to attend other Committees as non-voting members. Director Deutsch asked if an ex-officio member counts as a quorum in a Committee. Director Driscoll answered that if there are three or more Board Members attending a committee with the purpose of discussion of District business, then it is considered a Board Meeting under the Brown Act even if they are non-voting members.	Director Deutsch made a motion to approve the Board Committee assignments as presented. Director Chen seconded the motion. The motion carried unanimously.

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

4. Approval of Consideration of Primary Stroke Certification

Public Comments

Denise Lai and Carol Gottstein, MD made comments regarding the Consideration of Primary Stroke Certification.

Director Gorelick expressed concern about Alameda Hospital pursuing Primary Stroke Certification. He proposed that the Hospital forgo and cease pursuing Primary Stroke Certification (PSC) or alternatively to ask that Alameda County EMS calls be routed to other hospitals even if PSC is granted to Alameda Hospital or lastly to have a formal protocol associated with another hospital for "drip and ship." He did not believe that the first choice for stroke patients should be Alameda Hospital. Director Battani replied that she believes that this is the only responsible thing for the hospital to be doing at this time as it is the standard established by Alameda County as well as regulated by the Joint Commission.

Discussion ensued regarding the hospital pursuing Primary Stroke Certification.

Director Gorelick asked what the benefits were in taking stroke patients to Alameda Hospital. Director Deutsch responded that CT scans are performed on average within 12 minutes and some patients may arrive at the hospital in as few as five minutes. He noted that treatment is not performed until CT scans can be reviewed, therefore the less time it takes to get to the hospital, the better the outcome.

Director McCormick reviewed that a stroke patient will increasingly have more damage the longer it takes them to arrive at the hospital. Therefore, a stoke patient will be in better care at Alameda Hospital if they are an Alameda resident.

Director Gorelick moved that discussions be initiated with Alameda County EMS for an exception for EMS routing protocols for stroke patients, whether or not the hospital obtains Primary Stroke Certification. No second to the motion. Motion did not carry.

Director Battani made a motion to direct management to continue to pursue stroke certification and continue to work with the County on EMS transport protocols. . Director Deutsch seconded the motion. The motion carried with one abstention (Gorelick).

Director Chen commented he believes that the hospital should pursue stroke certification.

Director Battani stated that she would like management to continue to work in order to achieve stroke certification and work with the Alameda County EMS according to their standards and protocols.

Director Chen stated that Alameda Hospital has an opportunity to be the best hospital for stroke victims once we achieve certification. Director Deutsch noted that Alameda Hospital is currently a safe place for stroke patients, but the stroke certification will help to show our community that we continue to be the best, but in no way should it reflect that just because we do not have stroke certification that Alameda Hospital is an unsafe hospital. Director Battani added the Stroke Certification topic will be a standing item on the agenda for future Board Meetings.

B. President's Report

1. Update on Compensation Survey Process

Director Battani updated the Board on the process for evaluating the Compensation for the five top executives at the Hospital. She reviewed the firm Integrated Health Strategies has been selected to conduct the survey. She also reviewed the timeline for the completion of the survey as outlined in the enclosure in the Board packet. This survey process is an ongoing audit process to ensure that the hospital is in line with market standards and to allow the hospital to stay competitive in the marketplace, Director Battani informed the Board that the Board Members will be asked to participate in a salary compensation survey. The survey will evaluate how Alameda Hospital staff is paid in comparison to similar organizations. Director Battani commented that the Board will be asked to agree on overall compensation at the March Board Meeting.

2. Use of Electronic Devices During Board Meetings

Director Battani requested that Board Members limit use of electronic devices, including phone calls, texting, emailing, during Board meetings with the exception of emergencies or physician necessity. If calls need to be taken during a meeting, the Board meeting can pause briefly and resume after the call is complete. Director Gorelick stated he thought that the amount of distraction may be overestimated by text messaging or communications with family. He stated that he thought it

was important that no one take any communication from the audience regarding Board issues during a meeting as it is clearly not allowed.

Director Battani reaffirmed that she would like to encourage everyone to be fully engaged at all times during a meeting.

Director McCormick stated that he thought that it was acceptable to break for a few minutes if someone needed to take a call or be excused from the meeting and that he understood the concern regarding the use of electronic devices.

C. Chief Executive Officer's Report

1. Stroke Certification Update

Ms. Stebbins updated the Board on the status of the Hospital achieving stroke certification through the Joint Commission. Ms. Stebbins stated that Alameda Hospital was one of the first hospitals to obtain relationships with Eden, a comprehensive stroke center. Ms. Stebbins gave a presentation which will be posted online with the Board Packet.

2. Monthly Statistics

Ms. Stebbins reported that the December acute care census was 10% over budget. Sub-acute and South Shore census was slightly below budget for the month of December. Emergency Visits were approximately 10% below budget for the month of December. Surgical volume was below budget for both inpatient and outpatient surgeries.

Ms Stebbins informed the Board that on January 14th the Annual Holiday Party will be held. The Medical Staff underwrites this event every year. On Thursday, January 13th the Hospital Foundation will be involved with the launch party for the Alameda Magazine at the Harbor Bay Club. The Foundation will receive all proceeds from the event. The Annual Tenure Recognition Event for employees will be held on February 28th and invitations will be forthcoming. Board Members are encouraged and welcome to attend these events.

3. IT Projects Update

Ms. Stebbins deferred the update on IT Projects to the next Board meeting. She will be bringing a summary of the major IT projects in progress to the Board for information.

4. 401 (a) Pension Plan Contributions

Ms. Stebbins informed the Board of a recent development regarding the 401 (a) Pension Plan Contributions. She reported that our Human Resources Department, under guidance from our local pension and TDA Broker, has operated the plan on the assumption of making contributions for eligible employees of 6% of their wages up to the maximum wage limit published for Governmental Plans of $360,000. However, during a recent audit of our employee wages and contribution limits, it was discovered that this limit was only applicable to Governmental plans in existence before July 1, 1993. The 401(a) Plan was started in 2002 when the District was established. Therefore, although we are treated as a governmental agency, our plan limit on wages that are eligible for contributions is $245,000. This is the maximum for all other non-governmental organizations and corporations. Ms. Stebbins stated that she is the only employee affected and the excess contributions will be removed from her pension account and placed in a forfeiture account. Ms. Battani stated that she had recent inquires from the community regarding the Hospital participating in CALPERS and stated that Alameda Hospital does not participate in CALPERS benefit program. The Hospital utilizes a 401(a) plan which acts similar to a 401(k) plan.

D. Facilities Report

1. SB 1953 Seismic Compliance Update

As follow-up to last month's District Board Meeting, Mr. Easthope presented a SB 1953 Compliance Update. The presentation will be posted online with the board packet. The presentation, intended to provide an educational overview of seismic for the Board of Directors, included the history of SB 1953, extension options, a summary of Alameda Hospital's seismic compliance and what the next steps are in seismic planning. In addition to the presentation, a detailed memorandum was included in the board packet.

Director McCormick asked the status of financing in terms of seismic retrofitting. Mr. Easthope replied that Alameda Hospital continues to work with the State of California for funding sources as well as with Cal Mortgage. He mentioned that emphasis on the development of new programs to increase revenue will help the hospital increase financing options. He also stated that the hospital continues dialogue with State legislators regarding options for legislative assistance with the

hospital's seismic compliance. Director Chen asked what state legislators the Hospital has spoken to. Mr. Easthope stated that the hospital has had meetings with Senator Hancock and Assemblyman Sandre Swanson's office regarding Alameda Hospital and seismic compliance. She also stated that if other extension opportunities do not allow the Hospital to meet our situation that our State Legislators have expressed that they would be willing to assist the hospital with specific legislation to help the hospital. Ms. Stebbins stated that if the Hospital could to demonstrate a positive revenue trend by the year 2016 that it would greatly help our options for financing.

Director Gorelick stated that he could not find, in any legislation, the exception to the January 1, 2002 compliance date and indicated that the hospital was not in compliance at that time and remains non-complaint to this date. Mr. Easthope stated that there was no exception. He stated that in 2002 there had been work completed on the NPC work. Mr. Easthope stated the goal for OSHPD is to assist hospitals in meeting compliance standards. The Hospital has been in communication with OSHPD as well as submitting details plans to complete NPC work. Ms. Stebbins added that Alameda hospital is not the only hospital that is non-compliant with the NPC deadline and reiterated that we continue to upfront with OSHPD regarding our plans for seismic compliance.

Director Gorelick expressed his appreciation for the clarity and detail of the report Mr. Easthope presented. Director Gorelick asked if there was an option to meet requirement for SB 306. Mr. Easthope stated that SB 306 is no longer available. Director Gorelick asked what the cash flow per month / year would put us in a place to afford the $10 million for the retrofitting. Mr. Easthope indicated that the debt service per month on a $10 million dollar loan would be approximately $120,000. Mr. Easthope reiterated that the Hospital currently has been granted an extension to 2013.

2. Marina Village Space Planning

Mr. Easthope stated that there was a memorandum included in the Board packet that outlined the current and future space planning needs of the hospital for the Boards information. If there are questions regarding the material please let him know.

E. Medical Staff President Report

Dr. Yeh announced the addition of a new Neurologist, Claudine Dutaret, MD

	to the Medical Staff. Dr. Yeh informed the Board the Medical Staff CME program for the month will be presented by David Bonovich, MD on Tuesday, January 25th. CME Topic is "Medical and Endovascular Management of Cranial Aneurisms. Dr. Yeh also informed the Board that physicians are going to meet to discuss the EHR system on a monthly basis. He also invited the Board to the Annual Holiday Party sponsored by the Medical Staff on Friday, January 14th.	
	F. Finance and Management Committee Report 1. Summary of November 2010 Financials Ms. Stebbins stated that volumes remained strong for the month of November. Total Net Revenues exceeded budget by 5.7%. Bottom line for the month after allocation parcel taxes was $133,000 compared to a budget of $61,000.	
X. Board Comments	Ms. Stebbins mentioned the Memorial Service for one of the Alameda fire fighters will take place on the USS Hornet on Friday, January 14, 2011 beginning at 11:00 a.m. Director Chen expressed appreciation to Mary Bond for the tour of the hospital.	
XII. Adjournment	A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 10:17 p.m.	

Attest:

Jordan Battani
President

Elliott Gorelick
Secretary

Date: February 7, 2011

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

From: Michael McCormick , Chair – Finance and Management Committee
Deborah Stebbins, CEO

Subject: Approval of the Revisions to the Finance and Management Committee Structure and Purpose

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Recommendation:

The Finance and Management Committee recommends that the Board of Directors approve the the revisions to the standing committee structure as outlined below.

STRUCTURE AND PURPOSE:

1. Finance and Management Committee:

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

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

        i. Two members of the City of Alameda Health Care District Board of Directors both of whom shall be voting members of the committee. ~~The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-voting member of the committee.~~

        ~~i.~~ii. The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-noting

member, unless the President is serving as a voting member of the committee.

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

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

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

c. Terms: The committee shall be appointed annually.

d. Meeting Frequency: Committee shall meet monthly.

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING NOVEMBER 30, 2010

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
NOVEMBER 30, 2010

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
NOVEMBER, 2010

The management of the Alameda Hospital (the "Hospital") has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending November 30, 2010 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of November, 2010

- Gross patient revenue for the month of November was greater than budget by $1,909,000 or 9.8%. Inpatient and outpatient revenue was greater than budgeted by 16.9% and less than budget by 3.4% for the month, respectively. As a result of inpatient days being 3.7% greater than budgeted and an increased overall case mix index, gross revenues per adjusted patient day basis were 20.2% greater than budgeted at $5,749 compared to a budgeted amount of $5,096 for November.

- Total patient days for the month were 2,572 compared to the prior month's total patient days of 2,465 and the prior year's 2,258 total patient days. The average daily acute care census was 31.6 compared to a budget of 26.2 and an actual average daily census of 25.6 in the prior month; the average daily Sub-Acute census was 32.3 versus a budget of 33.5 and 32.6 in the prior month and the Skilled Nursing program had an average daily census of 21.9 versus a budget of 23.0 and prior month census of 22.5, respectively.

- Emergency Care Center (ECC) visits were 1,397 or 5.0% less than the budgeted 1,470 visits and were 1.0% less than the prior year's visits of 1,383.

- Total surgery cases were slightly less than budgeted expectations for the month at 178 cases versus the budgeted 182 cases. The current month's surgical volume was 21.1% greater than the same month prior year's 147 cases.

- Outpatient registrations were 7.2% below budgeted targets at 1,929 and slightly lower than the prior month's 2,032 outpatient visits.

- Combined excess revenue over expenses (profit) for November was $133,000 versus a budgeted excess of revenue over expenses (profit) of $61,000. This brings our year-to-date loss to $184,000 versus a budgeted profit of $332,000.

- Total assets decreased by $56,000 from the prior month as a result of a decrease in current assets of $121,000, an increase in net fixed assets of $55,000 and an increase in restricted contributions of $9,000. The following items make up the decrease in current assets:

- Total unrestricted cash and cash equivalents for November decreased by $110,000 and days cash on hand including restricted use funds declined to 2.7 days on hand in November from 3.3 days on hand in October.

    - Net patient accounts receivable decreased in November by $194,000 compared to an increase of $298,000 in October. Day's in outstanding receivables increased to 60.4 in November from 65.2 at October 31, 2010. Collections in November totaled $5.1 million compared to $4.5 million in October.

    - Other assets increased by $171,000 primarily as a result of the accrual of $187,000 (1/12th of the

estimated amount) for the estimated amount of Inter-Governmental transfer funds that are anticipated to be received in FY 2011.

- Total liabilities decreased by $199,000 compared to a decrease of $1,206,000 in the prior month. This decrease in the current month was the result of the following:

  - Accounts payable and accrued expenses increased by $610,000 while payroll and accrued expenses decreased by $262,000. As a result of this net increase of $348,000 the average payment period increased in November to 65.5 from 64.1 as of October 31, 2010.

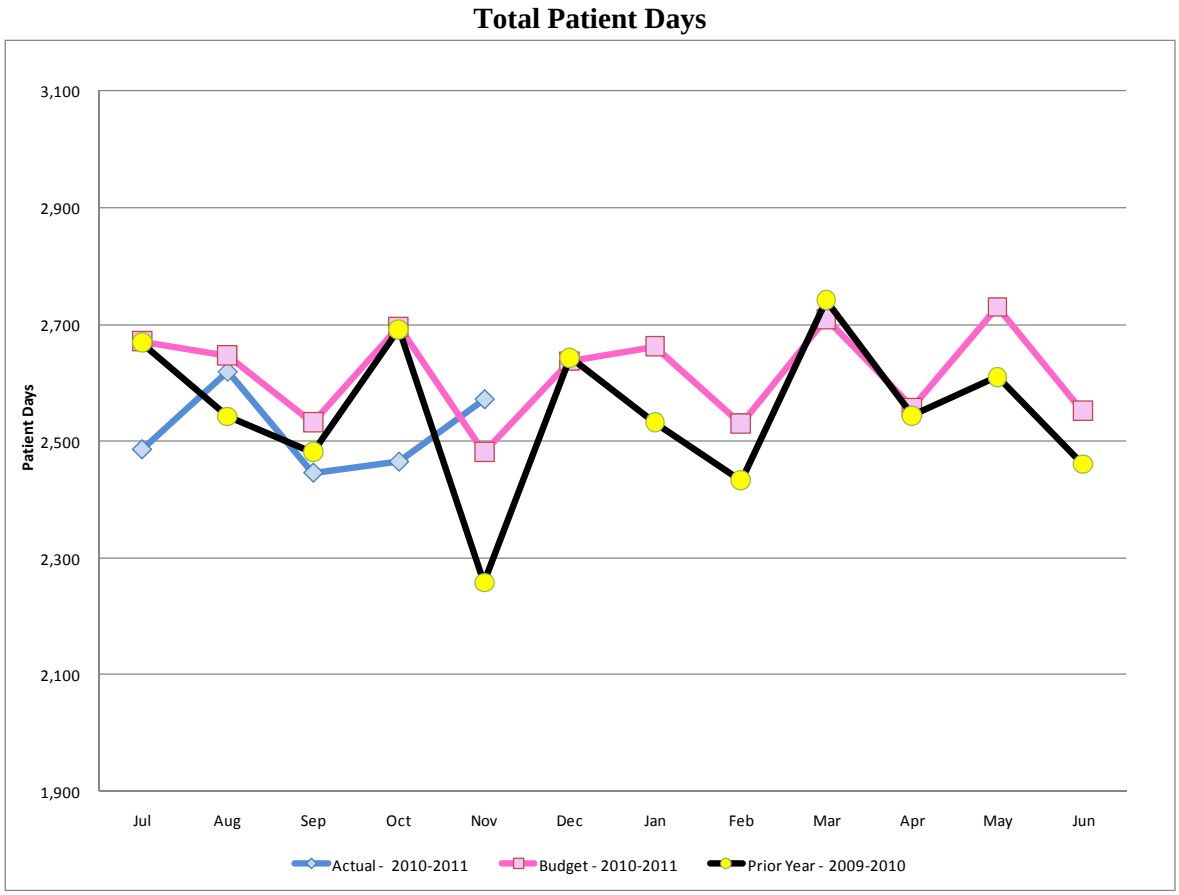
  - Payroll and benefit related accruals decreased by $262,000 from the prior month. This decrease was primarily the result of a decrease in accrued payroll and related payroll tax accruals of $416,000 offset by an increase in accrued time off of $108,000.

  - Other liabilities decreased by $509,000 as a result of the amortization of one-twelfth of the annual parcel tax revenues for the 2011 fiscal year which made up $478,000 of this total.

Volumes

The combined actual daily census was 85.7 versus a budget of 82.7 or a 3.7% favorable variance. The current month's favorable variance from the budgeted census was the result of an average daily census that exceeded budget in the acute care areas by 5.4 patients per day or 20.5%. The Sub-Acute and Skilled Nursing programs were below budgeted expectations with an average daily census of 32.3 versus the budgeted 33.5 and 21.9 versus the budgeted average daily census of 23.0, respectively.

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

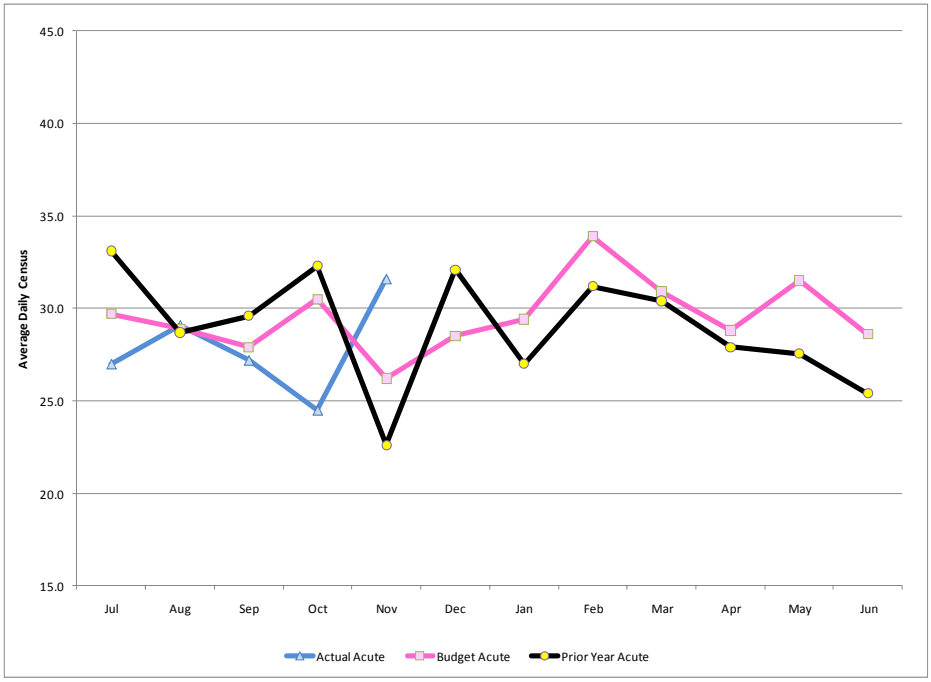


The various inpatient components of our inpatient volumes for the month of November are discussed in the following sections.

Acute Care

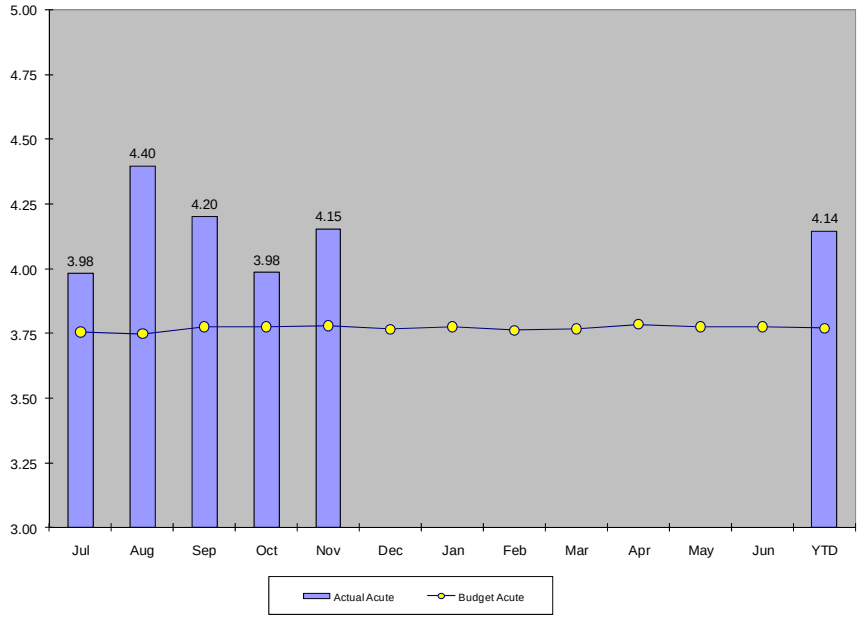
The acute care patient days were 20.5% (161 days) greater than budgeted and were 39.7% greater than the prior year's average daily census of 22.6. The acute care program is comprised of the Critical Care Unit (5.3 ADC, 82.8% favorable to budget), Definitive Observation Unit (8.5 ADC, 26.1% unfavorable to budget) and Med/Surg Units (17.8 ADC, 50.8% unfavorable to budget). The graph on the following page shows the inpatient acute care census by month for the current fiscal year, the operating budget and prior fiscal year actual.

Inpatient Acute Care Average Daily Census



The average length of stay (ALOS) increased from that of the prior month to 4.15 days for the month of November bringing the year-to-date average to 4.14 versus the budgeted FY 2011 average of 3.77. The graph below shows the ALOS by month and the budgeted ALOS for fiscal year 2011.

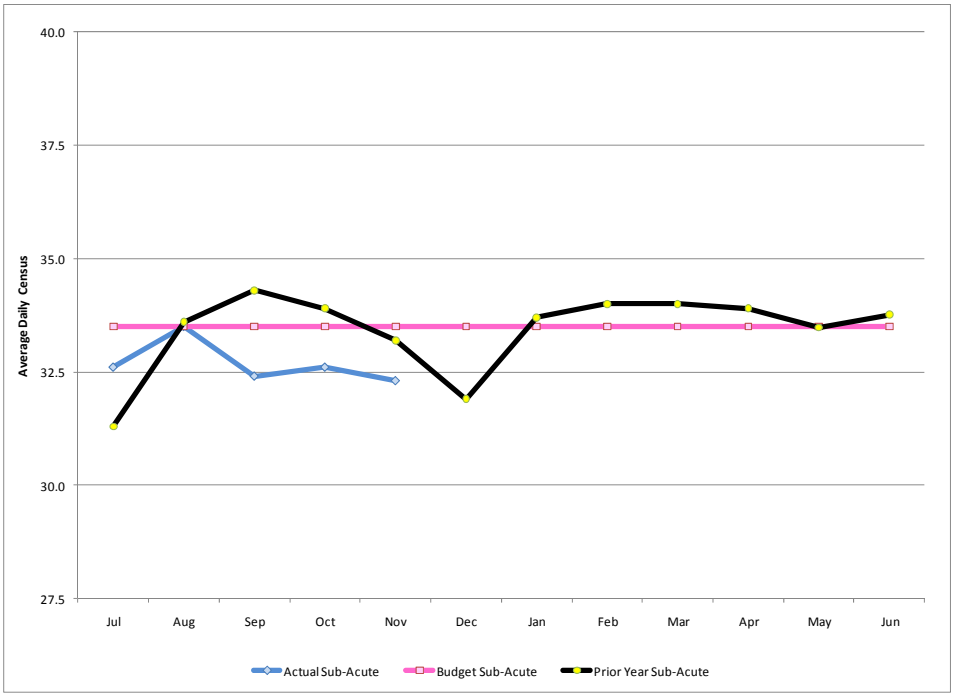
Average Length of Stay



Sub-Acute Care

The Sub-Acute program patient days were below budgeted projections with an average daily census of 32.3 for the month of November which was budgeted for an average daily census of 33.5. The graph on the following page shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

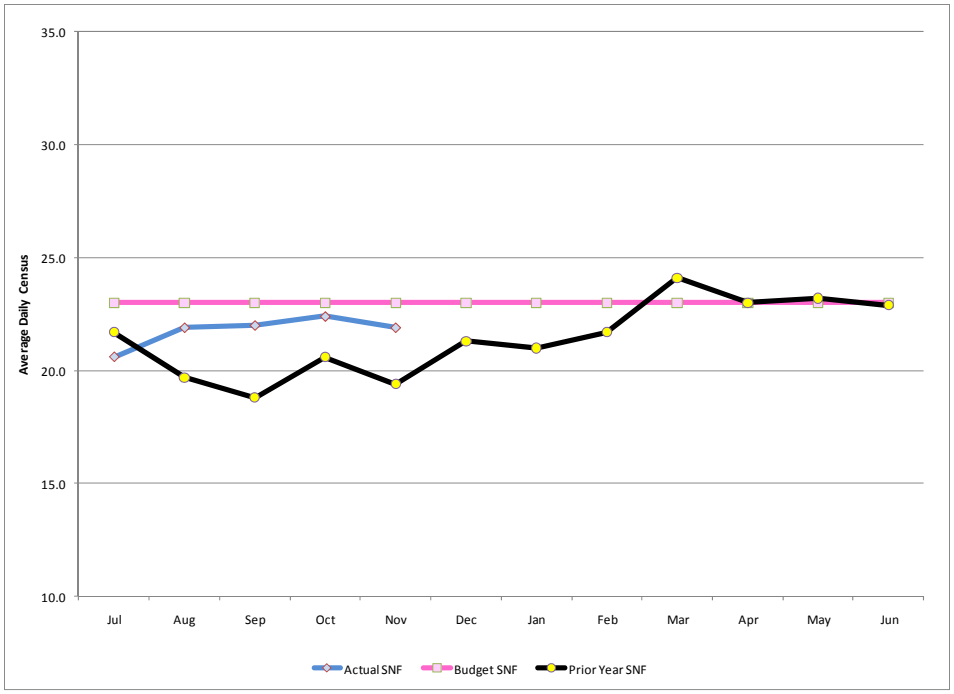
Sub-Acute Care Average Daily Census



Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were 4.8% or 33 patient days less than budgeted for the month of November. Comparing performance to the prior year this program remains slightly greater than the prior year's performance for the first five months of fiscal year 2010 with an average daily census of 21.8 versus 20.7. The following graph shows the Skilled Nursing Unit monthly average daily census as compared to budget and the prior year.

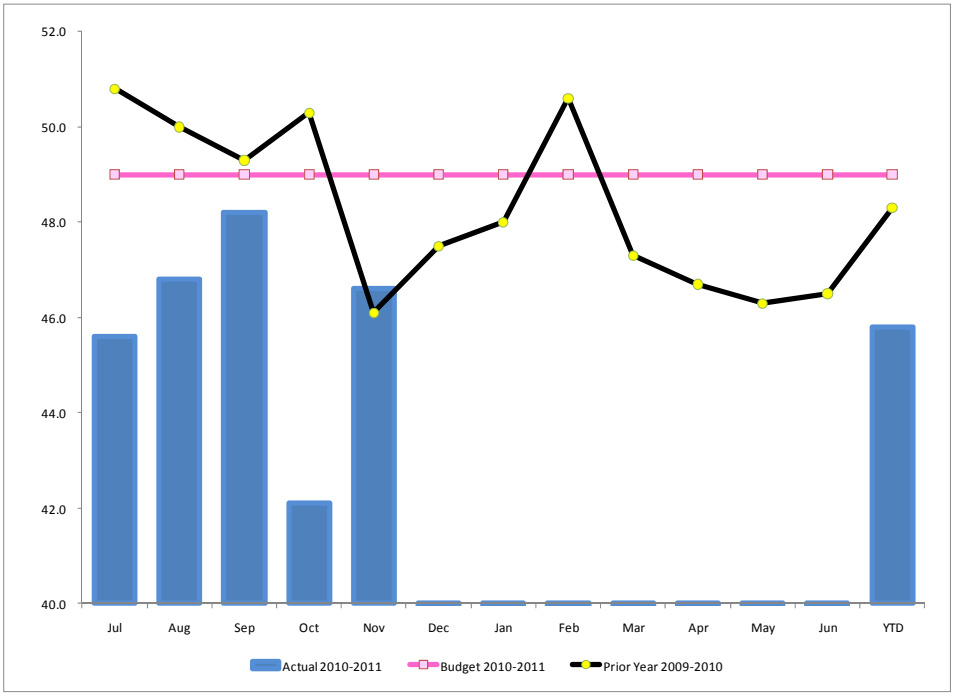
Skilled Nursing Unit Average Daily Census



Emergency Care Center (ECC)

Emergency Care Center visits in November totaled 1,397 and were 5.0% less than budgeted for the month with 17.3% of these visits resulting in inpatient admissions versus 15.9% in October. In November there were 289 ambulance arrivals versus 253 in the prior month, an increase of 14.2%. Of the 289 ambulance arrivals in the current month 161 or 55.7% were from Alameda Fire Department (AFD) ambulances. The graph below shows the Emergency Care Centers average visits per day for fiscal year 2011 as compared to budget and the prior year performance.

Emergency Care Center Visits per Day

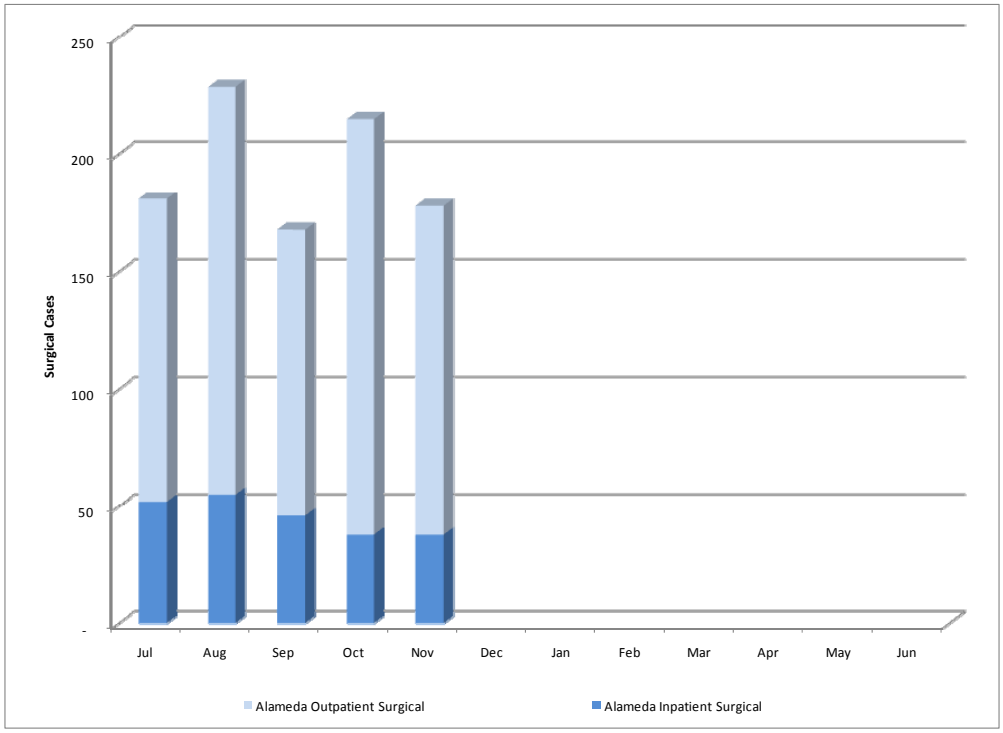


Surgery

Surgery cases were 178 versus the 182 budgeted cases and 147 cases in the prior year. In November, surgery cases decreased over the prior month by 17.2%. The decrease of 37 cases over the prior month was the result of a decrease in outpatient cases. Inpatient and outpatient cases totaled 38 and 140 versus 38 and 177 in November and October, respectively. The decrease in outpatient cases from the prior month was driven by decreases in GI cases (25), Ophthalmology cases (8), General (6), Plastics (4) and Pulmonary (3) offset by increases in Orthopedics (8) and Vascular (3).

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

Surgical Cases

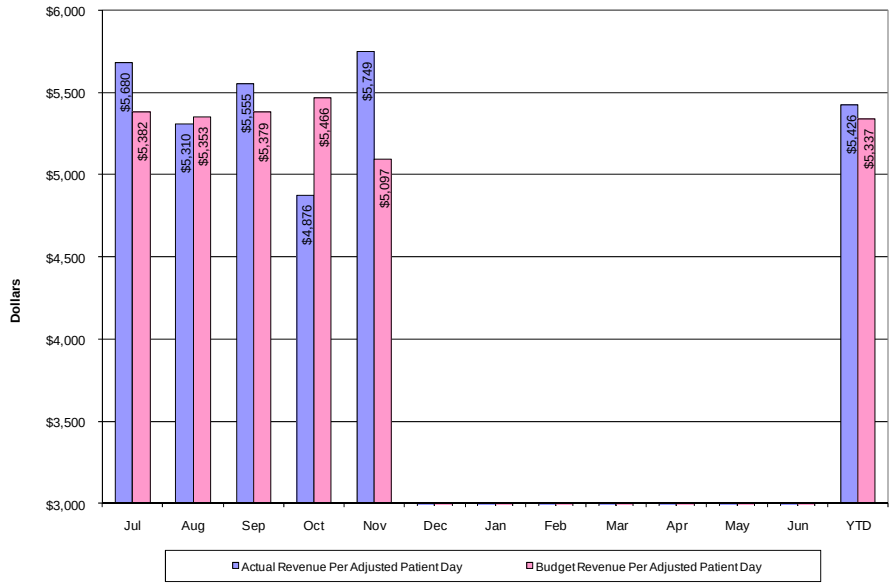


Income Statement

Gross Patient Charges

Gross patient charges in November were greater than budgeted by $1,909,000. This favorable variance was comprised of a favorable variance of $2,143,000 and an unfavorable variance of $234,000 in inpatient and outpatient revenues, respectively. On an adjusted patient day basis total patient revenue was $5,749 versus the budgeted $5,096 or a favorable variance of 12.8% from budget for the month of November. The following table shows the hospitals monthly gross revenue per adjusted patient day by month and year-to-date for fiscal year 2011 compared to budget.

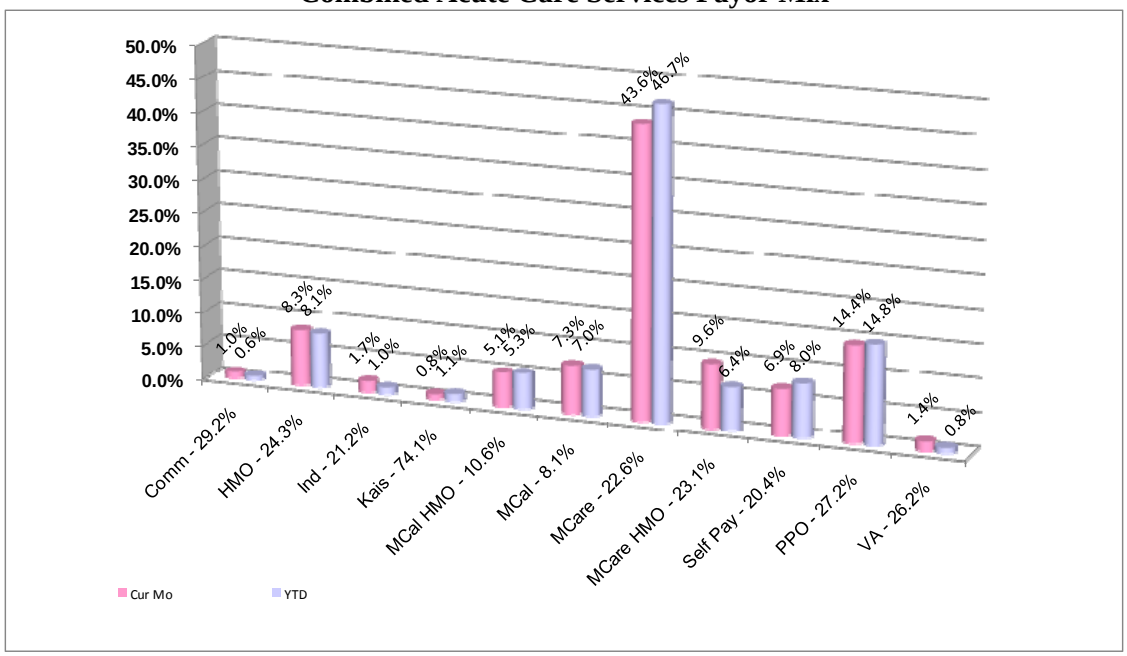
Gross Charges per Adjusted Patient Day



Payor Mix

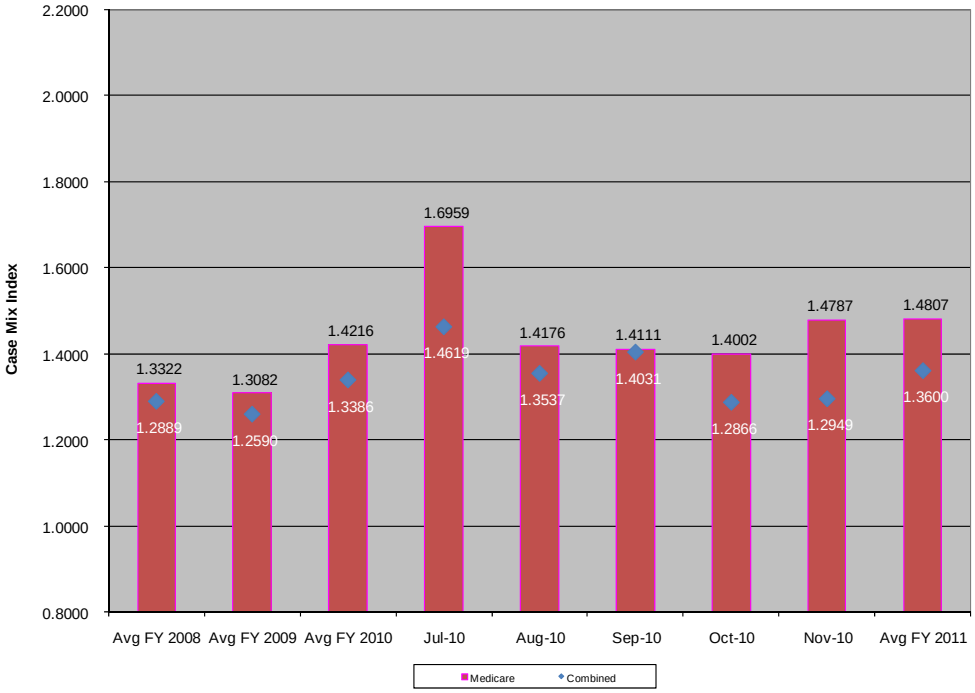
Combined inpatient and outpatient acute care Medicare and Medicare Advantage total gross revenue in November made up 53.2% of the months total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 22.7%, Medi-Cal Traditional and Medi-Cal HMO utilization at 14.7% and self pay at 6.9%. The graph below shows the percentage of gross revenues generated by each of the major payors for the current month and fiscal year to date as well as the current months estimated reimbursement for each payor for the combined inpatient and outpatient acute care services.

Combined Acute Care Services Payor Mix



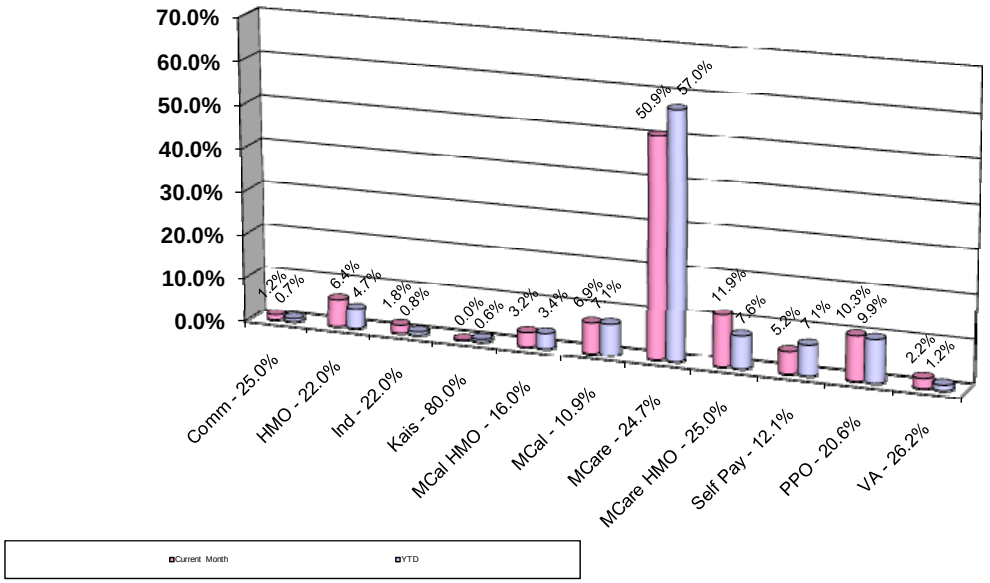
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 61.8% of our total inpatient acute care gross revenues followed by HMO/PPO at 16.7%, Medi-Cal and Medi-Cal HMO at 10.1% and Self Pay at 5.2% of the inpatient acute care revenue. The hospitals overall Case Mix Index (CMI) increased to 1.2949 from 1.2866 in the prior month and the Medicare CMI increased over the prior month from 1.4002 in October to 1.4787 in November. In November there were no outlier cases in the month. The estimated Medicare reimbursement decreased to 24.7% in November versus 25.8% in October. The graph on the following page shows the CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

Case Mix Index Comparison



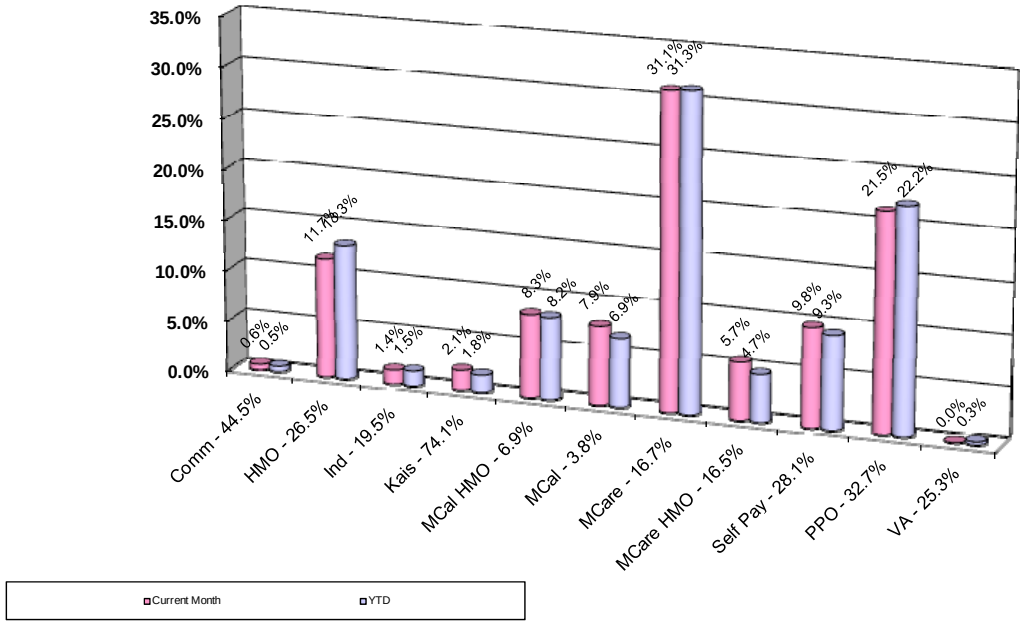
The overall net inpatient revenue percentage increased from the prior month to 22.2% in November versus 20.1% in October. The graph below shows inpatient acute care current month and year to date payor mix and current month estimated net revenue percentages for fiscal year 2011.

Inpatient Acute Care Payor Mix



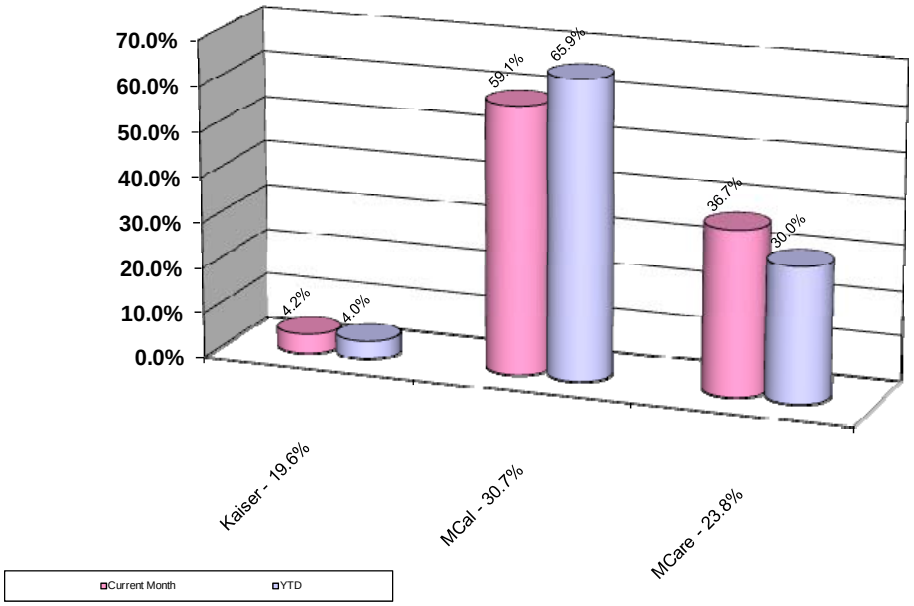
The outpatient gross revenue payor mix for November was comprised of 36.8% Medicare and Medicare Advantage, 33.2% HMO/PPO, 16.2% Medi-Cal and Medi-Cal HMO, and 9.8% self pay. The graph on the following page shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

Outpatient Services Payor Mix



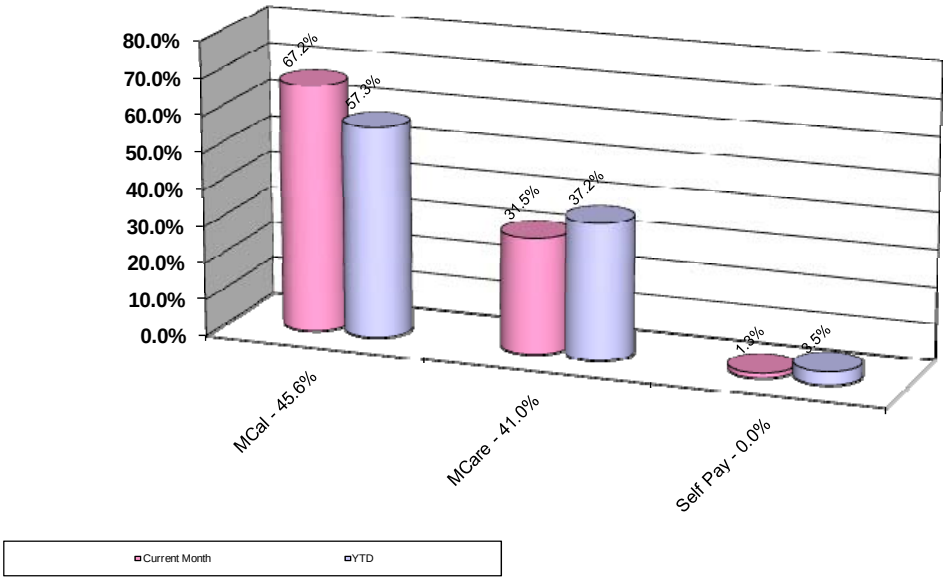
In November the Sub-Acute care program again was dominated by Medi-Cal utilization of 59.1% versus 61.0% in October. The graph below shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.

Inpatient Sub-Acute Care Payor Mix



In November the Skilled Nursing program was again comprised primarily of Medi-Cal at 67.2% and Medicare at 31.5%. The graph below shows the current month and fiscal year to date skilled nursing payor mix and the current months estimated level of reimbursement for each payor.

Inpatient Skilled Nursing Payor Mix

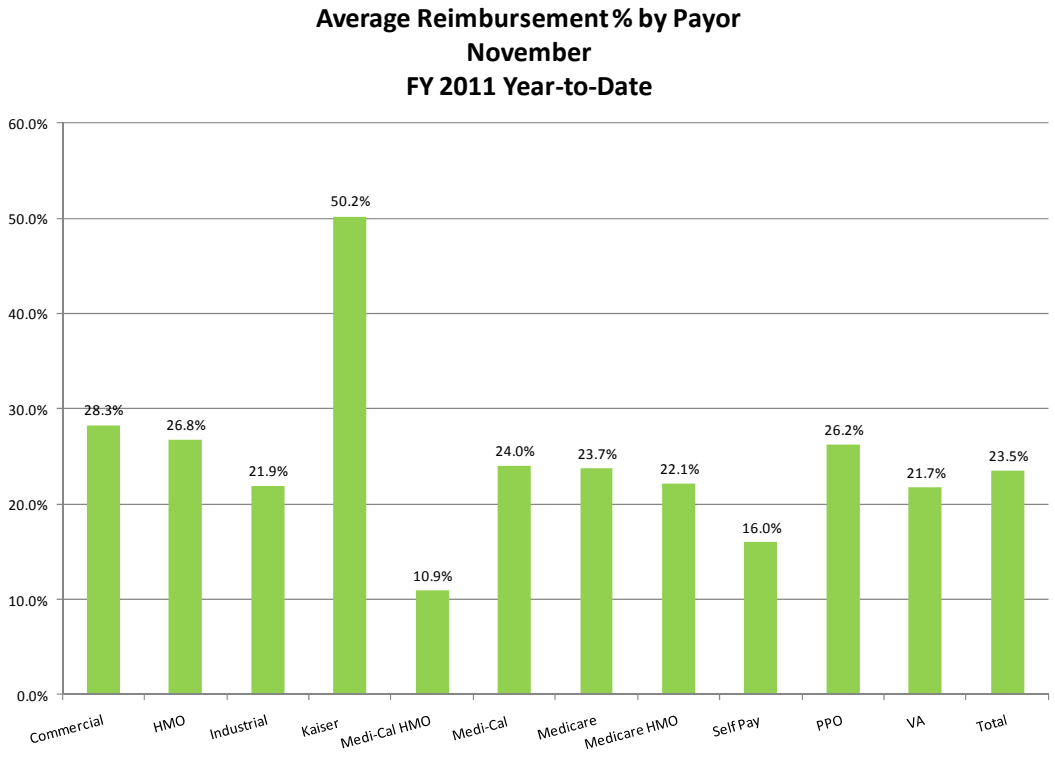


Deductions from Revenue

Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross. In the month of November contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 75.4% versus the budgeted 74.5%.

Net Patient Service Revenue

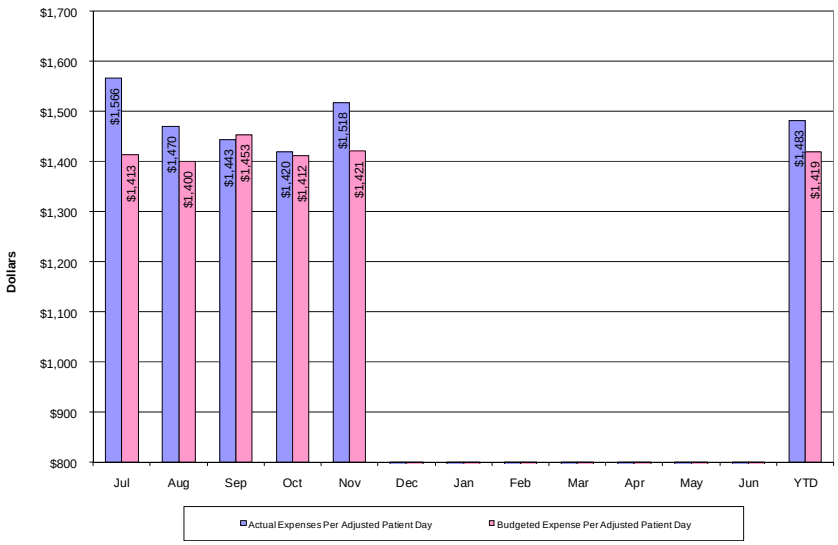
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. The graph on the following page shows the level of reimbursement that the Hospital has estimated for fiscal year 2011 by major payor category.



Total Operating Expenses

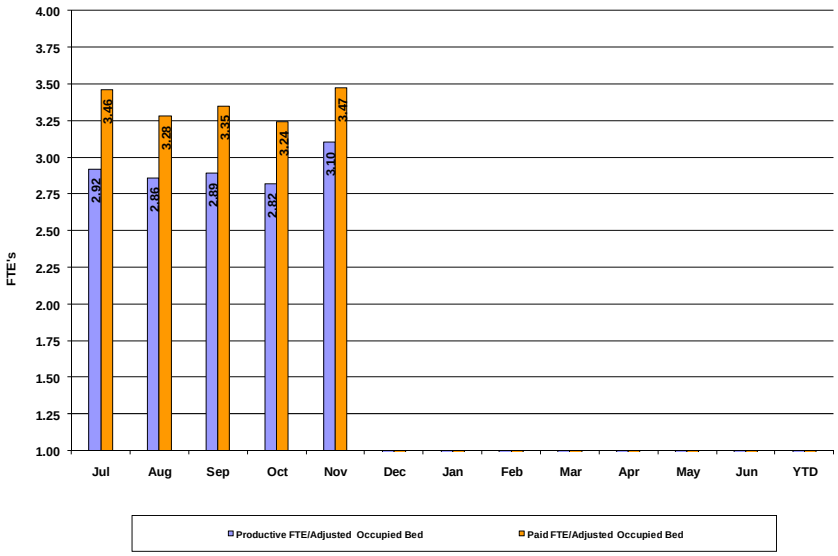
Total operating expenses were greater than the fixed budget by $217,000 or 4.0%. On an adjusted patient day basis, our cost per adjusted patient day was $1,518 which was $97 per adjusted patient day unfavorable to budget. This variance in expenses per adjusted patient day was primarily the result of an unfavorable variance in salaries, registry and benefit costs of $91. The graph below shows the actual hospital operating expenses on an adjusted patient day basis for the 2011 fiscal year by month as compared to budget and is followed by explanations of the significant areas of variance that were experienced in the current month.

Expenses per Adjusted Patient Day



Salary and Registry Expenses
Salary and registry costs combined were unfavorable to the fixed budget by $177,000 and were unfavorable to budgeted levels on a per adjusted patient day basis by $68. On an adjusted occupied bed basis, productive FTE's were unfavorable to budget by 10.7% at 3.12 FTE's versus the budgeted 2.81 FTE's. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2011 by month.

FTE's per Adjusted Occupied Bed



Benefits
Benefits were unfavorable to the fixed budget by $64,000 or 7.5% and $23 or 10.4% on an adjusted patient day basis. This unfavorable variance was the result of greater than budgeted time off accruals of $102,000 offset by lower than budgeted workers insurance expense of $25,000.

Professional Fees
Professional fees were $24,000 favorable to the fixed budget or 7.7% and $4 per adjusted patient day basis. This favorable variance was the result of a $29,000 favorable variance in physician fees offset by $9,000 unfavorable variance in consulting and management fees.

Purchased Services
Purchased services were $17,000 unfavorable to the fixed budget and $7 per adjusted patient day unfavorable to budget in the month of November. This unfavorable variance was the result of the reclassification of expenses incorrectly classified as supply expenses in August. On a year to date basis this expense category is $83,000 favorable to the fixed operating budget.

Rents and Leases
Rents and leases were $10,000 unfavorable to the fixed budget and $3 per adjusted patient day unfavorable to budget in the month of November. This unfavorable variance was the result of additional rental expense for respirators used in the sub-acute program. On a year to date basis this expense category is $9,000 favorable to the fixed budget.

The following pages include the detailed financial statements for the five months ended November 30, 2010, of fiscal year 2011.

ALAMEDA HOSPITAL
KEY STATISTICS
NOVEMBER 2010

	ACTUAL NOVEMBER 2010	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	NOVEMBER 2009	YTD NOVEMBER 2010	YTD FIXED BUDGET	VARIANCE	%	YTD NOVEMBER 2009
Discharges:										
Total Acute	228	208	20	9.6%	180	1,028	1,164	(136)	-11.7%	1,187
Total Sub-Acute	2	1	1	100.0%	2	8	7	1	14.3%	8
Total Skilled Nursing	5	12	(7)	-58.3%	8	40	63	(23)	-36.5%	60
	235	221	14	6.3%	190	1,076	1,234	(158)	-12.8%	1,255
Patient Days:										
Total Acute	947	786	161	20.5%	678	4,260	4,384	(124)	-2.8%	4,481
Total Sub-Acute	968	1,005	(37)	-3.7%	997	4,999	5,124	(125)	-2.4%	5,090
Total Skilled Nursing	657	690	(33)	-4.8%	583	3,329	3,519	(190)	-5.4%	3,071
	2,572	2,481	91	3.7%	2,258	12,588	13,027	(439)	-3.4%	12,642
Average Length of Stay										
Total Acute	4.15	3.78	0.37	9.9%	3.77	4.14	3.77	0.38	10.0%	3.78
Average Daily Census										
Total Acute	31.57	26.20	5.37	20.5%	22.60	27.84	28.65	(0.81)	-2.8%	29.29
Total Sub-Acute	32.27	33.50	(1.23)	-3.7%	33.23	32.67	33.49	(0.82)	-2.4%	33.27
Total Skilled Nursing	21.90	23.00	(1.10)	-4.8%	19.43	21.76	23.00	(1.24)	-5.4%	20.07
	85.73	82.70	3.03	3.7%	75.27	82.27	85.14	(1.63)	-1.9%	82.63
Emergency Room Visits	1,397	1,470	(73)	-5.0%	1,383	7,013	7,500	(487)	-6.5%	7,546
Outpatient Registrations	1,929	2,078	(149)	-7.2%	2,372	9,899	10,841	(942)	-8.7%	12,714
Surgery Cases:										
Inpatient	38	31	7	22.6%	40	229	241	(12)	-5.0%	289
Outpatient	140	151	(11)	-7.3%	400	742	726	16	2.2%	2,196
	178	182	(4)	-2.2%	440	971	967	4	0.4%	2,485
Kaiser Inpatient Cases	-	-	-	-	9	-	-	-	-	48
Kaiser Eye Cases	-	-	-	-	147	-	-	-	-	812
Kaiser Outpatient Cases	-	-	-	-	137	-	-	-	-	837
Total Kaiser Cases	-	-	-	-	293	-	-	-	-	1,697
% Kaiser Cases	0.0%	0.0%			66.6%	0.0%	0.0%			68.3%
Adjusted Occupied Bed	123.72	127.76	4.04	3.2%	138.36	123.65	128.94	(5.29)	-4.1%	146.56
Productive FTE	385.41	359.57	(25.84)	-7.2%	392.19	363.39	362.85	(0.54)	-0.1%	398.36
Total FTE	430.72	411.17	(19.55)	-4.8%	444.41	418.03	416.43	(1.60)	-0.4%	449.96
Productive FTE/Adj. Occ. Bed	3.12	2.81	(0.30)	-10.7%	2.83	2.94	2.81	(0.12)	-4.4%	2.72
Total FTE/ Adj. Occ. Bed	3.48	3.22	(0.26)	-8.2%	3.21	3.38	3.23	(0.15)	-4.7%	3.07

City of Alameda Health Care District
Statements of Financial Position
November 30, 2010
$ in thousands

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ (37,703)	$ 72,350	$ 3,480,668
Patient Accounts Receivable, net	9,905,665	10,100,021	9,558,147
Other Receivables	7,023,783	6,876,657	6,654,035
Third-Party Payer Settlement Receivables	490,632	467,417	374,557
Inventories	1,138,797	1,149,394	1,149,706
Prepaids and Other	711,403	687,919	453,872
Total Current Assets	19,232,577	19,353,758	21,670,985
Assets Limited as to Use, net	528,022	518,605	476,630
Property, Plant and Equipment, net	7,232,112	7,176,793	6,993,735
Total Assets	**$ 26,992,711**	**$ 27,049,156**	**$ 29,141,350**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 420,345	$ 422,456	$ 450,831
Accounts Payable and Accrued Expenses	7,392,365	6,782,865	6,112,296
Payroll Related Accruals	3,957,081	4,218,659	4,351,133
Deferred Revenue	3,345,977	3,823,823	5,736,951
Employee Health Related Accruals	534,416	565,180	645,750
Third-Party Payer Settlement Payable	290,000	290,000	500,000
Total Current Liabilities	15,940,184	16,102,983	17,796,961
Long Term Debt, net	1,077,465	1,113,763	1,236,831
Total Liabilities	17,017,649	17,216,746	19,033,792
Net Assets:			
Unrestricted	9,377,055	9,243,805	9,560,928
Temporarily Restricted	598,007	588,605	546,630
Total Net Assets	9,975,062	9,832,410	10,107,558
Total Liabilities and Net Assets	**$ 26,992,711**	**$ 27,049,156**	**$ 29,141,350**

City of Alameda Health Care District

Statements of Operations

November 30, 2010

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,572	2,481	91	3.7%	2,258	12,588	13,027	(439)	-3.4%	12,642
Discharges	235	222	13	5.9%	190	1,076	1,234	(158)	-12.8%	1,254
ADC (Average Daily Census)	85.7	82.7	3.03	3.7%	75.3	82	85.1	(2.87)	-3.4%	82.6
CMI (Case Mix Index)	1.2949				1.3094	1.3600				1.3206
Revenues										
Gross Inpatient Revenues	$ 14,787	$ 12,644	$ 2,143	16.9%	$ 11,601	$ 68,415	$ 69,543	$ (1,127)	-1.6%	$ 69,164
Gross Outpatient Revenues	6,628	6,862	(234)	-3.4%	9,725	34,586	35,627	(1,041)	-2.9%	53,488
Total Gross Revenues	21,414	19,505	1,909	9.8%	21,327	103,002	105,170	(2,168)	-2.1%	122,652
Contractual Deductions	15,376	13,851	(1,525)	-11.0%	15,639	73,787	75,561	1,774	2.3%	91,374
Bad Debts	582	547	(35)	-6.4%	498	3,105	3,161	56	1.8%	2,598
Charity and Other Adjustments	198	137	(62)	-45.1%	20	808	790	(17)	-2.2%	338
Net Patient Revenues	5,259	4,971	287	5.8%	5,170	25,303	25,658	(356)	-1.4%	28,341
Net Patient Revenue %	24.6%	25.5%			24.2%	24.6%	24.4%			23.1%
Net Clinic Revenue	29	28	1	2.7%	5	149	139	10	6.9%	49
Other Operating Revenue	9	10	(1)	-12.0%	(23)	47	66	(19)	-29.3%	268
Total Revenues	**5,296**	**5,009**	**287**	5.7%	**5,152**	**25,498**	**25,864**	**(365)**	-1.4%	**28,658**
Expenses										
Salaries	2,805	2,731	(73)	-2.7%	3,098	14,614	14,087	(528)	-3.7%	15,989
Registry	253	149	(104)	-69.7%	127	881	853	(29)	-3.4%	867
Benefits	918	854	(64)	-7.5%	918	3,903	4,383	480	10.9%	4,585
Professional Fees	287	311	24	7.7%	298	1,519	1,565	46	2.9%	1,527
Supplies	672	677	5	0.7%	781	3,785	3,484	(301)	-8.6%	4,440
Purchased Services	404	388	(17)	-4.3%	366	1,860	1,942	83	4.3%	1,994
Rents and Leases	78	68	(10)	-14.2%	65	336	345	9	2.7%	345
Utilities and Telephone	65	71	5	7.7%	64	297	360	64	17.7%	359
Insurance	29	35	7	18.7%	44	157	180	23	13.0%	224
Depreciation and amortization	80	73	(8)	-10.4%	104	408	366	(42)	-11.5%	507
Other Opertaing Expenses	62	79	17	21.9%	90	383	406	23	5.8%	456
Total Expenses	**5,654**	**5,436**	**(217)**	-4.0%	**5,957**	**28,142**	**27,971**	**(171)**	-0.6%	**31,292**
Operating gain (loss)	**(357)**	**(427)**	**70**	16.4%	**(805)**	**(2,644)**	**(2,107)**	**(537)**	25.5%	**(2,634)**
Non-Operating Income / (Expense)										
Parcel Taxes	478	481	(3)	-0.5%	481	2,390	2,389	1	0.0%	2,389
Investment Income	0	-	0	0.0%	1	7	-	7	0.0%	7
Interest Expense	(10)	(15)	5	30.8%	(8)	(42)	(61)	19	-31.1%	(44)
Other Income / (Expense)	22	22	0	0.4%	23	106	111	(5)	-4.6%	115
Net Non-Operating Income / (Expense)	**490**	**488**	**2**	**0.5%**	**496**	**2,460**	**2,439**	**21**	**0.9%**	**2,468**
Excess of Revenues Over Expenses	**$ 133**	**$ 61**	**$ 72**	**117.9%**	**$ (309)**	**$ (184)**	**$ 332**	**$ (516)**	**-155.4%**	**$ (167)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

November 30, 2010

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,970	$ 3,303	$ 666	20.2%	$ 2,795	$ 3,610	$ 3,530	$ 80	2.3%	$ 3,085
Gross Outpatient Revenues	1,779	1,793	(13)	-0.7%	2,343	1,825	1,808	17	0.9%	2,386
Total Gross Revenues	5,749	5,096	653	12.8%	5,138	5,435	5,338	97	1.8%	5,471
Contractual Deductions	4,128	3,619	(509)	-14.1%	3,768	3,893	3,835	(58)	-1.5%	4,076
Bad Debts	156	143	(13)	-9.4%	120	164	160	(3)	-2.1%	116
Charity and Other Adjustments	53	36	(18)	-49.1%	5	43	40	(3)	-6.2%	15
Net Patient Revenues	1,412	1,299	113	8.7%	1,245	1,335	1,302	33	2.5%	1,264
Net Patient Revenue %	24.6%	25.5%			24.2%	24.6%	24.4%			23.1%
Net Clinic Revenue	8	7	0	5.5%	1	8	7	1	11.1%	2
Other Operating Revenue	2	3	(0)	-9.6%	(5)	2	3	(1)	-26.5%	12
Total Revenues	**1,422**	**1,309**	**113**	8.6%	**1,241**	**1,346**	**1,313**	**33**	2.5%	**1,279**
Expenses										
Salaries	753	714	(39)	-5.5%	746	771	715	(56)	-7.8%	713
Registry	68	39	(29)	-74.4%	31	46	43	(3)	-7.4%	39
Benefits	246	223	(23)	-10.4%	221	206	222	17	7.4%	205
Professional Fees	77	81	4	5.1%	72	80	79	(1)	-0.9%	68
Supplies	180	177	(4)	-2.1%	188	200	177	(23)	-12.9%	198
Purchased Services	109	101	(7)	-7.2%	88	98	99	0	0.5%	89
Rents and Leases	21	18	(3)	-17.4%	16	18	18	(0)	-1.1%	15
Utilities and Telephone	18	18	1	5.1%	16	16	18	3	14.4%	16
Insurance	8	9	2	16.5%	11	8	9	1	9.6%	10
Depreciation and Amortization	22	19	(3)	-13.4%	25	22	19	(3)	-15.9%	23
Other Operating Expenses	17	21	4	19.7%	22	20	21	0	2.1%	20
Total Expenses	**1,518**	**1,420**	**(97)**	-6.9%	**1,435**	**1,485**	**1,420**	**(65)**	-4.6%	**1,396**
Operating Gain / (Loss)	**(96)**	**(112)**	**16**	14.0%	**(194)**	**(139)**	**(107)**	**(33)**	30.5%	**(117)**
Net Non-Operating Income / (Expense)	**132**	**128**	**4**	**3.2%**	**119**	**130**	**124**	**6**	**4.9%**	**110**
Excess of Revenues Over Expenses	**$ 36**	**$ 16**	**$ 20**	123.9%	**$ (74)**	**$ (9)**	**$ 17**	**$ (27)**	-155.3%	**$ (7)**

City of Alameda Health Care District
Statement of Cash Flows
For the Five Months Ended November 30, 2010
$ in thousands

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ 133,250	$ (183,872)
Items not requiring the use of cash:		
Depreciation and amortization	80,332	$ 408,112
Changes in certain assets and liabilities:		
Patient accounts receivable, net	194,356	(347,518)
Other Receivables	(147,126)	(369,748)
Third-Party Payer Settlements Receivable	(23,215)	(326,075)
Inventories	10,597	10,909
Prepaids and Other	(23,484)	(257,531)
Accounts payable and accrued liabilities	609,500	1,280,069
Payroll Related Accruals	(261,578)	(394,052)
Employee Health Plan Accruals	(30,764)	(111,334)
Deferred Revenues	(477,846)	(2,390,974)
Cash provided by (used in) operating activities	64,022	(2,682,014)
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(9,417)	(51,392)
Additions to Property, Plant and Equipment	(135,651)	(646,489)
Other	0	(1)
Cash provided by (used in) investing activities	(145,068)	(697,882)
Cash flows from financing activities		
Net Change in Long-Term Debt	(38,409)	(189,852)
Net Change in Restricted Funds	9,402	51,377
Cash provided by (used in) financing and fundraising activities	(29,007)	(138,475)
Net increase (decrease) in cash and cash equivalents	(110,053)	(3,518,371)
Cash and cash equivalents at beginning of period	72,350	3,480,668
Cash and cash equivalents at end of period	$ (37,703)	$ (37,703)

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING DECEMBER 31, 2010

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
DECEMBER 31, 2010

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
DECEMBER, 2010

The management of the Alameda Hospital (the "Hospital") has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending December 31, 2010 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of December, 2010

- Gross patient revenue for the month of December was greater than budget by $47,000 or 0.2%. Inpatient and outpatient revenue was greater than budgeted by 4.4% and less than budget by 8.2% for the month, respectively. On adjusted patient day basis gross patient revenue were 3.6% greater than budgeted at $5,593 compared to a budgeted amount of $5,399 for December.

- Total patient days for the month were 2,658 compared to the prior month's total patient days of 2,572 and the prior year's 2,643 total patient days. The average daily acute care census was 31.3 compared to a budget of 28.6 and an actual average daily census of 31.6 in the prior month; the average daily Sub-Acute census was 32.4 versus a budget of 33.5 and 32.3 in the prior month and the Skilled Nursing program had an average daily census of 22.0 versus a budget of 23.0 and prior month census of 21.9, respectively.

- Emergency Care Center (ECC) visits were 1,368 or 9.9% less than the budgeted 1,519 visits and were 7.1% less than the prior year's visits of 1,472.

- Total surgery cases were less than budgeted expectations for the month at 184 cases versus the budgeted 219 cases. The current month's surgical volume was 1.1% less than the same month prior year's 186 cases.

- Outpatient registrations were 4.4% below budgeted targets at 1,911 and slightly lower than the prior month's 1,929 outpatient visits.

- Combined excess revenue over expenses (profit) for December was $134,000 versus a budgeted excess of revenue over expenses (profit) of $239,000. This brings our year-to-date loss to $49,000 versus a budgeted profit of $571,000.

  - Total assets decreased by $847,000 from the prior month as a result of a decrease in current assets of $1,078,000, an increase in net fixed assets of $220,000 and an increase in restricted contributions of $11,000. The following items make up the decrease in current assets:

  - Total unrestricted cash and cash equivalents for December increased by $862,000 and days cash on hand including restricted use funds increased to 7.5 days on hand in December from 2.7 days on hand in November.

  - Net patient accounts receivable increased in December by $764,000 compared to a decrease of $194,000 in November. Day's in outstanding receivables increased to 64.9 in December from 60.4 at November 30, 2010. Collections in December totaled $4.1 million compared to $5.1 million in November.

  - Other assets decreased by $2,730,000 as a result of the receipt of the December installment of the parcel tax revenues offset by the accrual of $187,000 (1/12th of the estimated amount) for the estimated amount of Inter-

Governmental transfer funds that are anticipated to be received in FY 2011.

- Total liabilities decreased by $1,020,000 compared to a decrease of $199,000 in the prior month. This decrease in the current month was the result of the following:

  - Accounts payable and accrued expenses decreased by $812,000 while payroll and accrued expenses increased by $299,000. As a result of this net decrease of $513,000 and a slight decrease in average daily expenses as of December 31st, the average payment period decreased in December to 62.8 from 65.5 as of November 30, 2010.

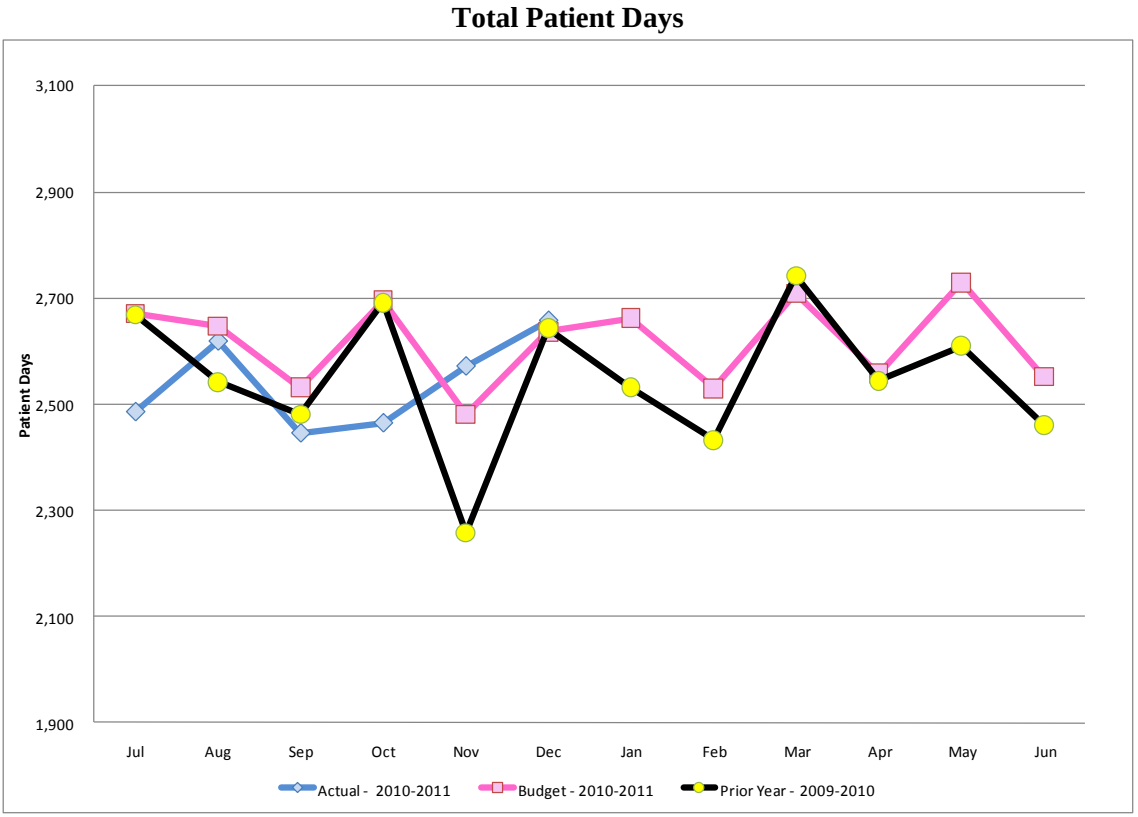
  - Payroll and benefit related accruals increased by $299,000 from the prior month. This decrease was primarily the result of an increase in accrued payroll and related payroll tax accruals of $416,000 offset by an increase in accrued time off of $102,000.

  - Other liabilities decreased by $469,000 as a result of the amortization of one-twelfth of the annual parcel tax revenues for the 2011 fiscal year which decreased other liabilities by $478,000.

Volumes

The combined actual daily census was 85.7 versus a budget of 85.1 or a 0.8% or 0.7 patients per day favorable variance. The current month's favorable variance from the budgeted census was the result of an acute care services average daily census that exceeded budget in the acute care areas by 2.83 patients per day or 9.9%. The Sub-Acute and Skilled Nursing programs were below budgeted expectations with an average daily census of 32.4 versus the budgeted 33.5 and 22.0 versus the budgeted average daily census of 23.0, respectively.

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

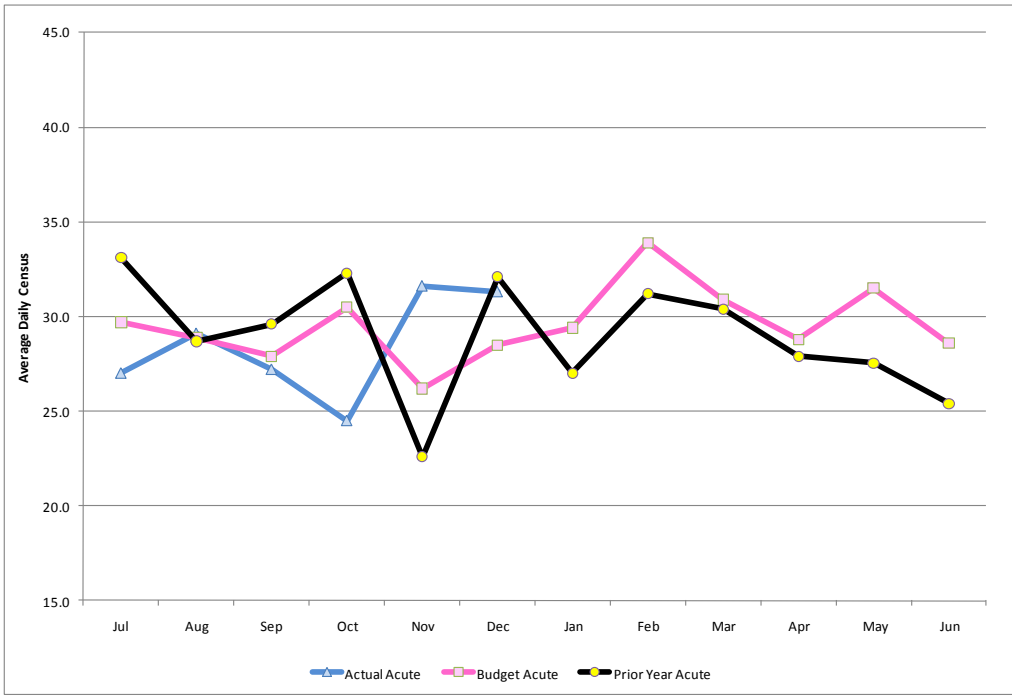


The various inpatient components of our inpatient volumes for the month of November are discussed in the following sections.

Acute Care

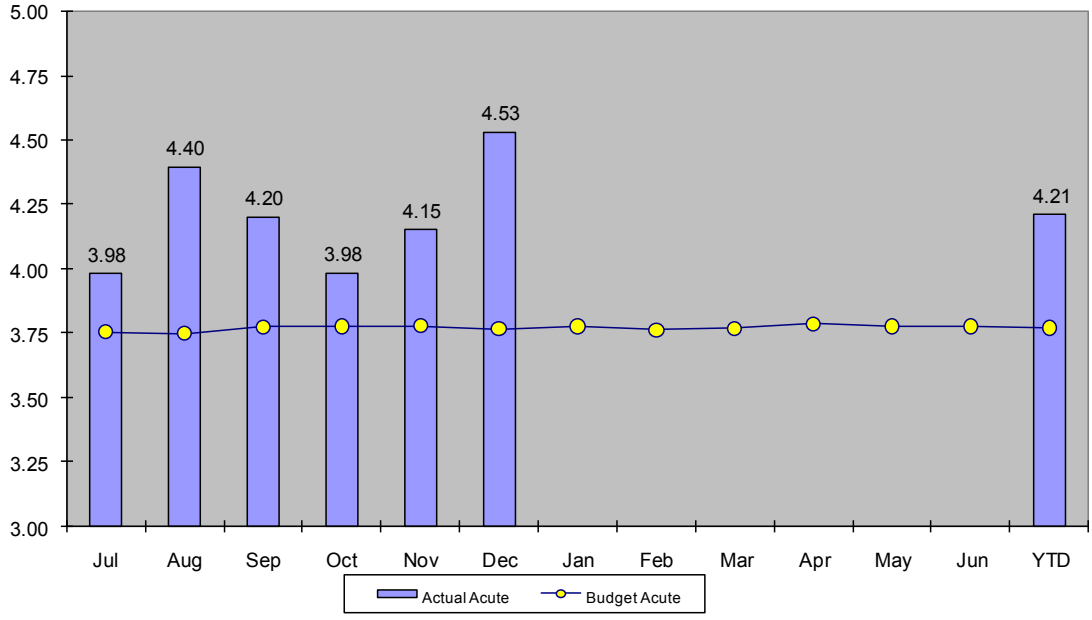
The acute care patient days were 9.9% (85 days) greater than budgeted and were on 2.4% less than the prior year's average daily census of 32.06. The acute care program is comprised of the Critical Care Unit (5.0 ADC, 49.0% favorable to budget), Definitive Observation Unit (8.4 ADC, 27.9% unfavorable to budget) and Med/Surg Units (17.8 ADC, 31.0% unfavorable to budget). The graph on the following page shows the inpatient acute care census by month for the current fiscal year, the operating budget and prior fiscal year actual.

Inpatient Acute Care Average Daily Census



The average length of stay (ALOS) increased from that of the prior month to 4.53 days for the month of December bringing the year-to-date average to 4.21 versus the budgeted FY 2011 average of 3.77. The graph below shows the ALOS by month and the budgeted ALOS for fiscal year 2011.

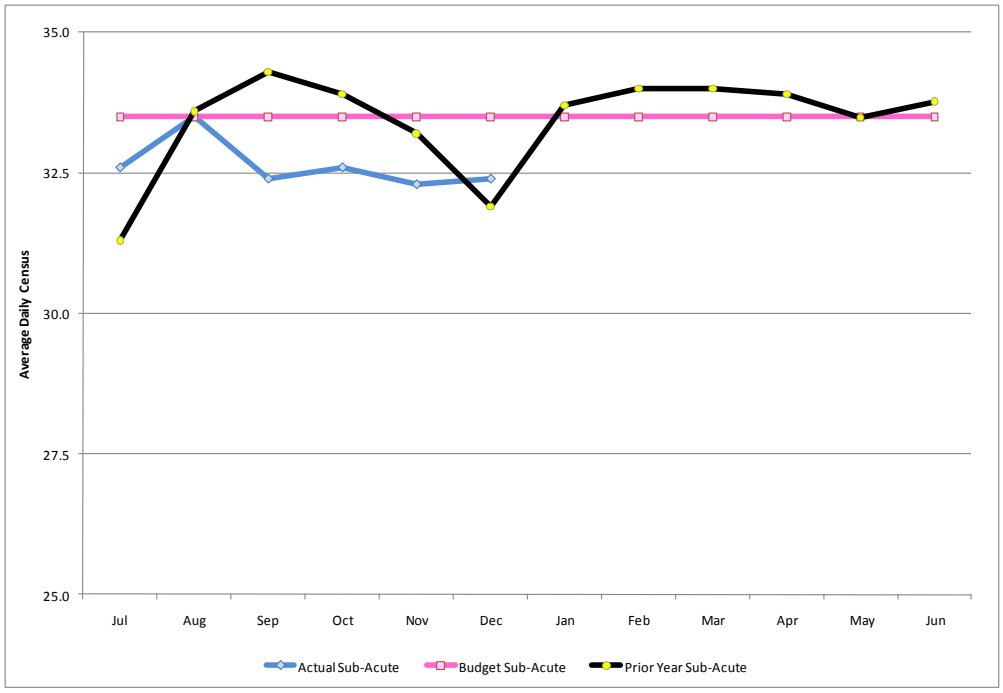
Average Length of Stay



Sub-Acute Care

The Sub-Acute program patient days were below budgeted projections with an average daily census of 32.4 for the month of December which was budgeted for an average daily census of 33.5. The graph on the following page shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

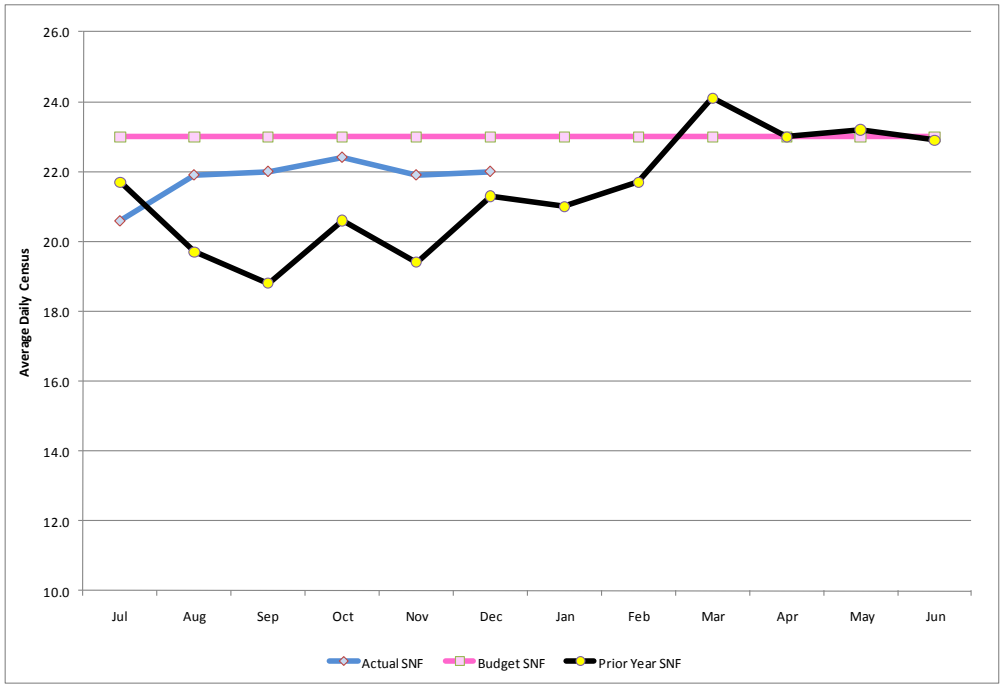
Sub-Acute Care Average Daily Census



Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were 4.3% or 30 patient days less than budgeted for the month of December. Comparing performance to the prior year this program remains slightly greater than the prior year's performance for the first six months of fiscal year 2010 with an average daily census of 21.8 versus 20.3. The following graph shows the Skilled Nursing Unit monthly average daily census as compared to budget and the prior year.

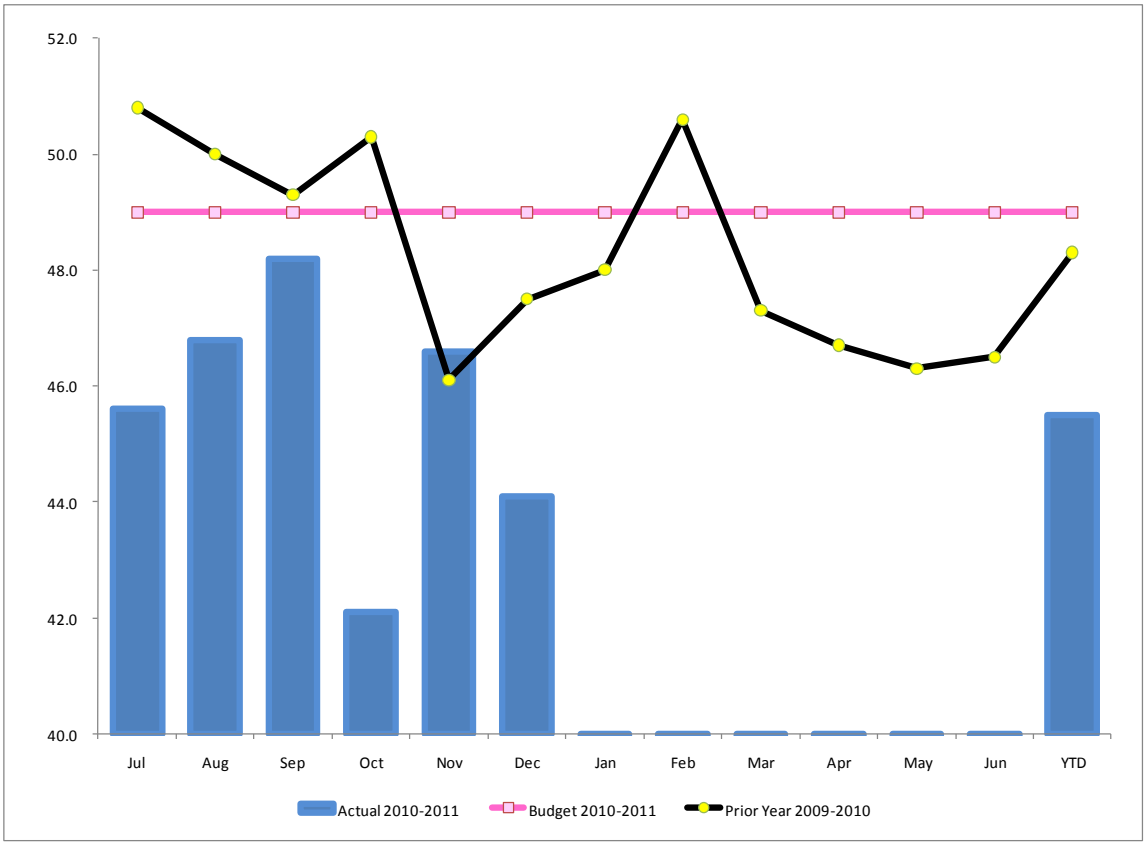
Skilled Nursing Unit Average Daily Census



Emergency Care Center (ECC)

Emergency Care Center visits in December totaled 1,368 and were 9.9% less than budgeted for the month with 16.0% of these visits resulting in inpatient admissions versus 17.3% in November. In December there were 277 ambulance arrivals versus 289 in the prior month, a decrease of 4.2%. Of the 277 ambulance arrivals in the current month 141 or 50.9% were from Alameda Fire Department (AFD) ambulances. The graph below shows the Emergency Care Centers average visits per day for fiscal year 2011 as compared to budget and the prior year performance.

Emergency Care Center Visits per Day

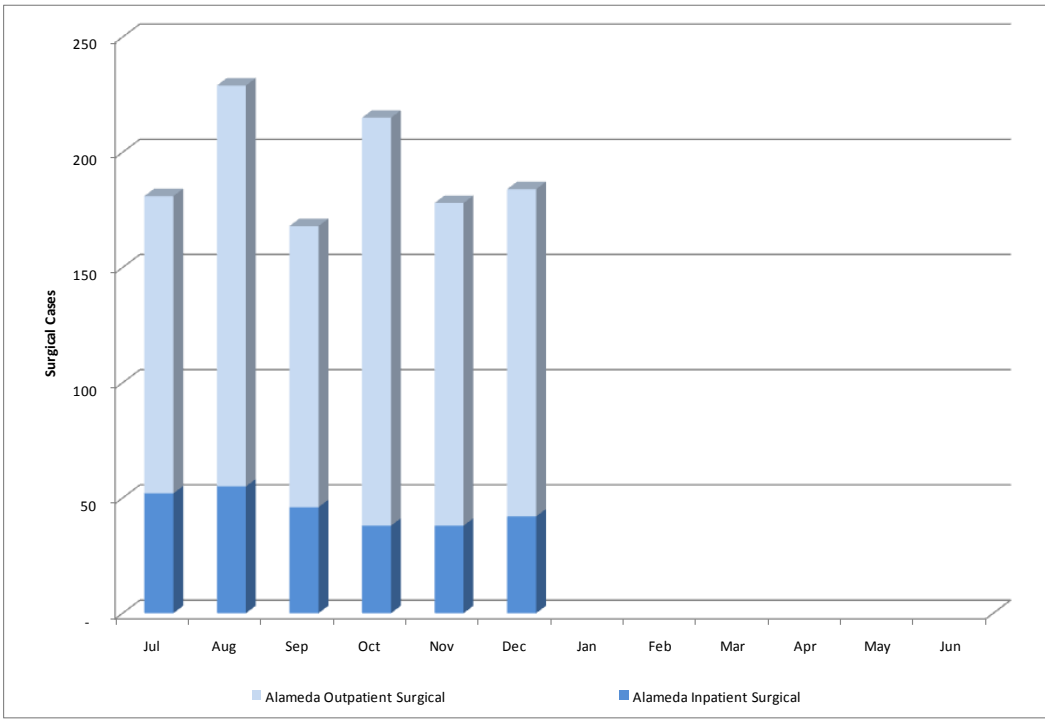


Surgery

Surgery cases were 184 versus the 219 budgeted cases and 186 cases in the prior year. In December, surgery cases increased over the prior month by 3.4%. The increase of 6 cases over the prior month was the result of an increase of 4 and 2 inpatient and outpatient cases, respectively. Inpatient and outpatient cases totaled 42 and 142 versus 38 and 140 in December and November, respectively. The slight increase in cases from the prior month was driven by increases in General (11), GI cases (4) and Plastics (3) offset by increases in Orthopedics (8) and Vascular (4).

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

Surgical Cases

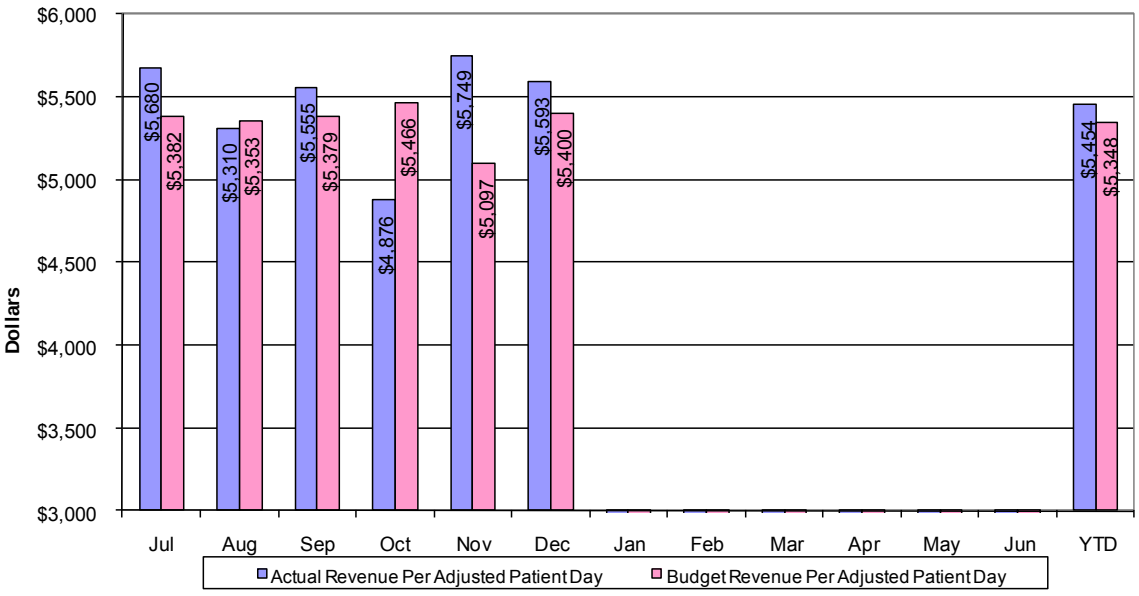


Income Statement

Gross Patient Charges

Gross patient charges in December were greater than budgeted by $47,000. This favorable variance was comprised of a favorable variance of $628,000 and an unfavorable variance of $581,000 in inpatient and outpatient revenues, respectively. On an adjusted patient day basis total patient revenue was $5,593 versus the budgeted $5,399 or a favorable variance of 3.6% from budget for the month of December. The following table shows the hospitals monthly gross revenue per adjusted patient day by month and year-to-date for fiscal year 2011 compared to budget.

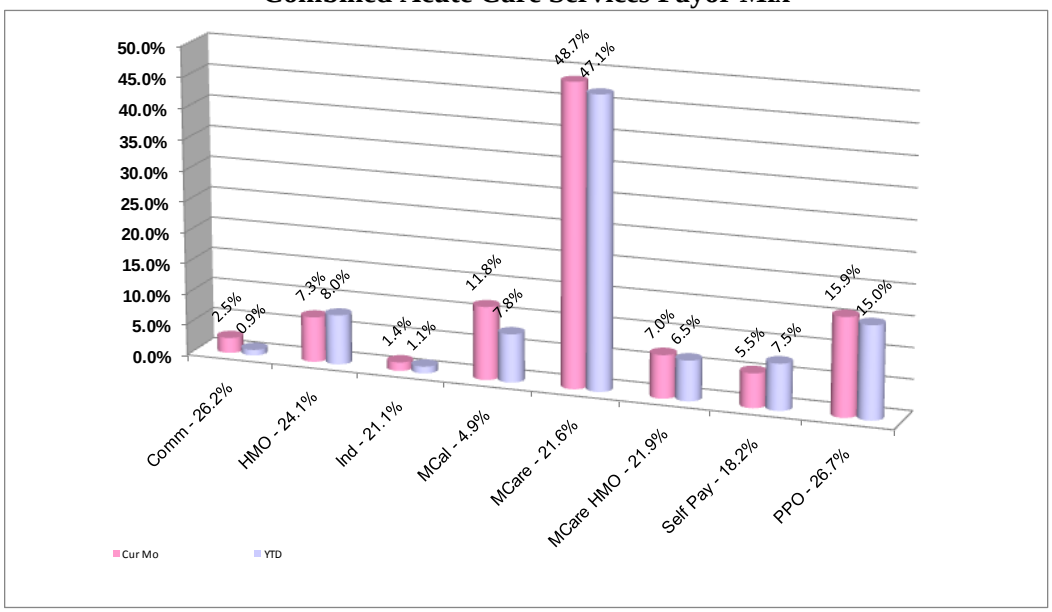
Gross Charges per Adjusted Patient Day



Payor Mix

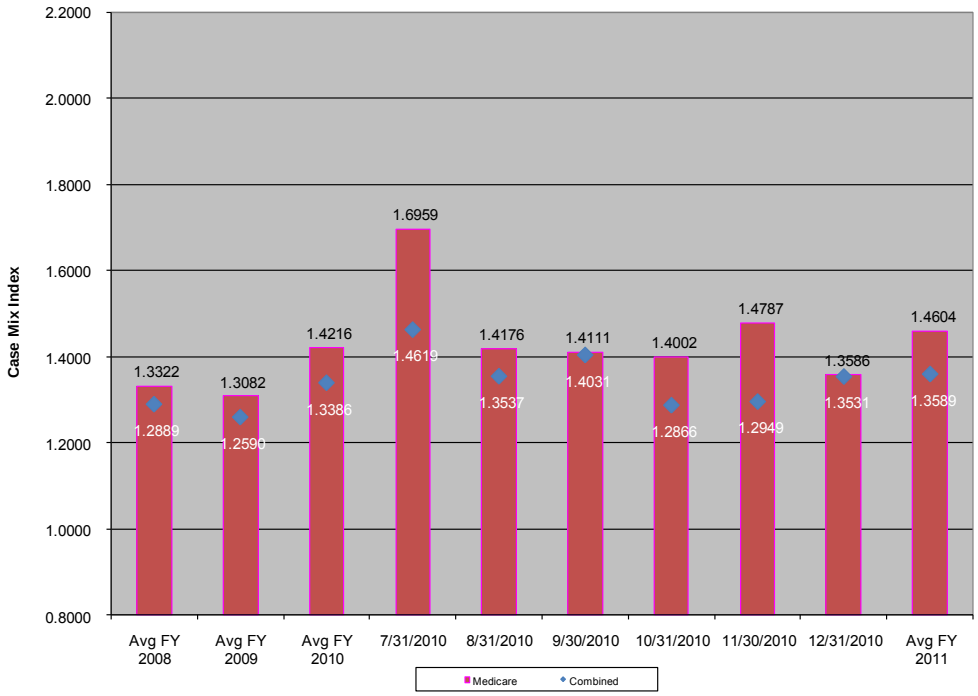
Combined inpatient and outpatient acute care Medicare and Medicare Advantage total gross revenue in December made up 55.7% of the months total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 23.2%, Medi-Cal Traditional and Medi-Cal HMO utilization at 11.8% and self pay at 5.5%. The graph below shows the percentage of gross revenues generated by each of the major payors for the current month and fiscal year to date as well as the current months estimated reimbursement for each payor for the combined inpatient and outpatient acute care services.

Combined Acute Care Services Payor Mix



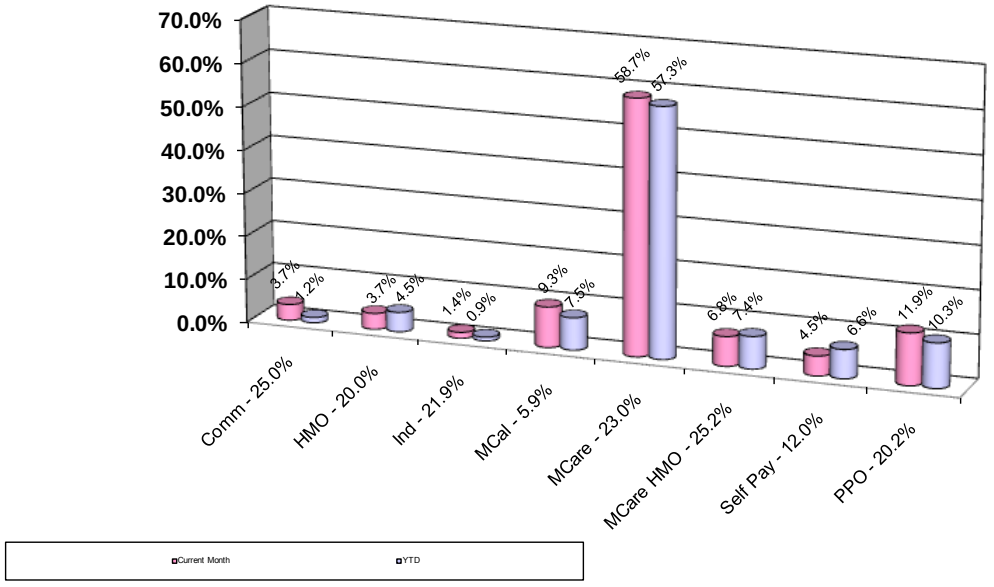
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 65.5% of our total inpatient acute care gross revenues followed by HMO/PPO at 15.6%, Medi-Cal and Medi-Cal HMO at 9.3% and Self Pay at 4.5% of the inpatient acute care revenue. The hospitals overall Case Mix Index (CMI) increased to 1.3531 from 1.22949 in the prior month and the Medicare CMI decreased over the prior month from 1.4787 in November to 1.3586 in December. In December there were three (3) outlier cases in the month. The estimated Medicare reimbursement decreased to 23.0% in December versus 24.7% in November. The graph on the following page shows the CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

Case Mix Index Comparison



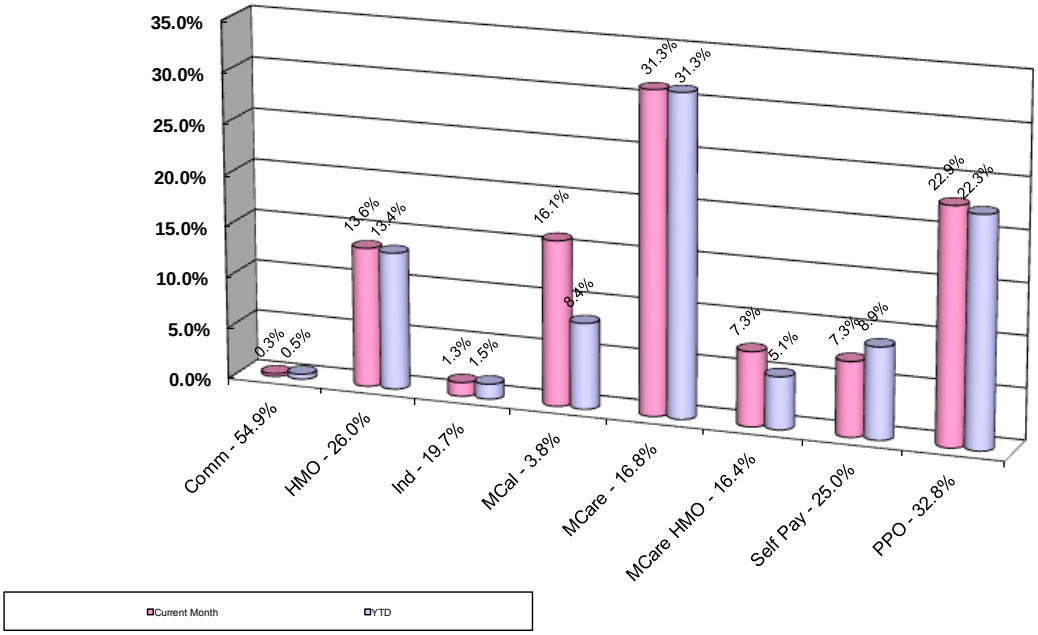
The overall net inpatient revenue percentage decreased from the prior month to 20.7% in December versus 22.2% in November. The graph below shows inpatient acute care current month and year to date payor mix and current month estimated net revenue percentages for fiscal year 2011.

Inpatient Acute Care Payor Mix



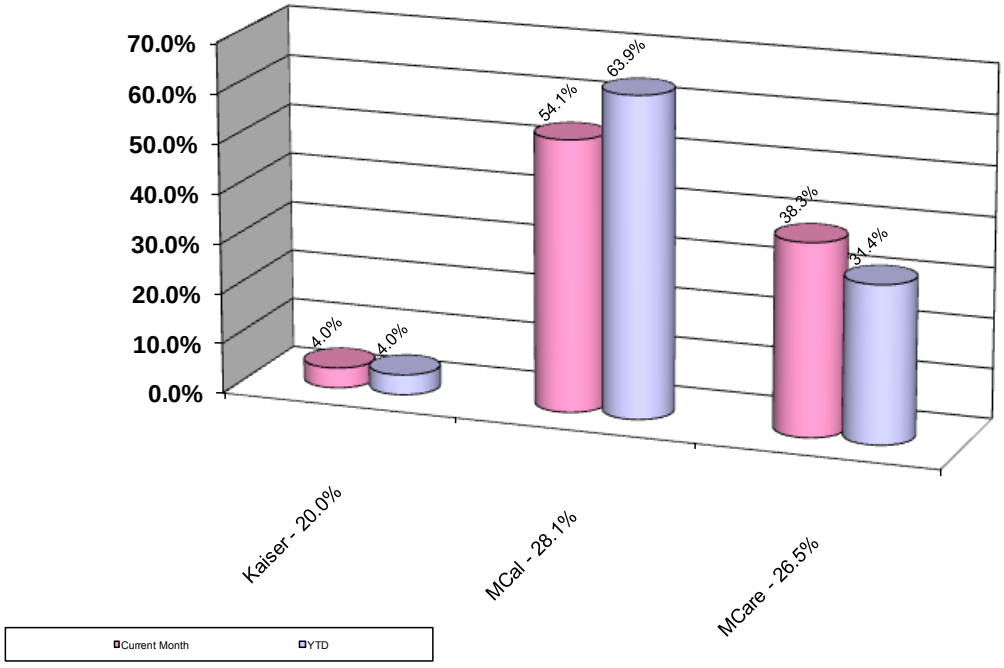
The outpatient gross revenue payor mix for December was comprised of 38.6% Medicare and Medicare Advantage, 36.5% HMO/PPO, 16.1% Medi-Cal and Medi-Cal HMO, and 7.3% self pay. The graph on the following page shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

Outpatient Services Payor Mix



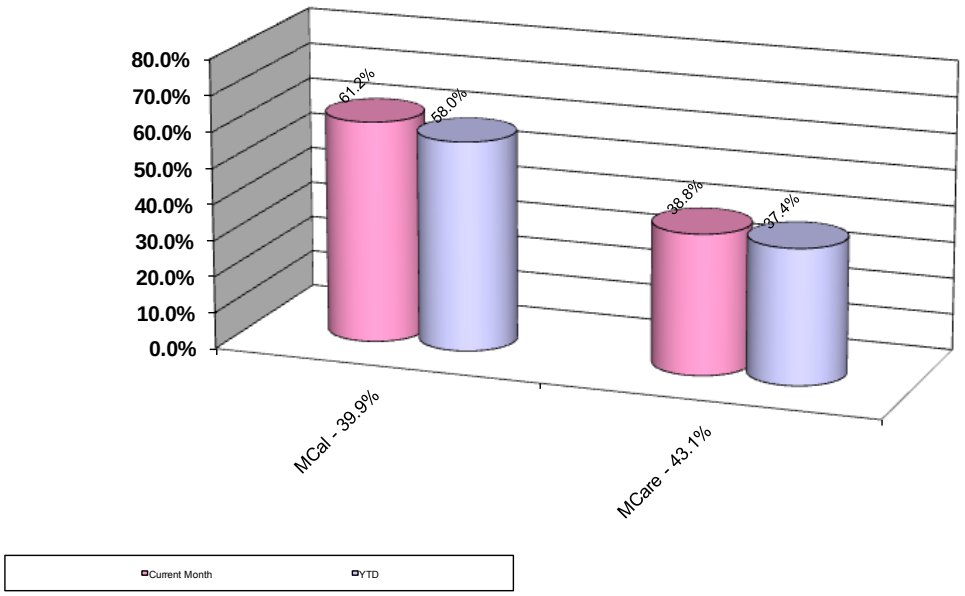
In December the Sub-Acute care program again was dominated by Medi-Cal utilization of 54.1% versus 59.1% in November. The graph below shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.

Inpatient Sub-Acute Care Payor Mix



In December the Skilled Nursing program was again comprised primarily of Medi-Cal at 61.2% and Medicare at 38.8%. The graph below shows the current month and fiscal year to date skilled nursing payor mix and the current months estimated level of reimbursement for each payor.

Inpatient Skilled Nursing Payor Mix

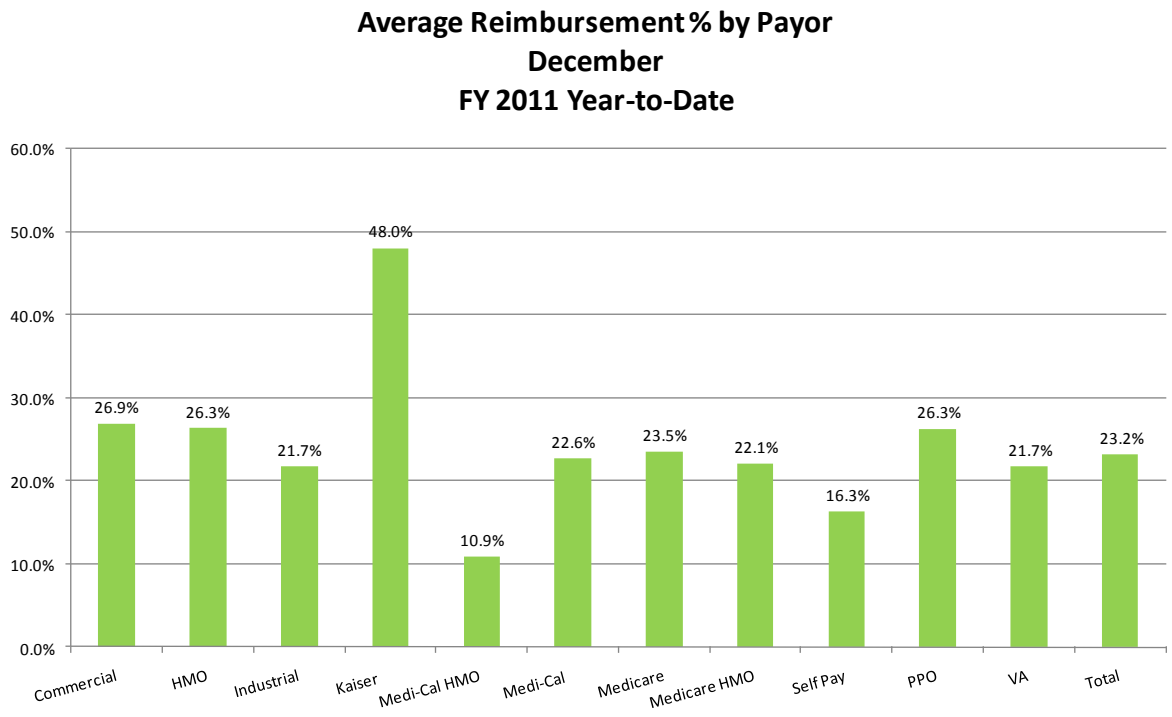


Deductions from Revenue

Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross. In the month of December contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 75.4% versus the budgeted 75.0%.

Net Patient Service Revenue

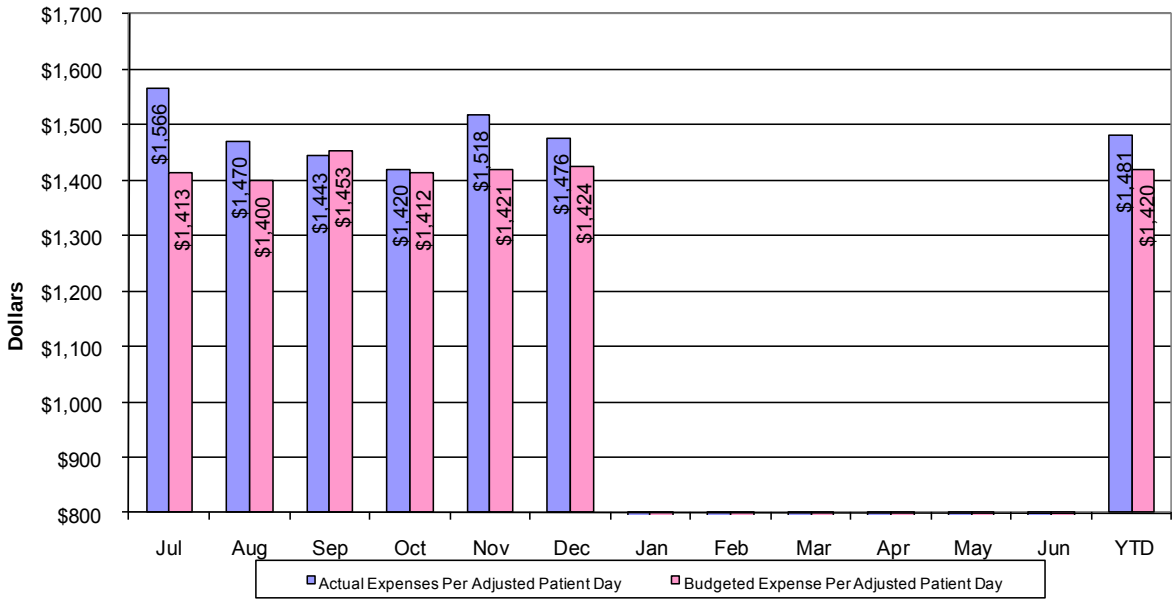
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. In addition, included in net patient service revenue are the estimated amounts to be received from participation in the State of California's Intergovernmental Transfer Program, $187,000 per month and $1,122,000 for the six month ended December 31, 2010. The graph on the following page shows the level of reimbursement that the Hospital has estimated for fiscal year 2011 by major payor category.



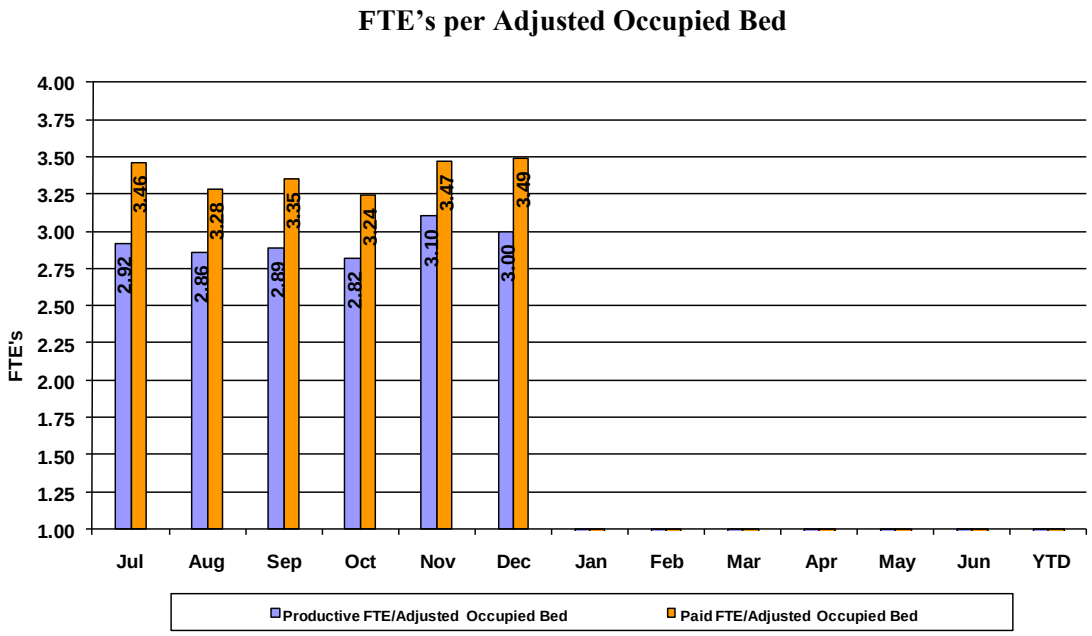
Total Operating Expenses

Total operating expenses were greater than the fixed budget by $17,000 or 0.3%. On an adjusted patient day basis, our cost per adjusted patient day was $1,476 which was $52 per adjusted patient day unfavorable to budget. This variance in expenses per adjusted patient day was primarily the result of an unfavorable variance in salaries and registry costs of $104. The graph below shows the actual hospital operating expenses on an adjusted patient day basis for the 2011 fiscal year by month as compared to budget and is followed by explanations of the significant areas of variance that were experienced in the current month.

Expenses per Adjusted Patient Day



Salary and Registry Expenses
Salary and registry costs combined were unfavorable to the fixed budget by $301,000 and were unfavorable to budgeted levels on a per adjusted patient day basis by $104. On an adjusted occupied bed basis, productive FTE's were unfavorable to budget by 6.4% at 3.02 FTE's versus the budgeted 2.84 FTE's. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2011 by month.



Benefits
Benefits were favorable to the fixed budget by $169,000 or 19.6% and $37 or 16.9% on an adjusted patient day basis. This favorable variance was the result of greater than budgeted group health insurance claims ($52,000), time off accruals ($96,000) and workers insurance expense ($25,000).

Supplies
Supplies expense was favorable $92,000 to the fixed budget and $18 per adjusted patient day. This favorable variance was the result of favorable variances in medical supplies of $111,000 offset by unfavorable variances in non-medical supplies of $14,000.

Purchased Services
Purchased services were $17,000 unfavorable to the fixed budget and $8 per adjusted patient day unfavorable to budget in the month of December. This unfavorable variance was the result of an unfavorable variance of $36,000 in non-medical expenses offset by lower than budgeted medical purchased services of $16,000 and repairs and maintenance of $4,000.

Utilities and Telephone
Utilities and telephone were $14,000 to the fixed budget and $3 per adjusted patient day favorable to budget in the month of December. This favorable variance was the result of lower than budgeted electricity costs in the month.

The following pages include the detailed financial statements for the six months ended December 31, 2010, of fiscal year 2011.

ALAMEDA HOSPITAL
KEY STATISTICS
DECEMBER 2010

	ACTUAL DECEMBER 2010	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	DECEMBER 2009	YTD DECEMBER 2010	YTD FIXED BUDGET	VARIANCE	%	YTD DECEMBER 2009
Discharges:										
Total Acute	214	235	(21)	-8.9%	273	1,242	1,399	(157)	-11.2%	1,460
Total Sub-Acute	4	2	2	100.0%	1	12	9	3	33.3%	9
Total Skilled Nursing	3	12	(9)	-75.0%	12	43	75	(32)	-42.7%	72
	221	249	(28)	-11.2%	286	1,297	1,483	(186)	-12.5%	1,541
Patient Days:										
Total Acute	970	885	85	9.6%	994	5,230	5,269	(39)	-0.7%	5,475
Total Sub-Acute	1,005	1,039	(34)	-3.3%	988	6,004	6,163	(159)	-2.6%	6,078
Total Skilled Nursing	683	713	(30)	-4.2%	661	4,012	4,232	(220)	-5.2%	3,732
	2,658	2,637	21	0.8%	2,643	15,246	15,664	(418)	-2.7%	15,285
Average Length of Stay										
Total Acute	4.53	3.77	0.77	20.4%	3.64	4.21	3.77	0.44	11.8%	3.75
Average Daily Census										
Total Acute	31.29	28.55	2.83	9.9%	32.06	28.42	28.64	(0.21)	-0.7%	29.76
Total Sub-Acute	32.42	33.52	(1.13)	-3.4%	31.87	32.63	33.49	(0.86)	-2.6%	33.03
Total Skilled Nursing	22.03	23.00	(1.00)	-4.3%	21.32	21.80	23.00	(1.20)	-5.2%	20.28
	85.74	85.06	0.70	0.8%	85.26	82.86	85.13	(1.08)	-1.3%	83.07
Emergency Room Visits	1,368	1,519	(151)	-9.9%	1,472	8,381	9,019	(638)	-7.1%	9,018
Outpatient Registrations	1,911	1,999	(88)	-4.4%	2,343	11,810	12,840	(1,030)	-8.0%	15,057
Surgery Cases:										
Inpatient	42	58	(16)	-27.6%	69	271	299	(28)	-9.4%	358
Outpatient	142	161	(19)	-11.8%	401	884	887	(3)	-0.3%	2,597
	184	219	(35)	-16.0%	470	1,155	1,186	(31)	-2.6%	2,955
Kaiser Inpatient Cases	-	-	-	-	11	-	-	-	-	59
Kaiser Eye Cases	-	-	-	-	135	-	-	-	-	947
Kaiser Outpatient Cases	-	-	-	-	138	-	-	-	-	975
Total Kaiser Cases	-	-	-	-	284	-	-	-	-	1,981
% Kaiser Cases	0.0%	0.0%			60.4%	0.0%	0.0%			67.0%
Adjusted Occupied Bed	122.57	127.67	5.10	4.0%	142.36	123.44	128.72	(5.28)	-4.1%	145.83
Productive FTE	370.60	362.97	(7.63)	-2.1%	395.02	364.60	365.32	0.72	0.2%	397.80
Total FTE	430.29	412.99	(17.30)	-4.2%	454.66	420.10	415.85	(4.25)	-1.0%	450.77
Productive FTE/Adj. Occ. Bed	3.02	2.84	(0.18)	-6.4%	2.77	2.95	2.84	(0.12)	-4.1%	2.73
Total FTE/ Adj. Occ. Bed	3.51	3.23	(0.28)	-8.5%	3.19	3.40	3.23	(0.17)	-5.3%	3.09

City of Alameda Health Care District
Statements of Financial Position
December 31, 2010
$ in thousands

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 824,459	$ (37,703)	$ 3,480,668
Patient Accounts Receivable, net	10,669,772	9,905,665	9,558,147
Other Receivables	4,330,040	7,023,783	6,654,035
Third-Party Payer Settlement Receivables	513,847	490,632	374,557
Inventories	1,141,407	1,138,797	1,149,706
Prepaids and Other	675,214	711,403	453,872
Total Current Assets	18,154,739	19,232,577	21,670,985
Assets Limited as to Use, net	539,259	528,022	476,630
Property, Plant and Equipment, net	7,451,772	7,232,112	6,993,735
Total Assets	**$ 26,145,770**	**$ 26,992,711**	**$ 29,141,350**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 418,224	$ 420,345	$ 450,831
Accounts Payable and Accrued Expenses	6,580,094	7,392,365	6,112,296
Payroll Related Accruals	4,256,191	3,957,081	4,351,133
Deferred Revenue	2,868,061	3,345,977	5,736,951
Employee Health Related Accruals	543,701	534,416	645,750
Third-Party Payer Settlement Payable	290,000	290,000	500,000
Total Current Liabilities	14,956,271	15,940,184	17,796,961
Long Term Debt, net	1,041,216	1,077,465	1,236,831
Total Liabilities	15,997,487	17,017,649	19,033,792
Net Assets:			
Unrestricted	9,511,448	9,377,055	9,560,928
Temporarily Restricted	636,835	598,007	546,630
Total Net Assets	10,148,283	9,975,062	10,107,558
Total Liabilities and Net Assets	**$ 26,145,770**	**$ 26,992,711**	**$ 29,141,350**

City of Alameda Health Care District

Statements of Operations

December 31, 2010

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,658	2,637	21	0.8%	2,643	15,246	15,664	(418)	-2.7%	15,285
Discharges	221	249	(28)	-11.2%	286	1,297	1,483	(186)	-12.5%	1,540
ADC (Average Daily Census)	85.7	85.1	0.68	0.8%	85.3	83	85.1	(2.27)	-2.7%	83.1
CMI (Case Mix Index)	1.3531				1.2620	1.3589				1.3108
Revenues										
Gross Inpatient Revenues	$ 14,866	$ 14,238	$ 628	4.4%	$ 14,827	$ 83,281	$ 83,781	$ (500)	-0.6%	$ 83,991
Gross Outpatient Revenues	6,521	7,102	(581)	-8.2%	10,003	41,108	42,730	(1,622)	-3.8%	63,491
Total Gross Revenues	21,387	21,340	47	0.2%	24,830	124,389	126,510	(2,122)	-1.7%	147,481
Contractual Deductions	15,389	15,221	(168)	-1.1%	18,438	89,176	90,785	1,609	1.8%	109,812
Bad Debts	670	634	(36)	-5.7%	738	3,774	3,794	20	0.5%	3,336
Charity and Other Adjustments	78	158	81	51.0%	(1)	885	949	64	6.7%	338
Net Patient Revenues	5,251	5,328	(77)	-1.4%	5,654	30,553	30,983	(429)	-1.4%	33,995
Net Patient Revenue %	24.6%	25.0%			22.8%	24.6%	24.5%			23.1%
Net Clinic Revenue	26	28	(2)	-7.4%	14	175	167	8	4.5%	63
Other Operating Revenue	12	14	(2)	-11.1%	16	59	83	(24)	-29.2%	284
Total Revenues	**5,289**	**5,369**	**(81)**	-1.5%	**5,685**	**30,787**	**31,233**	**(446)**	-1.4%	**34,343**
Expenses										
Salaries	3,045	2,829	(215)	-7.6%	3,136	17,659	16,916	(743)	-4.4%	19,125
Registry	258	171	(86)	-50.3%	149	1,139	1,024	(115)	-11.2%	1,016
Benefits	694	863	169	19.6%	894	4,597	5,245	649	12.4%	5,479
Professional Fees	309	316	7	2.1%	293	1,828	1,881	52	2.8%	1,820
Supplies	626	718	92	12.9%	940	4,411	4,202	(209)	-5.0%	5,380
Purchased Services	412	394	(17)	-4.4%	412	2,271	2,336	65	2.8%	2,406
Rents and Leases	72	70	(3)	-3.8%	69	408	415	7	1.6%	414
Utilities and Telephone	59	73	14	18.9%	65	356	433	78	17.9%	423
Insurance	31	36	4	12.0%	44	188	216	28	12.8%	267
Depreciation and amortization	79	74	(6)	-7.9%	104	488	440	(48)	-10.9%	611
Other Opertaing Expenses	61	85	24	28.6%	70	443	491	48	9.7%	526
Total Expenses	**5,645**	**5,628**	**(17)**	-0.3%	**6,175**	**33,787**	**33,599**	**(188)**	-0.6%	**37,467**
Operating gain (loss)	**(356)**	**(259)**	**(98)**	-37.7%	**(490)**	**(3,000)**	**(2,366)**	**(634)**	26.8%	**(3,124)**
Non-Operating Income / (Expense)										
Parcel Taxes	478	491	(13)	-2.6%	491	2,868	2,880	(12)	-0.4%	2,880
Investment Income	1	-	1	0.0%	2	7	-	7	0.0%	9
Interest Expense	(11)	(15)	4	29.7%	(8)	(52)	(76)	23	-30.8%	(52)
Other Income / (Expense)	22	22	0	0.7%	23	128	133	(5)	-3.7%	138
Net Non-Operating Income / (Expense)	**491**	**498**	**(7)**	**-1.4%**	**506**	**2,951**	**2,937**	**14**	**0.5%**	**2,974**
Excess of Revenues Over Expenses	**$ 134**	**$ 239**	**$ (105)**	**-43.8%**	**$ 17**	**$ (49)**	**$ 571**	**$ (620)**	**-108.7%**	**$ (150)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

December 31, 2010

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,887	$ 3,602	$ 285	7.9%	$ 3,350	$ 3,657	$ 3,542	$ 115	3.3%	$ 3,129
Gross Outpatient Revenues	1,705	1,797	(92)	-5.1%	2,260	1,805	1,807	(1)	-0.1%	2,366
Total Gross Revenues	5,593	5,399	194	3.6%	5,610	5,462	5,349	114	2.1%	5,495
Contractual Deductions	4,024	3,851	(173)	-4.5%	4,166	3,916	3,838	(78)	-2.0%	4,091
Bad Debts	175	160	(15)	-9.3%	167	166	160	(5)	-3.3%	124
Charity and Other Adjustments	20	40	20	49.4%	(0)	39	40	1	3.1%	13
Net Patient Revenues	1,373	1,348	25	1.9%	1,277	1,342	1,310	32	2.4%	1,267
Net Patient Revenue %	24.6%	25.0%			22.8%	24.6%	24.5%			23.1%
Net Clinic Revenue	7	7	(0)	-4.3%	3	8	7	1	8.6%	2
Other Operating Revenue	3	4	(0)	-8.2%	4	3	4	(1)	-26.4%	11
Total Revenues	**1,383**	**1,358**	**25**	1.8%	**1,284**	**1,352**	**1,321**	**32**	2.4%	**1,280**
Expenses										
Salaries	796	716	(80)	-11.2%	709	775	715	(60)	-8.4%	713
Registry	67	43	(24)	-55.4%	34	50	43	(7)	-15.5%	38
Benefits	181	218	37	16.9%	202	202	222	20	9.0%	204
Professional Fees	81	80	(1)	-1.2%	66	80	80	(1)	-1.0%	68
Supplies	164	182	18	9.9%	212	194	178	(16)	-9.0%	200
Purchased Services	108	100	(8)	-7.9%	93	100	99	(1)	-1.0%	90
Rents and Leases	19	18	(1)	-7.2%	16	18	18	(0)	-2.2%	15
Utilities and Telephone	15	18	3	16.2%	15	16	18	3	14.7%	16
Insurance	8	9	1	9.0%	10	8	9	1	9.5%	10
Depreciation and Amortization	21	19	(2)	-11.5%	23	21	19	(3)	-15.2%	23
Other Operating Expenses	16	21	6	26.2%	16	19	21	1	6.2%	20
Total Expenses	**1,476**	**1,424**	**(52)**	-3.7%	**1,395**	**1,484**	**1,421**	**(63)**	-4.5%	**1,396**
Operating Gain / (Loss)	**(93)**	**(65)**	**(28)**	-42.3%	**(111)**	**(132)**	**(100)**	**(32)**	31.8%	**(116)**
Net Non-Operating Income / (Expense)	**128**	**126**	**2**	**1.9%**	**114**	**130**	**124**	**5**	**4.4%**	**111**
Excess of Revenues Over Expenses	**$ 35**	**$ 61**	**$ (25)**	-41.9%	**$ 4**	**$ (2)**	**$ 24**	**$ (26)**	-107.9%	**$ (5)**

City of Alameda Health Care District
Statement of Cash Flows
For the Six Months Ended December 31, 2010
$ in thousands

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ 134,393	$ (49,479)
Items not requiring the use of cash:		
Depreciation and amortization	79,405	$ 487,517
Changes in certain assets and liabilities:		
Patient accounts receivable, net	(764,107)	(1,111,625)
Other Receivables	2,693,743	2,323,995
Third-Party Payer Settlements Receivable	(23,215)	(349,290)
Inventories	(2,610)	8,299
Prepaids and Other	36,189	(221,342)
Accounts payable and accrued liabilities	(812,271)	467,798
Payroll Related Accruals	299,110	(94,942)
Employee Health Plan Accruals	9,285	(102,049)
Deferred Revenues	(477,916)	(2,868,890)
Cash provided by (used in) operating activities	1,172,007	(1,510,007)
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(11,237)	(62,629)
Additions to Property, Plant and Equipment	(299,065)	(945,554)
Other	(0)	(1)
Cash provided by (used in) investing activities	(310,303)	(1,008,185)
Cash flows from financing activities		
Net Change in Long-Term Debt	(38,370)	(228,222)
Net Change in Restricted Funds	38,828	90,205
Cash provided by (used in) financing and fundraising activities	458	(138,017)
Net increase (decrease) in cash and cash equivalents	862,162	(2,656,209)
Cash and cash equivalents at beginning of period	(37,703)	3,480,668
Cash and cash equivalents at end of period	$ 824,459	$ 824,459

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: February 7, 2011

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

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approval to Purchase Nihon Kohden ECG Monitoring System

---

Recommendation:

Hospital Administration is recommending Board approval for the acquisition of a new ECG monitoring system for the Telemetry and Critical Care Nursing Units. The recommended system is provided by Nihon Kohden in the amount of $296,333 plus sales tax & shipping.

We are recommending that this capital acquisition be funded through the Banc of America master equipment lease that was established in May 2010 to fund the PACS and digital radiology upgrade project as well as to allow additional room to purchase other needed equipment upgrades. The total approved master equipment lease was for an amount up to $2.5 million and it is estimated that the PACS project and digital radiology upgrade will use approximately $1.8 million of this project.

The installation of this new monitoring system will require approved plans by the Office of Statewide Health Planning and Development (OSHPD). However, we do not anticipate the scope of review or the amount of in-house construction, to be significant (mostly electrical review).

Background:

Alameda Hospital as an organization is committed to deliver quality patient care. Having and maintaining the necessary equipment is an important component of our ability to provide this level of care. The CCU and Telemetry Unit ECG monitoring system is used to monitor patient's cardiac rhythm while admitted to the hospital allows for the proper diagnosis, monitoring and treatment of the patient.

The existing systems are about 15+ years old and can no longer be supported or maintained at a level that is acceptable to meet our commitment to the delivery of quality patient care. In recent months, the frequency of repairs, equipment part replacements and system downtime have resulted in the need to replace this system as soon as possible. In addition, the software system is no longer upgradable or supported.

Under the direction of Penny Lampa-de Leon, our CCU/Telemetry Nurse Manager, the clinical staff and Medical Staff has gone through the process of evaluating replacement options and has recommended the Nihon Kohden system to hospital administration.

Discussion:

With the assistance of Tom Jones, Director of Engineering, both Philips and Nihon Kohden were solicited to present options for an ECG monitoring system for the hospital. Both companies sent representatives to discuss and present their systems and offers. It was also requested that GE be included in the process and they did perform a site inspection and evaluation of our needs but did declined to submit a proposal. GE declined primarily because Nihon Kohden has already installed antennas throughout CCU and the Telemetry Units about 3 years ago when their system was installed in the Emergency Care Center (ECC), and as a result, felt that their quote would be more expensive than the other two.

Staff and physicians were provided hands on practice with Nihon's features during the one day vendor fair. Those who participated were satisfied with the modern features presented and their questions were answered satisfactorily. In addition, because the Nihon Kohden system has been used in the ECC for the past few years, staff has working experience with this system and are pleased with its performance. Furthermore, having one compatible and standard monitoring system throughout the hospital (ECC, CCU and Telemetry Units) will be of great benefit to the continuity of care as patients transition between these units.

Furthermore, the Nihon Kohden system has advanced technology features, a net connect option (included), 5 year warranty, system support for the life of the product, training support for staff, making it the recommended system by those involved in the evaluation process.

The price of each system was also considered. Given that the Nihon Kohden's antennas have already been installed, their quote was more competitive than the Phillips quote which was $354,689 plus tax & shipping.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: February 7, 2011

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

From: Deborah Stebbins, CEO

Subject: IT Projects Update

For your information and as follow-up to requests from past Board meetings, please find attached a summary of the current IT Projects being implemented at Alameda Hospital.

City of Alameda Health Care District

Current IT Projects - Feburary, 2011

PROJECT/SYSTEM	DESCRIPTION	DEPARTMENT	PROJECT LEADER(S)	STATUS/TIMELINE
PACS	Digital Imaging Capture and Retention	Imaging	J. Ellis K. Roberson M. Pesch	In Process Go Live March 2011
ECHO	Physician Credentialling and PI Data Collection Support	QRM Medical Staff Office	K. Roberson	Implemented. Needs Software Upgrade
Alliance / MedAssets	Executive Decision and Budget Support System	Administration Finance	D. Neapolitan	Implemented. Need to expand use and application to more functions
ANSOS	Departmental Scheduling	Nursing	M. Bond	Recent decision to limit use to Nursing only due to termination of McKesson Time & Attendance application
McKesson	Time and Attendance System	Hospital Wide	D. Neapolitan	System implementation terminated due to inability of vendor to support new product
Evaluation of New Time & Attendace System and Structure	Time and Attendance System	Hospital Wide	D. Neapolitan P. Weiss	Timeline TBD
Evaluation of Remedy Proposal	IT Work Ticket Management System	IT	K. Roberson Interim IT Director	3/1/2011
Meditech Upgrade to 5.6.5	Necessary Platform for full development of Meaningful use E.H.R	IT with Hospital wide impact	Interim IT Director	1/16/2011 start 4/2012 Go Live
Evaluation of Options for System Back-up and Redundancy	Provides additional security for datat recapture in event of unplanned system downtime	IT with recommendations to Executive Staff; capital requirements may necessitate Board approval	R. Lundy-Paine as Special Projects	Proposals received and under review

City of Alameda Health Care District

Current IT Projects - Feburary, 2011

PROJECT/SYSTEM	DESCRIPTION	DEPARTMENT	PROJECT LEADER(S)	STATUS/TIMELINE
HCCS	Mandatory annual Staff Training and competency review (on-line)	Hospital Wide	M. Bond	System running; will be refined over next two months based on initial user feedback
Advanced Clinical Systems				
Patient Care System (PCS)		Hospital Wide	M. Bond	April 2010 to November 2010
PCS: Status Board		Hospital Wide	M. Bond	June 2010
PCS: Point of Care Software		Hospital Wide	M. Bond	June 2010 to July 2010
PCS: E-MAR		Hospital Wide	M. Bond	June 2010 to August 2010
Bedside Medication Verification with on-line Medication Administration Record (MAR)		Hospital Wide	M. Bond	June 2010 to September 2010
Physician Care Manager Phase I	Progress Notes	Hospital Wide	M. Bond	February 2011 to October 2011
Physician Care Manager Phase II	Physician Order Entry	Hospital Wide	M. Bond	September 2011 to May 2012
Emergency Department Management Phase II		Hospital Wide	M. Bond	October 2010 to April 2011
Emergency Department Management Phase II		Hospital Wide	M. Bond	October 2011 to April 2012
Operating Room Management		Hospital Wide	M. Bond	September 2010 to February 2011
Scanning and Archiving		Hospital Wide	M. Bond	April 2011 to September 2011

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: January 25, 2011

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

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Follow-up on NPC-2 discussion from 1/10/2011 Board Meeting

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As a follow up to discussion at the January 10, 2011, open session, board meeting, I am providing additional information regarding the District's Non-Structural Performance Category 2 (NPC-2) compliance status.

It was presented a the January 10, 2011 meeting that there remain some open items with regards to the hospital completing all of the seismic work required to change its NPC status from NPC-1 to NPC-2 (for all buildings), which, as stipulated by SB 1953, was required by January 1, 2002.

The first point of clarification is that this January 1, 2002 deadline passed before the District was formed, but once the District was up and running, it analyzed the situation, assessed its compliance capability, and submitted a plan for seismic compliance to the State of California. This plan was submitted in June 2004.

The plan proposed that the District be granted an extension of time so that the District's NPC-1 buildings could be brought up to NPC-3 status (not just NPC-2 status) by January 1, 2013. The plan also addressed compliance with the more serious SPC (structural) requirements.

By letter dated November 17, 2004, the State of California, which is responsible for both licensing of general acute care hospitals and seismic compliance, approved that proposal, granted the requested extension of time and took no action with respect to Alameda Hospital's license. Accordingly, there is no basis to claim that Alameda Hospital, which remains fully licensed and accredited, has no legal authority to operate and has been in violation of state law for 9 years.

Attachments:

November 17, 2004 Letter from OSHPD

oshpd Office of Statewide Health Planning and Development
David M. Carlisle, M.D., Ph.D., Director
1600 9th Street, Room 433
Sacramento, California 95814
(916) 654-1606
Fax (916) 653-1448
www.oshpd.ca.gov

Alameda Hospital
ADMINISTRATION
NOV 24 2004

November 17, 2004

Cheif Executive Officer
Alameda Hospital
2070 Clinton Avenue
Alameda, California 94501

To Whom It May Concern:

The purpose of this letter is to respond to your request for time extensions from the SB 1953 compliance deadline of 2008 for Alameda Hospital.

Your request for time extensions based upon a loss of health care capacity under the provisions of Health and Safety Code 130060(a) and Title 24, Part 1, Chapter 6, Article 1, Section 1.5 is approved as follows:

> Having reviewed the information provided, it is clear that the loss of Alameda Hospital will result in a loss of health care capacity. Based upon your request, and the Compliance Plans submitted to the Office, the following extension to **January 1, 2013** is granted:
>
> Facility ID # 11210
> Alameda Hospital
> 2070 Clinton Avenue
> Alameda, California 94501

If you have any questions, please contact John Rosskopf, Interim Chief Deputy Director at (916) 654-1606.

Sincerely,

David M. Carlisle, M.D., Ph.D.
Director

cc: Kurt Schaefer, Deputy Director, FDD
FDD file

Summary of SB 499 Reports

Compliance Timeline	Number of Hospitals With SPC-1 Buildings	Number of SPC-1 Buildings
By January 1, 2013	129* (57.6%**)	403* (59.5%***)
Between January 1, 2013 to January 1, 2015	55* (82.1%**)	153* (82.1%***)
Between January 1, 2015 to January 1, 2020	26* (93.8%**)	97* (96.5%***)
Beyond January 1, 2020	14*	24*
Totals	224	677

Summary of SB 499 Reports

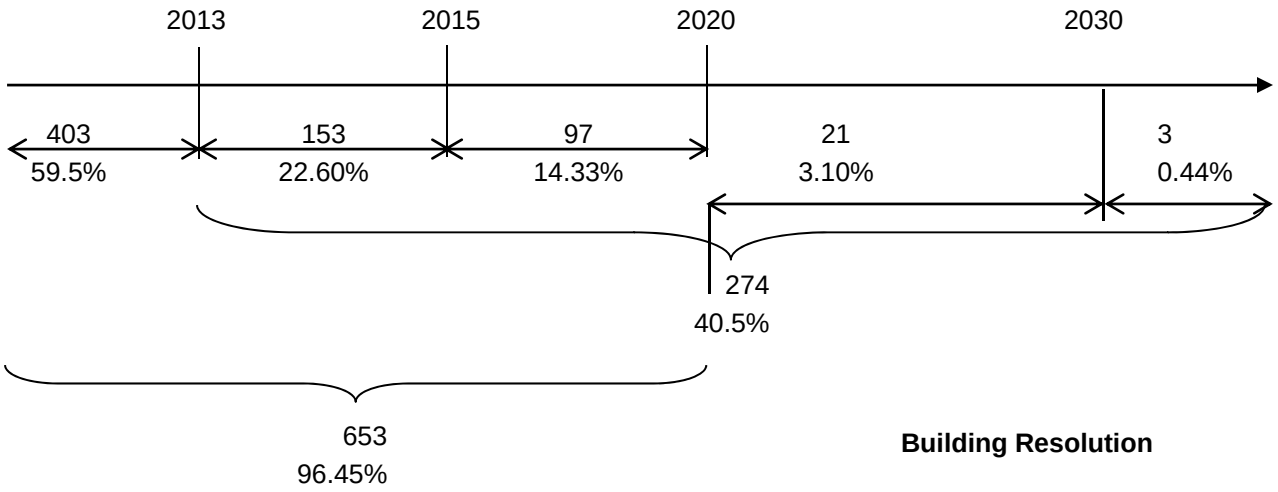
- **The compliance timeline for SPC-1 buildings is self-reported by the hospitals and does not automatically make a hospital eligible for an extension to the compliance date reported.**

- **To be eligible for an extension, a hospital must meet the initial eligibility criteria and maintain its eligibility by complying with subsequent milestones and requirements.**

- **Currently, no extensions exist in the law for SPC-1 seismic safety compliance beyond January 1, 2020.**

* Total number of hospitals indicating compliance or total number of buildings reported to be complaint by a specified timeline
** Cumulative percentage of hospitals reporting compliance by a specified timeline
*** Cumulative percentage of buildings reported to be compliant by a specified timeline

Status of SB 499 Reports



Building Resolution

None provided	62	9.16%
Remove	171	25.26%
Replace	198	29.25%
Retrofit	246	36.34%
	677	100.00%

Earthquake-Compliant Hospital Buildings vs. Access to Care: California's Careful Balancing Act

An Issue Summary

Hospitals are a vital part of communities throughout California, providing life-saving care 24 hours a day, seven days a week, regardless of patients' ability to pay. Hospitals also provide a safe haven to communities in times of natural disaster, such as earthquakes, or during public health epidemics, such as the recent H1N1 influenza.

While California hospitals put the needs of patients and public safety first, hospitals are facing significant challenges in complying with the state's mandated deadlines for earthquake building requirements. The goal of having earthquake-compliant hospital buildings is a worthy public policy objective supported by the hospital community. However, more than 270 hospital buildings may be forced to close and health care services eliminated if they cannot comply with the mandated 2013/2015 deadlines.

The Issue

The burden of meeting the state's seismic retrofit requirements will be impossible for a substantial number of California hospitals. Due to the impacts of the nearly two-year recession, many of California's community hospitals are not credit worthy and are unable to raise the capital necessary to meet the requirements of this unfunded mandate, which is estimated to cost hospitals as much as $110 billion. Due to the serious economic decline in California and across the nation, California's community hospitals have sustained sizable losses in their investment portfolios, are facing decreased income from operations, and are dealing with declines in their philanthropic contributions.

These economic impacts, along with the rising cost of the uninsured and other charity care costs, have seriously weakened hospitals' financial positions and their ability to fund the construction of new hospital buildings – estimated at nearly $2 million per bed.

The impact on hospitals and health systems in California is becoming clearer: more than half of California's hospitals are operating in the red, many are not credit worthy, and a number of hospitals are on the brink of, or in, bankruptcy. In this environment, ensuring access to the capital markets has become urgent. However, the bond markets that provide the bulk of capital to the hospital industry are more difficult and costly to access, even for hospitals with positive bottom lines. This financial environment is has jeopardized hospitals' ability to meet the seismic retrofit and rebuilding deadlines required by SB 1953.

Cain Brothers, national investment bankers and capital advisers to hospitals, report that:

"Adding the additional burden of meeting seismic retrofit requirements will be difficult for all hospitals and may not be possible for some of the most financially vulnerable hospitals and health systems. For those that have the ability to raise the capital to meet the requirements of SB 1953, diverting this capital away from core operations and their balance sheets will mean compromising these hospitals' ability to provide capital to their core operations and will significantly limit financial flexibility in the future."

In 1994, a few months after the Northridge earthquake, California's Legislature enacted SB 1953 requiring all California hospitals to meet sweeping new earthquake-compliance standards. This law, the largest unfunded mandate passed in state history, was intended to ensure the California's community hospitals would remain operational after a large earthquake. While California's hospitals have been working hard to meet the seismic deadlines, the eroding financial condition of hospitals is impeding many others from beginning or completing their building projects. If hospitals cannot meet the current deadlines, they will be forced to close. This will leave California's growing population with less access to life-saving health care services and health care workers with no place to care for patients.

Since 1994, a number of important programs and statutes have been enacted to help hospitals implement seismic building projects. They include:

- New policies and procedures implemented by the Office of Statewide Health Planning and Development (OSHPD) to expedite plan reviews and construction.

- Implementation of Hazards US (HAZUS). Developed by OSHPD in conjunction with the Hospital Building Safety Board, HAZUS is a state-of-the-art modeling technology that allows for more accurate evaluation of the seismic-safety level of hospital buildings. Through HAZUS, a number of hospital buildings have been reclassified to lower levels of risk, taking them from Structural Performance Category (SPC-1) with the highest risk of collapse to SPC-2 (lower category of risk). As a result, more than half of the hospital buildings that had to be retrofitted or replaced by 2013/2015 now can be rebuilt by 2030. This was expanded to additional hospitals in 2009 through SB 499.

- California's SB 1661 law, enacted in 2006, which allows up to a two-year extension for compliance. Under prescribed conditions, hospitals may apply for a deadline extension from 2013 to 2015 if they demonstrate a good-faith effort to meet the original mandate. Hospitals were required to submit reports on all SPC-1 buildings to OSHPD by June 30, 2009.

- SB 306, enacted in 2007, allows hospitals that meet specific financial criteria, as well as county- and city-owned hospitals, to receive an extension to 2020, only if 2030 seismic-mandate requirements are met by the earlier deadline.

While hospitals throughout California have made significant progress, it is not enough. More must be done to ensure access to critical hospital services remains available for all Californians. In 2009, the California HealthCare Foundation (CHCF) released a report titled *Facts and Find-*

ings for Policymakers: Hospital Seismic Safety, which recommended that policymakers consider new and appropriate policy changes to the original SB 1953 mandate based on the final requests for HAZUS exemptions and the reports from hospitals on all existing SPC-1 buildings.

Policy Recommendation

The California Hospital Association (CHA) concurs with CHCF's recommendation that policymakers should re-evaluate seismic-compliance requirements for hospitals. While California's earthquake compliance law is an important goal shared equally by hospital leaders, health care workers, patients and community members, policymakers must now provide more flexible options for hospitals to meet the compliance requirements given the dire economic environment.

There is a delicate balance between ensuring that seismically safe hospitals are available during, and accessible after, an earthquake, and ensuring hospitals have the resources to stay open and meet mandated deadlines prior to experiencing an earthquake. CHA recommends:

- The 2013 seismic deadline be moved to 2015 to ensure hospitals that miss the 2013 deadline are not forced to close.

- Hospitals/health systems are allowed an additional extension of up to five years to the 2015 deadline under prescribed conditions.

- Hospitals may receive an extension to 2020 if they meet 2030 seismic requirements by 2020 under prescribed conditions

- Hospitals and health systems must be granted special circumstance extensions when project delays occur due to circumstances beyond the hospital's control.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Presentations and Handouts from February 7, 2011 District Board Meeting

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Compensation Philosophy Discussion

Presented by:

Bill Hopkins, Senior Consultant

February 7, 2011

What is a Compensation Philosophy?

The compensation philosophy is the framework that guides pay decisions

Compensation Philosophy

The foundation of virtually all well-run compensation programs is a clearly stated, comprehensive philosophy statement

Rationale - *In the absence of a defined philosophy:*

- *Employees will create their own based on their perceptions*
- *Leadership will have difficulty defending or communicating the program (e.g., directors and managers sympathize with staff, rather than leading)*
- *Pay decisions often lead to a patchwork of programs and policies designed to address specific issues at specific times (i.e., inherited, or jockeyed, or band-aided approaches that made sense at the time)*

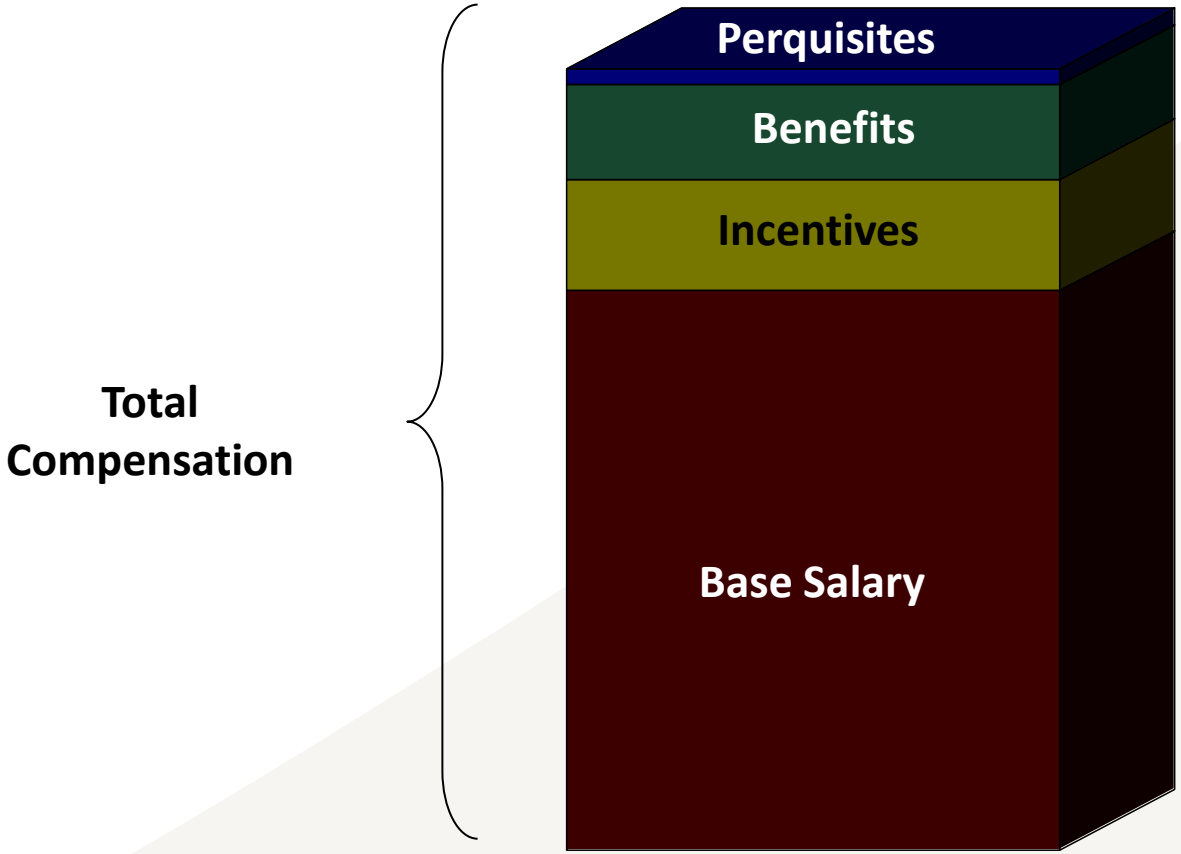
Types of Compensation Philosophies

Compensation philosophies typically fall into five patterns

- ***Middle of the Road***
- ***Paying for performance***
- ***Paying for talent***
- ***Paying for stability***
- ***Mission-based pay***

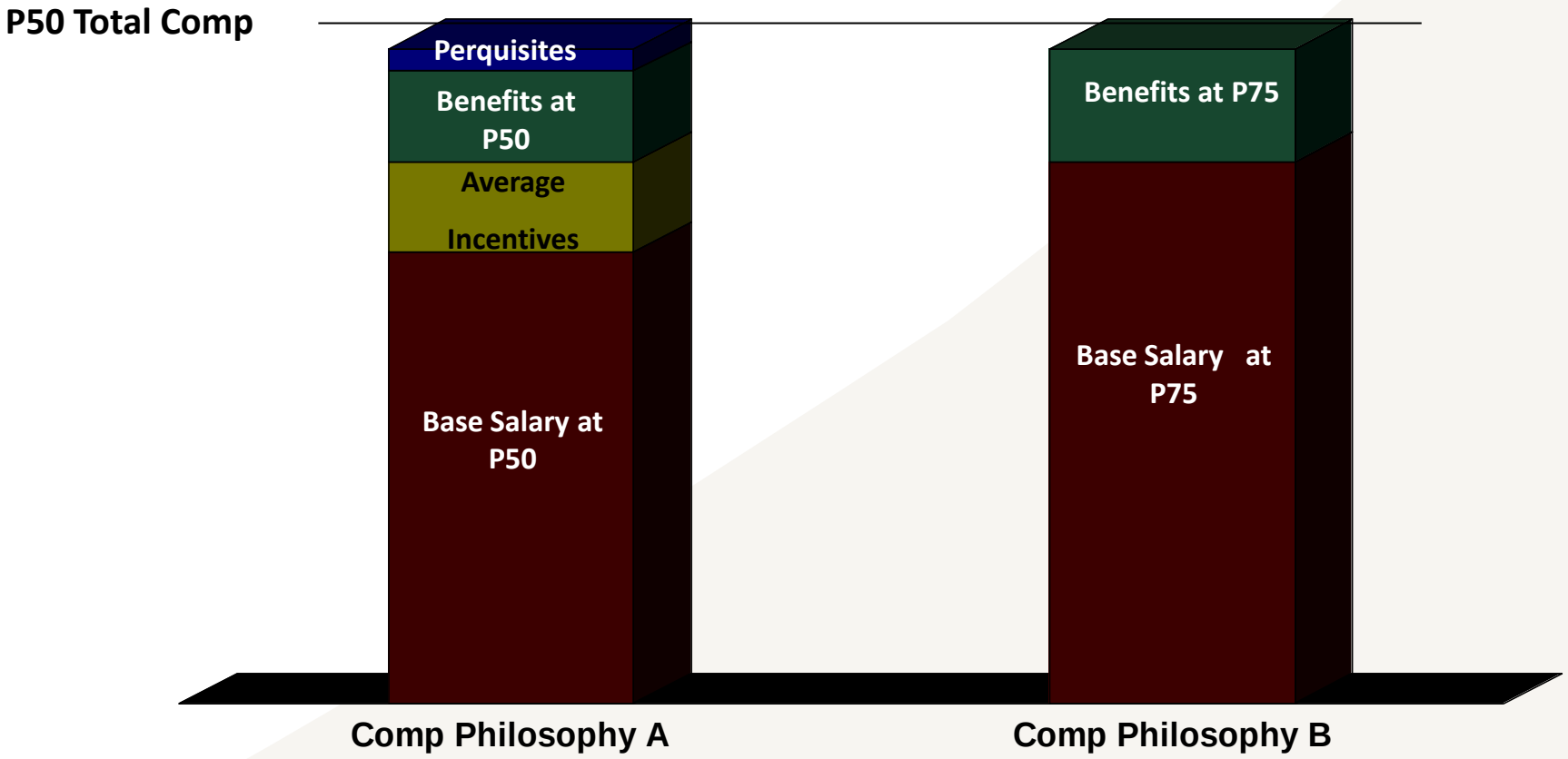
Elements of Total Compensation

Total compensation is defined as the sum of the following elements: base salary, incentives, benefits, and perquisites



Competitive Positioning Example

The graphs below illustrate total compensation targeted (hypothetically) at the 50th percentile, using two very different approaches



What Are Other Healthcare Organizations Doing?

Executives

- The most common (over half) is a “median” philosophy
- Just under half intentionally position salaries above median
  - About one-quarter position salaries at the 60th or 65th percentiles
  - Another one-quarter position salaries at the 75th percentile
- Almost one-third target total cash compensation (salaries plus incentives) at the 75th percentile
  - Quite often, organizations which target total compensation at the 75th percentile also offer the opportunity to earn above the 75th percentile for exceptional performance
- A few hospitals define pay targets that are below median due to financial constraints

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Compensation Philosophy Decision Points

Compensation Philosophy Worksheet

Question	Interview Summary	Decision
What should be the role of the Board?	All agree they must set CEO pay All but two wanted to just set a philosophy for the CEO to use to administer compensation for the other executives Two wanted to review and approve CEO's recommendations for other executives	

Compensation Philosophy Worksheet

Question	Interview Summary	Decision
What peer group should the Board use in comparing compensation levels?	Most felt looking at a national sample of small independent hospitals was best. Regional data and cost-of-living information would also be very important, but most worried about sufficient sample sizes. Some members felt looking at city managers, police chiefs, and superintendents could also help. All agreed that teaching hospitals should not be included. Others felt comparing to other small independent hospitals in urban and suburban markets.	

Compensation Philosophy Worksheet

Question	Interview Summary	Decision
Where should Alameda Hospital target base salaries?	Most felt that targeting base salaries at or slightly above median would be best. Many observed the difficulty in managing Alameda Hospital during this turnaround. Nearly all said that although they may target median or above, it should only pay what it necessary to keep the team.	
Is incentive compensation important ? Should opportunity levels be below average, average, or above average?	Nearly all were in favor of using incentive compensation. Most felt given the current economic difficulties focusing the plan on cost containment and financial measures was important. Two favored smaller opportunity levels, while the others felt having average levels was best.	

Compensation Philosophy Worksheet

Question	Interview Summary	Decision
Where should Alameda Hospital target benefits?	Almost all felt benefits should be generally competitive and that a fair retirement should be provided.	
Where should Alameda target perquisites?	All felt these should be minimal and very limited in offering.	
Where should Alameda Hospital target severance?	Most felt this should be limited to a minimal amount. Definitely no more than 18 months and one said they should not pay any severance.	

Compensation Philosophy Worksheet

Question	Interview Summary	Decision
Results in total compensation for on-plan performance.	Most said median or the 60th percentile, one said there should not be a target.	

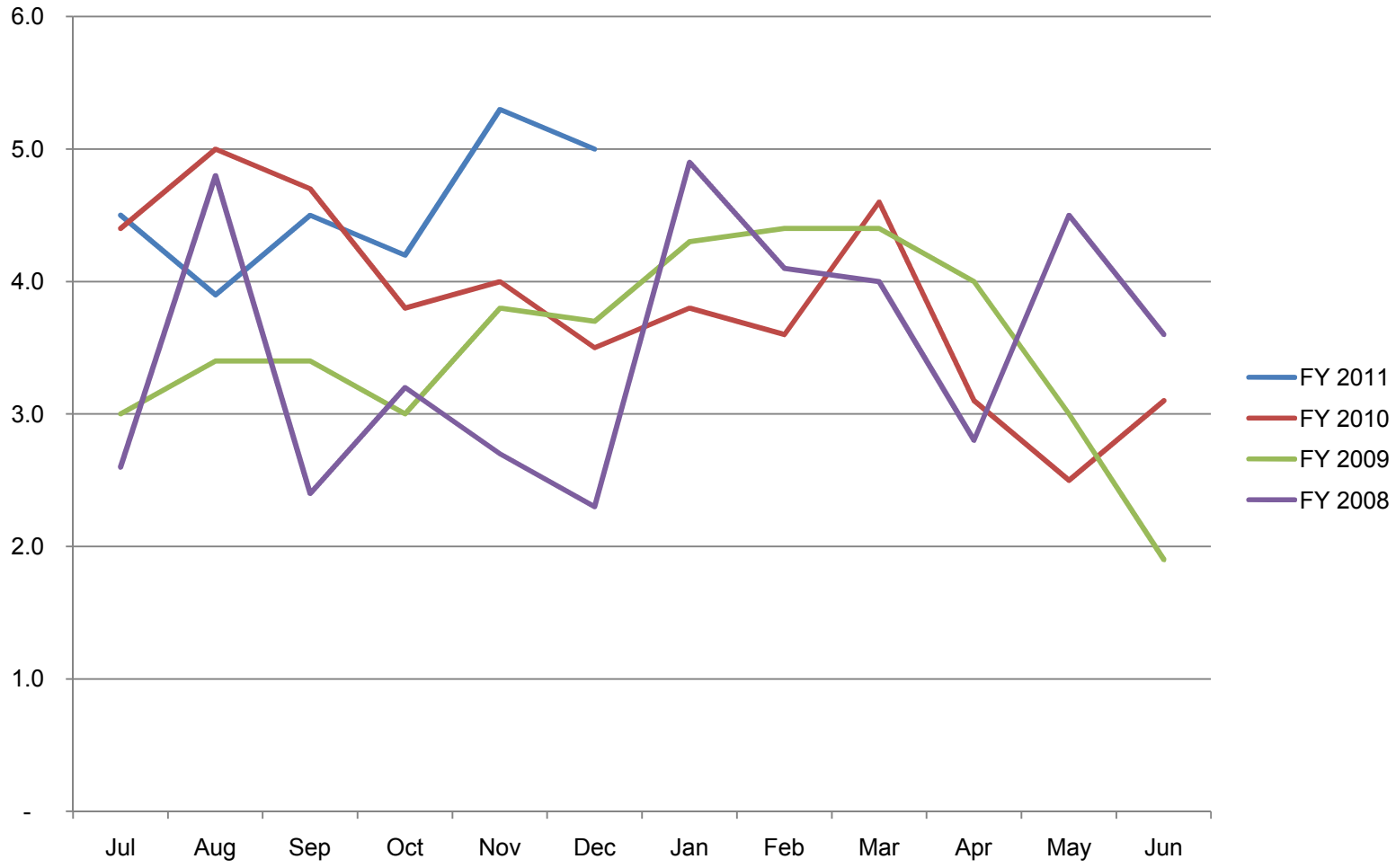
City of Alameda Health Care District
Board of Directors Meeting
February 7, 2011

CCU Volume Trends and Contribution Margin Comparison

Presented by
Deborah Stebbins, CEO

Alameda Hospital

CCU
Average Daily Census



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Comparison of CCU vs Med/Surg

Based on Patient Discharge Date

		Cases	Days	ALOS	Charges	Net Rev	Direct Expense	Contribution Margin
CCU Only Patients								
FY 10		**422**	**2,279**	**5.4**	**$ 29,980,578**	**$ 6,400,392**	**$ 5,706,823**	**$ 693,569**
	Per Case				$ 71,044	$ 15,167	$ 13,523	$ 1,644
	Per Day				$ 13,155	$ 2,808	$ 2,504	$ 304
FY 11		**89**	**541**	**6.1**	**$ 7,036,155**	**$ 1,494,839**	**$ 1,309,074**	**$ 185,765**
	Per Case				$ 79,058	$ 16,796	$ 14,709	$ 2,087
	Per Day				$ 13,006	$ 2,763	$ 2,420	$ 343
Medical / Surgical Only Patients								
FY 10		**1,655**	**6,634**	**4.0**	**$ 72,010,737**	**$ 15,772,112**	**$ 12,589,372**	**$ 3,182,740**
	Per Case				$ 43,511	$ 9,530	$ 7,607	$ 1,923
	Per Day				$ 10,855	$ 2,377	$ 1,898	$ 480
FY 11		**338**	**1,396**	**4.1**	**$ 14,906,648**	**$ 3,227,064**	**$ 2,738,797**	**$ 488,267**
	Per Case				$ 44,103	$ 9,548	$ 8,103	$ 1,445
	Per Day				$ 10,678	$ 2,312	$ 1,962	$ 350

Alameda Hospital

Based on zero balance accounts. Direct expense includes routine and ancillary costs.

City of Alameda Health Care District
Board of Directors Meeting
February 7, 2011

Alameda Hospital Cash Management

Presented by

David Neapolitan, CFO

Alameda Hospital

Alameda Hospital Cash Management

- Cash Activity Monitored Daily
  - Review of deposits received electronically and by check
  - Weekly review of Accounts Payable aging report
  - Bi-weekly review of payroll requirements
  - Maintain weekly spend to one fourth of estimated monthly collections plus allocation of parcel tax proceeds.

- Annual Parcel Tax Funds
  - Approximately $5.9 million annually
  - Received in three installments
    - December (49%),
    - April (46%), and
    - August (5%).
  - Allocated to be used in 12 equal installments ($492K)

Alameda Hospital

FY 2011 Activity

As of December 2010 used $2.6 million:

- Operations - $1.5 M
  - Growth in Net Accounts Receivable - $1.1M.
  - Growth in IGT Receivable - $1.1M.
  - Prepayment of Insurance Policies -$0.2M.
  - Offset by Depreciation (non-cash) $0.5M.
  - Receipt of AB 915 Funds.
  - Receipt of Provider Fee.
- Investing - $1.0M
  - Purchase of capital assets $0.9 M.
- Financing – $0.1 M
  - Repayment of Bank Loan - $0.2 M.

Alameda Hospital

Cash Flow Issues November / December

- Holidays slowed cash receipts.
- Medi-Cal delays in settling approximately $2.5 million in accounts.
- Late December delays in Medicare payments as result of a CMS modification to their claims processing system that caused inpatient claims to be inappropriately denied.

Alameda Hospital