Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

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

Monday, May 4, 2009

Location:

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

Office of the Clerk: (510) 814-4001

Regular Meeting

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

I. Call to Order (5:30 p.m. – 2 East Board Room) — Jordan Battani

II. Roll Call — Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A. Approval of Closed Session Minutes

1. March 2, 2009
2. March 12, 2009

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

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

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

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

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

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

A. Announcements from Closed Session Jordan Battani

VI. Consent Agenda

A. Approval of March 2, 2009 & March 12, 2009 Minutes **ACTION ITEM** [enclosure]

B. Approval of Annual Report for Environment of Care **ACTION ITEM** [enclosure]

C. Approval of Administrative Policy No. 86 - Identity Theft Prevention Program **ACTION ITEM** [enclosure]

D. Approval of Annual Compliance Report **ACTION ITEM** [enclosure]

E. Acceptance of February 2009 Financial Statements **ACTION ITEM** [enclosure]

F. Approval of Selection of FYE June 30, 2009 Auditor **ACTION ITEM** [enclosure]

G. Approval of Mission Statement for CME Program **ACTION ITEM** [enclosure]

H. Approval of Revisions to Medical Staff Application for Medical Privileges **ACTION ITEM** [enclosure]

I. Approval of Amendments to Medical Staff Rules and Regulations Article 16: Medical Records –Elements of H&P **ACTION ITEM** [enclosure]

J. Approval of Amendments to Medical Staff Rules and Regulations Article 34 (New): Medical Staff Professional Practice Evaluation **ACTION ITEM** [enclosure]

VII. Regular Agenda

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

1. Recommendation for Approval of SEIU Collective Bargaining Agreement **ACTION ITEM** [enclosure]

2. Preparations for Hospital Swine Flu Outbreak [enclosure]

3. Foundation 2009 Action Plan [enclosure]

4. Informational Items

a. San Leandro Hospital Update [enclosure]

b. California Hospital Association Summary of ARRA [enclosure]

B. Finance and Management Committee Report

1. Committee Report

- March 25, 2009 Meeting — Steve Wasson
- April 29, 2009 Meeting — Jordan Battani

2. Acceptance of March 2009 Financial Statements — David A. Neapolitan
ACTION ITEM [enclosure]

C. Strategic Planning and Community Relations Committee Report

1. Committee Report — Robert Bonta

- March 17, 2009
- April 21, 2009

2. Approval of Board Meeting Video / Broadcasting Option — Deborah E. Stebbins
ACTION ITEM [enclosure]

3. Update of Public Bid and Planning Process for Alameda Towne Center Medical Office Space [enclosure] — Kerry Easthope

D. Medical Staff President Report — Alka Sharma, MD

VIII. General Public Comments

IX. Board Comments

X. Adjournment Into Executive Closed Session (If Needed)

XI. Reconvene to Public Session

A. Announcements from Closed Session — Jordan Battani

XII. Adjournment

The next regularly scheduled board meeting will be on Monday, June 1, 2009.
Closed Session will begin at 6:00 p.m. Open Session will follow at approximately 7:30 p.m.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

March 2, 2009

Directors Present:
Jordan Battani
Robert Bonta
Robert Deutsch, MD
Steve Wasson
Alka Sharma, M.D.

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

Medical Staff Present:

Legal Counsel Present:
Thomas Driscoll, Esq.

Excused:
J. Michael McCormick

Submitted by: Kristen Thorson

Action		
1. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 6:06 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors was present and that Director McCormick was absent from the meeting.	
3. General Public Comments	None at this time.	
4. Adjourn into Executive Closed Session	At 6:07 p.m. the meeting adjourned to Executive Closed Session.	

5. Reconvene to Public Session	Jordan Battani reconvened the meeting into public session at 7:33 p.m. and made the following closed session announcements.	
6. Closed Session Announcements	[A] Minutes [B] Quality Improvement Committee [C] Medical Executive Committee Report and Approval of Credentialing Recommendations	[A] The Closed Session Minutes for the January 27, 2009 and February 2, 2009 meetings were approved. The Quality improvement Reports were accepted as presented for the months of November and December 2008 and January 2009. The 3rd Quarter 2008 Risk Management Report was also accepted as presented. [C] Medical Executive Committee Report and Approval of Credentialing Recommendations were approved as presented.

Initial Appointment:

Name	Specialty	Affiliation
○ Maryam Kermani, MD	Family Practice	Alameda Family Physicians
○ David Levin, MD	Pathology	Western Labs
○ Pedram Taher, MD	Internal Medicine/Hospitalist	AIM

Reappointments – Medical Staff

Name	Specialty	Status	Appointment Period
○ Richard Baxter, MD	Radiology	Courtesy	03/01/09 – 07/31/10
○ Gregory Broderick-Villa, MD	General Surgery	Courtesy	03/01/09 – 08/31/09
○ Christopher Chen, MD	Orthopedics	Courtesy	04/01/09 – 03/31/11
○ Huilan Cheng, MD	Gastroenterology	Courtesy	04/01/09 – 03/31/11
○ Lisa Collins, MD	Anesthesiology	Active	03/01/09 – 02/28/11
○ Maria DeGuzman, MD	Anesthesiology	Courtesy	03/01/09 – 02/28/11

Erik Gaensler, MD	Radiology	Courtesy	03/01/09 – 11/30/09
Philip Gardner, MD	Ophthalmology	Courtesy	04/01/09 – 03/31/11
Robert Gingery, MD	Vascular Surgery	Active	03/01/09 – 02/28/11
Joshua Hatch, MD	Orthopedics	Courtesy	04/01/09 – 03/31/11
Jon-Petter Haugen, MD	Ophthalmology	Courtesy	03/01/09 – 02/28/11
Lisa Higa, MD	Gastroenterology	Courtesy	04/01/09 – 03/31/11
General Hilliard, MD	Cardiology	Courtesy	04/01/09 – 03/31/11
Rupert Horoupian, MD	General Surgery	Courtesy	04/01/09 – 10/31/10
Suzanne Ishii, DPM	Podiatry	Courtesy	03/01/09 – 02/28/11
George Kazantsev, MD	General Surgery	Courtesy	04/01/09 – 12/31/10
Robert Kim, MD	Radiology	Courtesy	03/01/09 – 11/30/10
Teresa Kim, MD	General Surgery	Courtesy	03/01/09 – 10/31/09
Mei Po Kung, MD	Internal Medicine	Courtesy	03/01/09 – 02/28/11
Annie Lai, MD	Radiology	Courtesy	03/01/09 – 07/31/10
Ho-Yin Li, MD	Anesthesiology	Courtesy	04/01/09 – 03/31/11
Craig Leong, MD	Ophthalmology	Courtesy	03/31/09 – 02/28/11
Donald Liberty, DDS	Oral Surgery	Courtesy	03/01/09 – 02/28/11
Norman Moscow, MD	Radiology	Courtesy	04/01/09 – 03/31/11
Jeffrey Niccoli, DPM	Podiatry	Active	04/01/09 – 03/31/11
Anne B. Parker, MD	Pediatrics	Active	03/01/09 – 02/28/11
Anthony Poggio, DPM	Podiatry	Active	03/01/09 – 02/28/11
Thomas Quinn, MD	Cardiology	Courtesy	04/01/09 – 03/31/11
Concepcion Regacho, MD	Anesthesiology	Courtesy	04/01/09 – 03/31/11
Carmelo Roco, MD	Internal Medicine	Courtesy	04/01/09 – 03/31/11
Ronald Rubenstein, MD	Otolaryngology	Courtesy	04/01/09 – 03/31/11
Robert Shimshak, MD	Radiology	Courtesy	03/01/09 – 08/31/09
Steven Stanten, MD	General Surgery	Courtesy	03/01/09 – 08/31/09
Thomas Sugarman, MD	Emergency Medicine	Courtesy	04/01/09 – 03/31/11
Jonathan Svahn, MD	General Surgery	Courtesy	04/01/09 – 03/31/11
Yong-Yong Tam, MD	Emergency Medicine	Active	03/01/09 – 02/28/11
Ming-Chien Tang, MD	Anesthesiology	Courtesy	03/01/09 – 02/28/11
Ajay Upadhyay, MD	General Surgery	Courtesy	03/01/09 - 01/31/10

○ Jessie Xiong, MD	Pathology	Courtesy	03/01/09 - 02/28/11

Reappointment – Allied Health Professional Status

Name	Specialty	Appointment Period
○ Annette Chenevey, CRNA	Nurse Anesthetist	04/01/09 – 03/31/11
○ Megan Palsa, PA-C	Physician Assistant	03/01/09 – 02/28/11
○ Aaron Peters, PA-C	Physician Assistant	03/01/09 – 12/31/09
○ Brent Sommer, CRNA	Nurse Anesthetist	04/01/09 – 03/31/11
○ Brian Strieff, PA-C	Physician Assistant	03/01/09 – 02/28/11

7. Consent Agenda	Approval of January 27, 2009 Minutes Approval of February 2, 2009 Minutes Approval of Revisions to Administrative Policy No. 47 – Resources for Interpretive, Hearing Impaired and Deaf Patients Approval Executive Incentive Compensation Criteria and Formula Director Bonta pulled item C. from the consent calendar for discussion. Director Bonta asked for clarification on the policy in regards to use of the Hands On services for the hearing impaired. Mary Bond, Executive Director of Nursing Services clarified that the 5 day notice for service is a general time frame and there has not been a problem with securing the service for patients on a shorter notice. Director Bonta was satisfied with the response and clarification.	Director Bonta moved to approve the consent agenda items A., B., and D. as presented. Director Wasson seconded the motion. The motion carried unanimously. Director Bonta move to approve the balance of the consent agenda, item C. Director Deutsch seconded the motion. The motion carried unanimously.
8. Regular Agenda	A. <u>Finance and Management Committee Report</u> 1. **February 25, 2009 Committee Report** Steve Wasson stated that the January Financial Statements were presented at the meeting and that he would pass the discussion onto David Neapolitan to brief the Board of the financial performance for the month. 2. **Acceptance of January 2009 Financial Statements** David Neapolitan reviewed the January Financial Statements as presented in the Board Packet. Overall census for the month was 83.3 versus a budget of 92. Total gross patient revenue was less than budget by $2,363,034. Surgery cases	Director Deutsch moved to accept the January 2009 Financial Statements as presented. Director

	were 490 versus a budget of 417. Overall financial performance for the month was a profit of $20,381 versus a budgeted profit of $22,196 and year to date performance was a profit of $110,915 versus a budgeted loss of $62,665. Director Wasson asked Mr. Neapolitan to update the Board on the budget process and timeline. Mr. Neapolitan stated that volume assumptions will be brought to the Finance Committee in March or April. A draft budget will be brought to the committee in May and to the Board for final approval in June. 3. Approval for Authorization to Apply for Help II Funding Mr. Neapolitan asked the Board for approval to seek low interest funds for capital projects from the California Health Facilities Financing Authority, HELP II (Healthcare Expansion Loan Program) as outlined in the enclosure in the Board packet.	Wasson seconded the motion. The motion carried unanimously. Director Deutsch moved to approve authorization for the District to apply for Help II Funding. Director Bonta seconded the motion. The motion carried unanimously.
	B. Strategic Planning and Community Relations Committee Report 1. February 17, 2009 Committee Report Director Bonta stated that at the last Committee meeting and continued the master plan discussion. The committee had been presented with 3 options for new buildings on the hospital foot print. The cost between the 3 options was relatively the same with some modest differences in the amount of time it would take to complete the each of the options. The Committee made progress on the discussion and look forward to more discussion in order to make a decision about master planning. Director Bonta discussed the enhancements that have been recently added to the hospital website. Ms. Stebbins presented a progress report on the six pillars of the strategic plan and where we are with them and what has been accomplished so far. 2. Update on Board Meeting Video / Broadcasting Options Ms. Stebbins reported that staff is researching different options to bring to the Strategic Planning and Community Relations Committee for a recommendation to the Board for approval.	

3. Update of Public Bid and Planning Process for Alameda Towne Center (ATC) Medical Office Space

Kerry Easthope updated the board of the progress of the ATC project. Six companies have submitted a prequalification form in which 5 of the 6 qualify for the project. Qualified bidders will be notified this week and will be asked to attend a bid conference to receive the bid packet on March 5, 2009. Bid documents will be received on March 30, 2009 and a decision will be made at that time. The process for bidding is a standard process the public entities use. The entire process from bidding to completion of the work should be finished by July 1, 2009.

C. **Chief Executive Officer's Report**

1. **Representation at California Special District Association Annual Dinner**

Ms. Stebbins informed the Board that the Annual CSDA Dinner will be held on Thursday, March 26 and to let staff know if they are interested in attending.

2. **Key Statistics**

Statistics:	**February Prelim**	**February Budget**	**January Actual**
Average Daily Census	89.9	92.5	83.29
Patient Days	2,516	1,948	2,582
ER Visits	1,383	1,45	1,496
OP Registrations	2,298	2,525	2,705
Total Surgeries	472	412	490

3. **April District Board Meeting**

Ms. Stebbins reported the three Board Members will not be at the April Board Meeting. She asked them if they wanted to reschedule or cancel the meeting in April. Budget Assumptions would normally be brought to the Board in April. The Board was asked their opinion if the volume assumptions could be brought to the Finance Committee instead of the Board. Board Members all agreed that it

The Board members agreed to cancel the April 6, 2009 Regular Board meeting.

	was appropriate for the majority of the discussion on budget assumption to take place at the committee level. If needed, the Board could call a special meeting with 24 hours notice. 4. **Board Meeting Times** Ms. Stebbins made a suggestion to the Board on the process and timing of the open and closed meetings. Many other boards convene for public session first and then adjourn to executive session. This format would allow the Board more time for discussion in closed session. Director Battani stated that starting the open session Board meeting earlier would possibly impede the public from coming to the meetings. Board and management will be more diligent in reconveming to public session at 7:30 pm. In the future. If discussions are not concluded in closed session at 7:30 p.m., the Board can reconvene into closed session after the open session. 5. **Foundation Matching Funds Campaign** Dennis Eloe spoke on behalf of the Foundation about the Ventilator Challenge. They have received an anonymous $15,000 matching gift donation for every new or increased donation to the Foundation. Management has taken on the challenge along with a hospital wide challenge to help participate in the campaign for the new ventilators. Mr. Eloe invited the Board to participate in the challenge.	
	D. Medical Staff President Report 1. Approval of Amendments to Medical Staff Rules and Regulations, Article 2. *Anesthesia Service* 2. Approval of Amendments to Medical Staff Rules and Regulations, Article 16. *Medical Records*	Director Wasson moved to approve the amendments to the Medical Staff Rules and Regulations. Director Deutsch seconded the motion. The Motion carried unanimously.
9. General Public Comments	None.	

10. Board Comments	None.	
11. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at p.m.

Attest:

Jordan Battani
President

Robert Bonta
Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

March 12, 2009

Directors Present:
Jordan Battani
Robert Bonta
Robert Deutsch, MD
J. Michael McCormick

Medical Staff Present:
Alka Sharma, M.D.

Excused:
Steve Wasson

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

Legal Counsel Present:
Thomas Driscoll, Esq.

Submitted by: Kristen Thorson

Topic	Discussion	Action / Follow-Up
1. Call to Order	Jordan Battani called the Open Session of the Special Meeting of the Board of Directors of the City of Alameda Health Care District to order at 5:54 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that all Director were present except Director Wasson.	
3. Closed Session	At 5:55 p.m. the meeting adjourned to Executive Closed Session.	
5. Reconvene to Public Session & Adjournment	Jordan Battani reconvened the meeting into public session at 8:00 p.m.	
6. Closed Session Announcements	No announcements or action was taken in Executive Closed Session.	
8. General Public Comments	None at this time.	
10. Board Comments	None at this time.	
11. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 8:03 p.m.

Attest:

_____
Jordan Battani
President

_____
Robert Bonta
Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: March 27, 2009

TO: Board of Directors, City of Alameda Healthcare District

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Annual Report for Environment of Care

The hospital Safety Committee hereby submits the enclosed 2008 Annual Environment of Care reports for approval by the district board of directors. The Safety Committee meets bi-monthly. At each of these meetings, each subcommittee reports on its activities. These activities are then summarized on an annual report that includes key accomplishments and goals for the upcoming year.

Enclosed are subcommittee annual reports covering the following areas of Environment of Care.

- Emergency Management
- Medical Equipment Management Plan
- Utilities Management
- Fire / Life Safety Management
- Human Resources Safety Plan
- Hazardous Materials and Waste Management
- Security Management
- Staff Education and Training

This past year there has been special focus on updating the Emergency Management plan, as there have been several changes and updates in this area as required by the Joint Commission. There is also an exerted effort to have greater employee involvement in emergency management education and exercises. There have been many personnel changes during calendar year 2008 that have changed the composition of the Safety Committee. Although these personnel changes can be challenging, it also provides the opportunity for new employees to participate in the committee and bring new ideas, recommendations and energy.

The committees meetings and activities were well documented and well organized. It is our goal to maintain this level of preparation and progress to ensure a safe environment of care during the 2009 calendar year.

Alameda Hospital
2008 Annual Evaluation of the Environment of Care Program
Emergency Management

I. Summary of Effectiveness

The basis of the Alameda Hospital Emergency Management program is to provide a program that ensures effective mitigation, preparation, response & recovery in all disasters or emergencies affecting the environment. The hospital has developed an "all hazards' approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of the cause.

A major task in 2008 was completing the objectives and planning in the six critical areas of emergency as identified by the Joint Commission: communication, resources & assets, safety & security, staff roles and responsibilities, utilities and clinical activities. The entire Emergency Management Manual was revised and re-organized in accordance with these six critical areas.

II. Scope

The scope of the Emergency Management Plan addresses issues for patients, visitors, personnel, volunteers, physicians, and property. Program administration is delegated by the Safety Committee to the Safety Officer, Emergency Management Coordinator, and Emergency Management Subcommittee. The Alameda Hospital EM program works in collaboration with the city of Alameda, Alameda County Emergency Medical Service Agencies, Bay Area hospitals, and other State and Federal agencies.

III. Objectives and Goals for 2008

2008 Specific Objectives and Goals	Status
Activate and utilize the Emergency Operations Plan and HICS in all disaster drills and exercises in all aspects as appropriate.	The Alameda Hospital Operations Plan & HICS were utilized in all disaster drills & exercises.

Education and re-education of all staff to the Alameda Hospital emergency management plan with focus on revisions and changes, HICS and Joint Commission standards.	99% of Alameda Hospital staff completed orientation & MAT training. Additional inservices were held intermittently. The disaster after action conferences were utilized to provide education and reinforcement of the Emergency Management Program.
Train additional staff in First Responder awareness.	Classes completed: Disaster Triage Training CBRNE Training Hospital DeCon Operations Wet Decontamination Training & Drill
Increased education for Emergency Room staff in all aspects of patient management during a disaster, patient triage and patient flow.	22 Emergency Dept. persons received increased training in patient management, patient triage and patient flow.
Inventory, evaluate and re-organize equipment and supplies in the Disaster Preparedness trailers.	Disaster Preparedness storage trailer and bin were inventoried, evaluated & re-organized. Disaster storage area diagram and equipment & supply list developed.
Revise and update HVA incorporating Alameda City HVA priorities.	G. Williams attended Alameda City & Alameda County disaster planning groups and participated in HVA discussions. Priorities established were incorporated in Alameda Hospital HVA.
Participate in statewide disaster exercise for 2008	There wasn't a statewide drill this year. Alameda Hospital participated in the SUASI Bay Area and Regional Silver Sentinel drill and Alameda County table-top pandemic drill exercise.
Assess ability to prioritize, manage and allocate resources during a surge event.	Assessed in June 11, 2008 drill – in hospital surge due to inability to accommodate patients on SNF/SUB Unit
Demonstrate the ability to communicate facility needs to outside vendors, outside suppliers, EMS, Alameda City and corporate healthcare system.	Partially demonstrated in Silver Sentinel
Continue to plan, establish and exercise ability to activate alternate care sites.	Ongoing

IV Performance

Performance indicators included:

A. Participation in drills: Total 2W staff participation in June 11th drill & 65% participation from rest of hospital.

B. Wet Decontamination Drill – 12 Emergency Department personnel from all three shifts fully participated.

V Goals for 2009

A. Continue education & training of all staff to Alameda Hospital Emergency Management updated plan. Reinforce HICS & Decontamination training.

B. Participate in California Statewide Disaster exercises.

C. Implement CAHAN alerting system in Alameda Hospital.

D. Increase ReddiNet Capabilities at Alameda Hospital.

E. Conduct Internal Code drills for all internal code procedures.

Alameda Hospital

2008 Annual Review
Of the
Medical Equipment Management Plan

Mission Statement

It is the mission of the Biomedical Engineering department to ensure that hospital clinical equipment is in an optimal and safe condition. We are responsible for the testing, repair, and scheduled maintenance of all contracted clinical equipment owned, leased and/or operated by the hospital, its employees, and physicians.

Goals and Objectives

Test and ensure the operating safety of all clinical equipment utilized in the Hospital according to the requirements set forth by JCAHO, NFPA, CAP, AOA, state law, and the manufacturer of the equipment.

Perform immediate service, timely repair, and proper documentation of all contracted clinical equipment found to be malfunctioning and/or operating outside of required safety standards.

Conduct and document appropriate preventive maintenance procedures on contracted equipment as scheduled.

Monitor and review any and all activity performed by outside contractors for the Biomedical Engineering department.

Provide professional advice for repair versus replacement decisions and for clinical equipment evaluations and pre-purchase activities.

Reduce the amount of Human Factor and Can Not Duplicate symptom service calls by obtaining or providing in-service education for all clinical areas regarding the safe and proper use of medical instrumentation.

Strive for a planned maintenance (PM) completion rate of at least 95%.

Planned Maintenance and Corrective Maintenance

For the calendar year 2008, there were 1451 completed Planned Maintenance (PM) actions of 1487 scheduled. An additional 53 PM actions were completed out of schedule bringing the annualized cumulative PM compliance up to 98.9%. This exceeded our set threshold of 95.0%.

	PM Scheduled	PM Completed	PM Carried Forward
1st Quarter	429	422	7
2nd Quarter	377	373	4
3rd Quarter	359	357	2
4th Quarter	450	453	3
Totals	1615	1605	16

385 Corrective Maintenance (CM) actions were completed during the year. 5 of these repair items were classified as Operator Error or Misuse. A total of 8 Can Not Duplicate (CND) errors were recorded for the year. No specific trends were identified within these CND and Operator Error failures. 2 items were coded as being Abuse. These mostly include pulled power cords or dropped equipment and are not necessarily considered as intentional in nature.

	CM Completed	CND Errors	Operator Errors	Device Abuse
1st Quarter	160	0	1	1
2nd Quarter	63	0	0	0
3rd Quarter	94	5	0	0
4th Quarter	68	3	1	1
Totals	385	8	5	2

Equipment Inventory and Service Documentation

At the close of 2008 there were 1615 items on the active equipment inventory. There were 162 items retired and 179 items added for the year. The majority of these changes were rental equipment entering and exiting the hospital.

As a continuing performance improvement standard and goal, Equipment Inventory accuracy continues to be addressed. Utilizing a PDA system, equipment make, model, serial number information, as well as location, and contract coverage levels are being verified and corrected on a monthly basis. As purchase information is provided by the hospital, initial purchase price and PO information is being included in the equipment records. New equipment control numbers are being added to existing equipment. These new identification tags identify the equipment within the GE Healthcare network and allow for nationwide tracking tying the equipment to our site.

Biomedical Engineering continues to support the hospital in their retirement and acquisition of medical equipment. End of Product Life (EOPL) letters are distributed through GE to help watch for items that are nearing the end of their serviceable life. As the manufacturers set End of Product Life dates, service & support or replacement options are discussed with the department directors.

Inspections

The Biomed program at Alameda Hospital did not received GE Healthcare internal inspections/audits in 2008. We are scheduled to have a GE Healthcare internal inspections/audits in 2009.

Summary

The Medical Equipment Management Program for Alameda Hospital was effective in 2008. The planned maintenance (PM) compliance percentage continually exceeded 95%. The new Nihon Kohden Telemetry System in Emergency Department was introduced with zero major repairs in 2008. Biomedical Engineering continues to support the hospital capital equipment planning committee with recommendations for the replacement of obsolete/aged equipment. The use of the PDA has improved the capture and recall of information in the database with the ability to make timely updates to the data.

2008 Performance Improvement Standards and Goals

Maintain a Planned Maintenance (PM) completion rate of at least 95%

Continue to verify equipment inventory accuracy. Verify equipment make, model and serial numbers. Expanding out to include locations and contract coverage levels.

Verify Planned Maintenance (PM) schedules and coverage levels. Update department logbooks with current content on a semi-annual basis.

Improve implementation of both the GEHC and Hospital policies in regards to temporary equipment (Demo/Loaner/Rental) being brought into the facility.

Alameda Hospital
2008 Annual Evaluation of the Environment of Care Program
Utilities Management

I. Summary of Effectiveness

The utility program continues to be diligent and successful with an active Safety Committee and support from Administration.

A. All preventative maintenance (PM's) completed

B. Extensive unplanned issues (see below) were evaluated and projects were developed to address the problems.

II. Scope

Alameda Hospital strives to maintain a Utilities System program which promotes a safe, controlled and comfortable environment of care for the benefit of patients, staff and visitors. Management of the Program is the responsibility of the Engineering Department.

It includes continuous monitoring, regular preventive maintenance, inspections, repairs, testing and corrective work orders. These activities continuously evaluate risks associated with utility systems and equipment and determine which factors, if any, need monitoring to assure proper performance. Services offered and sites covered by the plan remain essentially the same.

III. Objectives and Goals for 2008

Overall Goals:

- Assess and minimize the risks of utility failures
- Reduce the potential for hospital-acquired illness
- Ensure the operational reliability of utility systems through PM's

2008 Specific Objectives and Goals	Status
1. Implement new Joint Commission Environment of Care for Utilities	1. Joint Commission was late in finishing the changes Will continue goal in 2009
2. Address Joint Commission New Life Safety Code and Standards	2. Joint Commission was late in finishing the changes. Will continue the goal in 2009.

IV. Performance Indicators 2008:

A. Complete Preventative Building Maintenance: 100% complete

B. Service all work order request and incident reports: 98% complete

C. Projects:
Nurse Call for 2 South: 90% completed
Satellite Pharmacy; OSHPD Drawing 95% completed

V. New Unplanned Issues in 2008

New unplanned issues addressed by the Safety Committee in 2008 include:

A. New Nurse Call System for 2 South

B. VHA Patient Education Channel installed

C. Surgery Air Handler deterioration

VI. Objectives and Goals for 2009

A. Zurich Insurance Recommendations

1. Seismic shut-off for Natural gas
2. Sprinkler pipe bracing

B. Control Air Compressor replacement

VII. Performance Indicators for 2009

A. Building Maintenance Program

B. Work Orders

C. Projects completed

Alameda Hospital
2008 Annual Evaluation of the Environment of Care Program
Fire/Life Safety Management

I. Summary of Effectiveness

The Fire/Life Safety Program continues to be diligent and successful with an active Safety Committee, Fire subcommittee, Safety Officer and support from Administration.

A. All fire safety exercises were conducted and evaluated with minimal intervention. In-service provided as needed. The need for Interim Life Safety Measures was appropriately evaluated and activated if determined necessary. No fire watches were required.

B. Fire Exercises were conducted on the weekend for all shifts.

II. Scope

The scope of the Fire (and Life) Safety Plan addresses the protection of patients, staff, physicians, visitors and property from fire, smoke and other products of combustion by following established operational plans and systems. Alameda Hospital strives to meet the Life Safety Code (NFPA-101), JCAHO, State and local regulations. The Plan is administered by the Safety Committee, Fire Safety subcommittee, Safety Officer and Engineering Director. Sites, services and hours of operation have not materially changed.

III. Objectives and Goals for 2008

1. Respond throughout the year to identified problems and relevant published information.

2. Continue questions on monitor sheet for Associate Knowledge and Life Safety.

3. Continue to review/revise fire alarm panel descriptions. (Continue process)

4. Review and update for department specific plan.

5. Develop a department specific plan for the Women's Health Center.

2008 Specific Objectives and Goals	Status
1. Respond throughout the year to identified problems and relevant published information regarding life safety	JCAHO Newsletter regularly reviewed as well as their website; OSHPD
2. Fire quiz exercise conducted on-site for all shifts	Weekend quizzes were conducted on-site for all shifts.
3. Fire alarm panel descriptions	On going, updated when Honeywell works on a projects.
4. review and up date for department specific plans	On going; six plans were reviewed in 2008
5. Develop a department specific plan for Women's Health Center.	Completed

Alameda Hospital
2008 Annual Evaluation of the Environment of Care Program
Fire/Life Safety Management

IV. Performance

Performance Indicators included:

A. A system was developed to score/rate the performance at the fire site during an exercise and track outcome. Overall rating for this year was: 1.9 / 3.0 – 63%

1.8 for night
2.0 for days
1.8 for PM

B. Increase staff knowledge each quarter: Questions 5 & 6 Life Safety and 3&5, Associate Knowledge target 95% Accuracy;
Life Safety was 100%
Associate was 98%

V. New Unplanned Issues in 2008

Recognize needed replacement of kitchen ansul system, will schedule for early 2009

VI. Objectives and Goals for 2009

1. Ansul replacement
2. Continue to review and update more department specific plans

VII. Performance Indicators for 2009

1. Track and evaluate scoring of performance at the fire site during exercises.

2 Reinforce staff knowledge each quarter with regard to question #3 & 5, Life Safety and #5 & 6, Associate Knowledge with a goal of 95% compliance.

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: March 19, 2009

To: Alameda Hospital Safety Committee

From: Patricia D. Carter, Sr. Human Resources Specialist

CC: Phyllis J. Weiss, Director of Human Resources

Subject: 2008 Annual Evaluation - Human Resources Safety Plan

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I. Summary of Effectiveness

The safety program continues to be diligent and successful with an active Safety Committee and support from Administration.

A. Employee Injury and Illness Subcommittee worked effectively to address occupational injury and illness such as the following:

- Worked with Managers and Engineering to fix any structural problems.
- Hazel Lau, Ergonomic Specialist, pro-actively performed ergonomic evaluations and in-service training (both departmentally and individually).
- Continued focus on prevention including accident site visits/assessments and employee training.

II. Scope

The scope of the Safety Management Plan encompasses all employees as well as registry, students, contracted employees, patients, volunteers, visitors and the medical staff. Services offered and sites covered by the plan remain essentially the same. The Plan is administered by a Safety Officer, Safety Committee and subcommittees.

Objectives and Goals for 2008
Overall Goals:

Continue to:

- Reduce number of injuries in the workplace

- Reduce amount of lost time due to injuries
- Educate and train employees and managers to proactively prevent injuries.

2008 Specific Objectives and Goals	Status
1. Continue ergonomics training for all departments	Ongoing. Hazel Lau, Ergonomics Specialist, continues to train employees regarding equipment.
2. Help manage usage of benchmark equipment	Monthly industrial injury reports were also reviewed with affected Department heads, to promote awareness and prevention.
3. Continue Manager and employee training regarding injury reporting procedures.	Human Resources incorporated injury reporting requirements in new hire orientation and new manager training.
4. Work with Zurich's Risk Engineering Department to assess and prevent risk, and to improve our benchmarking date.	Human Resources and Ergonomic Specialist, Hazel Lau, met with Zurich's Risk Engineer several times throughout the year, received benchmarking data and toured the facility. HR is currently working with Liberty Mutual, the current Workers' Comp. Insurance company, to obtain safety training materials for the new hire orientation.

IV. Performance

Performance indicators included:

Indicator	2004	2005	2006	2007	2008
# Staff in TAW	10.9	12	16	12	11
Total Hours Worked	1047	1047	1990	1818.75	1442
Total Salary Paid	$26,045	$26,045	$66,154	$50,474.03	$36,636

Track and improve employee injury rate.

2008: 1/4.2 Days
2007: 1/4.7 Days
2006: 1/4.6 Days
2005: 1/5.9 Days
2004: 1/5.1 Days

V. New Unplanned Issues in 2008

New unplanned issues addressed by the Safety Committee in 2008 include:

- Continued to create and provide temporary alternative work (TAW) to injured employees
- Manager awareness of safety issues within their functional areas.
- Working with Engineering and Hazel Lau, Ergonomics Specialist, to identify structural and other hazards.
- Employee awareness of patient lifting equipment and training. Hazel Lau continues to educate pro-actively, as well as in response to injury.
- Direct patient care for patient with scabies resulted in 16 employee exposure reports (included in the performance indicators above). However, none of these employees were found to have contracted scabies. Employees were sent to Alameda Centre Physicians for exam and preventative treatment.
- Alameda Hospital took over management of South Shore Convalescent Hospital, resulting in approximately 50 additional employees added to our workers' compensation insurance.
- Hazel Lau, Ergonomic Specialist, has completed in-service training for the South Shore employees regarding body mechanics. Rosemarie Delahaye, has provided in-service training to these employees regarding Infection Control including hand washing and personal protective equipment.
- Replaced Emeryville Occupational Medical Group (Dr. Gest) with Alameda Centre Physicians (Dr. Lam and Dr. Kong). This change has resulted in more complete and timely paperwork and more flexible and reliable scheduling of appointments.

VI. Objectives and Goals for 2009

1. Continue ergonomics training for all departments and new hires.
2. Help manage usage of equipment. – staff awareness and training
3. Continue Manager and employee training regarding injury reporting procedures.
4. Work with Liberty Mutual's Risk Engineering Department to assess and prevent risk, and to improve our benchmarking data.

Performance Indicators for 2009

1. Track employee injury and exposure statistics.
2. Track injuries by type and department to find trends.
3. Track timeliness of workers' comp. reports to ensure compliance with legal reporting requirements.

Alameda Hospital
2008 Annual Evaluation of the Environment of Care Program
Hazardous Materials and Waste Management

Scope

The scope of the Hazmat Committee is to ensure that hazardous materials and hazardous wastes are managed appropriately and that all employees are notified and trained in the safe use and disposal of these materials as it pertains to their job. Applicable personnel receive training in the proper management of all forms of wastes generated. The Plan is administered by the Hazardous Materials/Waste Management Subcommittee and Safety Officer under the direction of the Safety Committee. Services offered and sites covered by the Plan remain essentially the same.

Summary of Effectiveness for 2008 Objectives and Goals

2008 Goals	Effectiveness
Determine mechanism for securing MSDS copies from departments	In-service department director to forward all new MSDS to Engineering
Determine mechanism for managers to review department list online for accuracy	Cancelled; committee will form a new plan for 2009
Reconcile and update MSDS inventory against MSDS online	Completed
Develop mechanism to organize MSDS online by department	Completed
Look for new training material	Found training from Stericycle for : 1) proper packaging and handling of hazardous waste 2) Hazardous manifest report training

2008 Quality Performance Indicators

Quality Indicator	Performance and Goals	Evaluation and Effectiveness
Organize chemical inventory list and MSDS by department	100%	Completed
Update department chemical list Inventory list from managers against the MSDS online	0%	Revised new plan for 2009 Goal #2

Objectives and Goals for 2009

1. Training for
   - proper packaging of Hazardous Materials
   - HazMat manifest
2. Give department chemical list in printed form to Director of each department for review to be done annually.
3. Continue to look for new training material
4. Define hazardous spill teams – responsibilities and goals

Performance Indicators for 2009

1. Department chemical list reviewed by department director and returned
2. Number of new MSDS sent to committee
3. Hazardous spills
4. Resource Conservation and Recovery Act –RCRA – Pharmaceutical Waste Disposal Program

Alameda Hospital

MEMORANDUM

TO: Kerry Easthope, Assistant Administrator

FROM: Tony Corica, Security Subcommittee Chairman

DATE: January 26, 2009

SUBJECT: Framework for security incident reporting and summary of reportable security incident for 2008

In order to assure a safe environment for patients, personnel, and visitors, Alameda Hospital has an integrated security program that encourages employee/visitor vigilance in reporting any situations that poses a threat to life, health and/or property. Theses reports may be generated via communication with Administration or any employee or visitor, via the Security Officer's Daily Activity Report or a number of other sources. Reportable incidents, including theft, exterior building/parking lot/property damage and problems with loiterers/visitors/patients, etc., are communicated to the Safety Committee on a bi-monthly basis.

A summary of the reportable security incidents for 2008 is shown below. No employees sustained an injury due to a security incident in 2008.

2008 SUMMARY OF SECURITY INCIDENTS

	Reported Theft of Hospital Equipment	Thefts from individuals	Reported exterior building graffiti parking lot damage to property	Reported problems w/visitors/loitering public/patients	Total # of reportable security incidents
2008 Total	0	3	0	8	11
Nov-Dec 08				1	1
Sept.- Oct 08				3	3
July – Aug 08				1	1
May – June 08		1			1
Mar – Apr 08			0	3	3
Jan – Feb 08		2			2

Cc: Tom Jones, Gina Arnone

Alameda Hospital
2008 Annual Evaluation of the Environment of Care Program
Security Management

I. Summary of Effectiveness

The Safety Program continues to be diligent and successful with an active Security Committee and support from Administration.

A. Security Officers' post orders were reviewed to ensure they meet current needs.
B. The Hospital began a "stacked parking" program in October, 2003 after an in-depth evaluation of the effective means to meet the growing demand for parking spaces with no ability to expand. In 2005, an additional attendant was added. Parking attendants are on the campus Monday – Friday, 7:00am – 5:00pm. This program has provided an additional physical presence that enhances our security.
C. A comprehensive security risk assessment was performed by Securitas Services in December 2006. It showed that the area surrounding Alameda Hospital has a very low rating for potentials security incidents.
D. The Security Management Plan and Program was reviewed. The low number of security incidents continued in 2008.
E. There were a total of 11 reportable security incidents in 2008. While there were slight increases or reductions in the areas measured, the total number of reportable security incidents in 2008 totaled only eleven (11). No employees sustained an injury due to these incidents. Please see Section V., New Unplanned Issues Addressed in 2008 for the actions taken.

II. Scope

The scope of the Security Management Plan addresses security issues for patients, visitors, personnel, volunteers, physicians, and property. A close working relationship is maintained with Alameda Police Department. Hospital personnel, including the PBX Operator, are trained on how to summon help for emergency and non-emergency situations. Standardized codes facilitate widespread communication and trained security officers provide additional service. All incident reports are reviewed within 72 hours by the Security Subcommittee Chair. The Plan is administered by the subcommittee Chair, Safety Committee, and Safety Officer.

The scope changed in late 2003 with the addition of stacked parking attendants and standardization of emergency codes to facilitate emergency communications. Those security enhancements were communicated and maintained during 2008. The Security Management Program was reviewed by Joint Commission Surveyors in May, 2007. No recommendations were made following their review.

III. Objectives and Goals for 2008

Overall Goals:

- A safe and secure environment for all persons associated with the facility,
- A facility equipped to meet the security needs of employees, patients, visitors, physicians, and volunteers.
- Compliance with state regulations, security standards and policies, procedures, and practices of the Hospital.

2008 Specific Objectives and Goals	Status
1. Continue compliance with AB508	A comprehensive risk assessment conducted in December 2006 showed a low threat level. There were only 11 reportable incidents in 2008.
2. Provide bi-monthly reports to Safety Committee supporting the Information Collection and Evaluation System (I.C.E.S.)	All reports completed and discussed at Safety Committee.
3. Increase employee security awareness with articles in the "Pulse," and the Hospital web site, and training in Orientation/ Mandatory Annual Training.	All these activities were completed. Self defense classes were held.
4. Reduce total reportable security incidents by 5%.	Total reportable incidents increased from 9 in 2007 to 11 in 2008. While the indicator as not met, security incidents remain low and no injuries by staff were sustained.
5. Reduce "Reported Problems with visitors loitering public/patients" by 5%	These problems increased from 6 to 8 in 2008. Standard not met. See V.B for actions taken.

IV. Performance

Performance indicators included the following (*Refer to attached graphs).*

A. Increase in total reportable incidents: 2000 – 27 incidents 2001 - 14 incidents 2002 - 10 incidents 2003 - 11 incidents 2004 - 10 incidents 2005 - 6 incidents 2006 - 10 incidents 2007 – 9 incidents 2008 - 11 incidents	C. Increase in theft from individuals: 2000 – 5 incidents 2001 – 1 incident 2002 – 3 incidents 2003 – 1 incident 2004 – 4 incidents 2005 – 3 incidents 2006 - 2 incidents 2007 – 1 incident 2008 - 3 incidents
B. Increase in problems with visitors, public, or patients: 2000 – 20 incidents 2001 - 13 incidents 2002 – 7 incidents 2003 - 6 incidents 2004 - 4 incidents 2005 - 2 incidents 2006 - 3 incidents 2007 - 6 incidents 2008 - 8 incidents	D. Decrease in the theft of Hospital equipment: 2000 – 0 incidents 2001 - 0 incidents 2002 - 0 incidents 2003 - 3 incidents 2004 - 1 incident 2005 - 1 incident 2006 - 0 incidents 2007 - 1 incident 2008 - 0 incidents

E. Decrease in Exterior/Lot Damage:

2000 – 1 incident
2001 - 0 incidents
2002 – 0 incidents
2003 - 1 incident
2004 - 1 incident
2005 - 0 incidents
2006 - 5 incidents
2007 - 1 incident
2008 - 0 incidents

V. New Unplanned Issues Addressed in 2008

New unplanned issues addressed by the Security Committee in 2008 include:

A. Several reported cases of personnel falsely representing themselves as Joint Commission (JC) representatives were reported to Hospitals. This was discussed at Management Staff meetings. All managers were instructed to contact Hospital Administration and Security should JC representatives appear. Photo identification would then be required and a call to the JC office to verify that an inspection had been authorized would be made before the inspection was begun. Hospital escorts (Administration or designee) would then accompany the surveyors.

B. The increase in the "Reported Problems with visitors, loitering public and patients" leads to the following actions being taken:

1. Security Officer coverage has been extended from 7:00am to 7:30am. On weekdays, the Security Officer will not leave until the Parking Lot Attendant arrives. On weekends, the Security Officer will not leave until his relief officer arrives;
2. Additional Detex system buttons have been installed in the parking lot. Regular security rounds of the Hospital now include the rear parking lot to the light standard near the lagoon to the parking office kiosk, as well as all floors within the Hospital;
3. Security Officers will be stationed in the main parking lot from 5:30am – 7:30am;
4. Alameda Police Department has agreed to more frequently patrol our parking area, and;
5. Employees were asked to be increasingly vigilant regarding suspicious activity in the Hospital and Parking Lot.

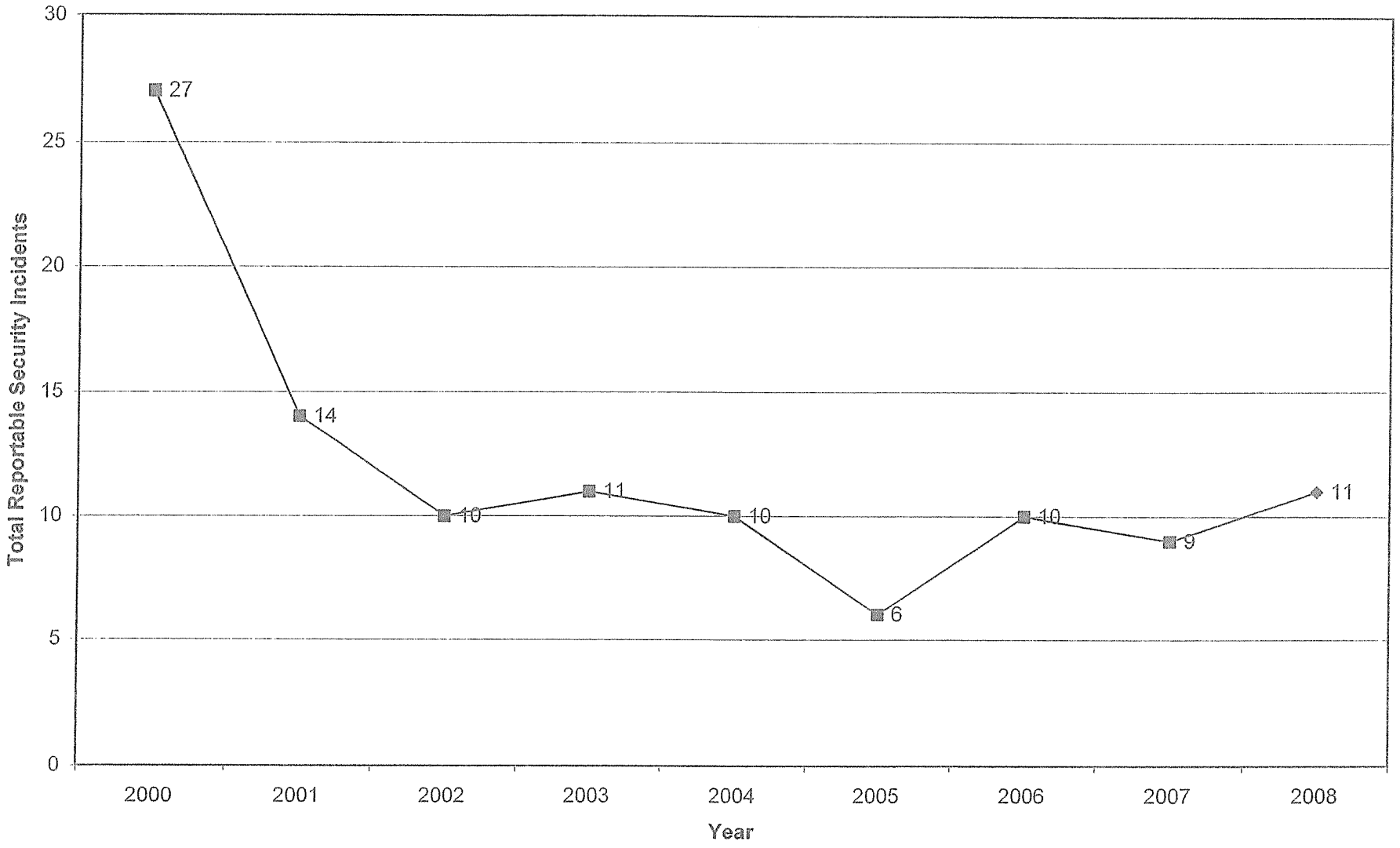
C. All elevators in the Hospital are now checked by the Security Office during their regular rounds by physically calling the individual cars to ensure they are in working order.

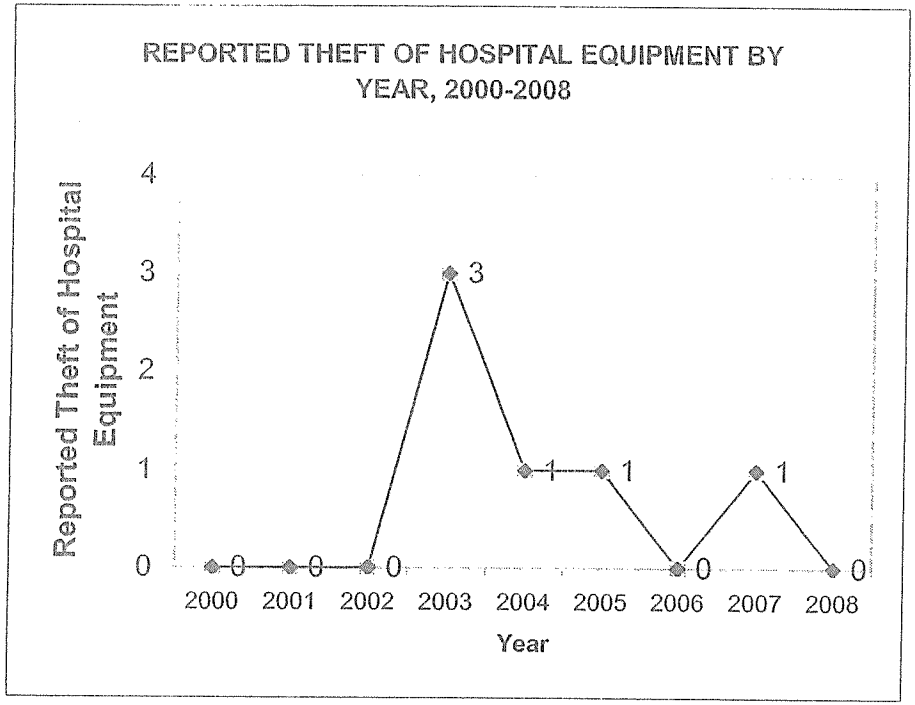
VI. Objectives and Goals for 2009

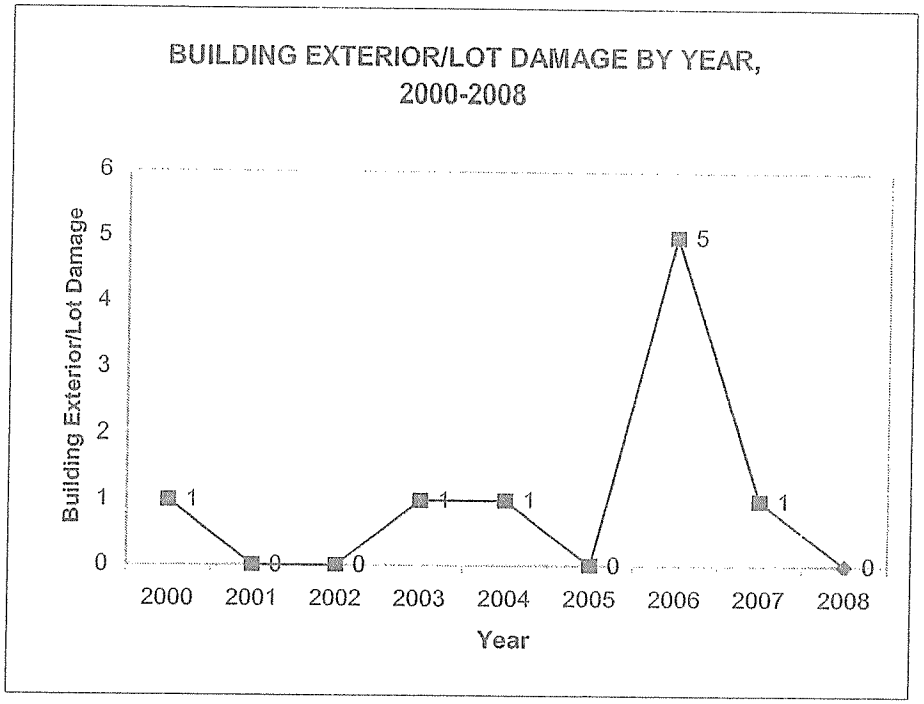
A. Consider implementation of the recommendations of the December 2006 risk assessment (closed circuit TV recording capabilities).
B. Increase security awareness with staff by utilizing various communication tools (Pulse, Orientation, MAT).
C. Provide bi-monthly reports to Safety Committee with the objective of effective and timely resolution of security incidents.
D. See improvement in the Performance Indicators identified in IV. Specifically a 5% reduction in reportable incidents, problems with visitors, public or patients, and theft from individuals, which increased slightly in 2008, will be sought.

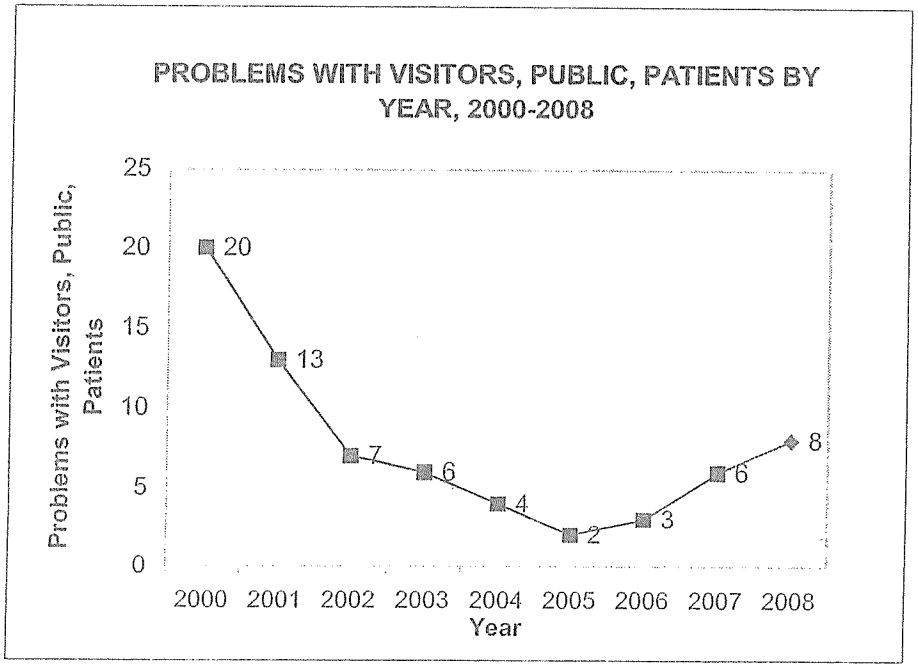
Attachments

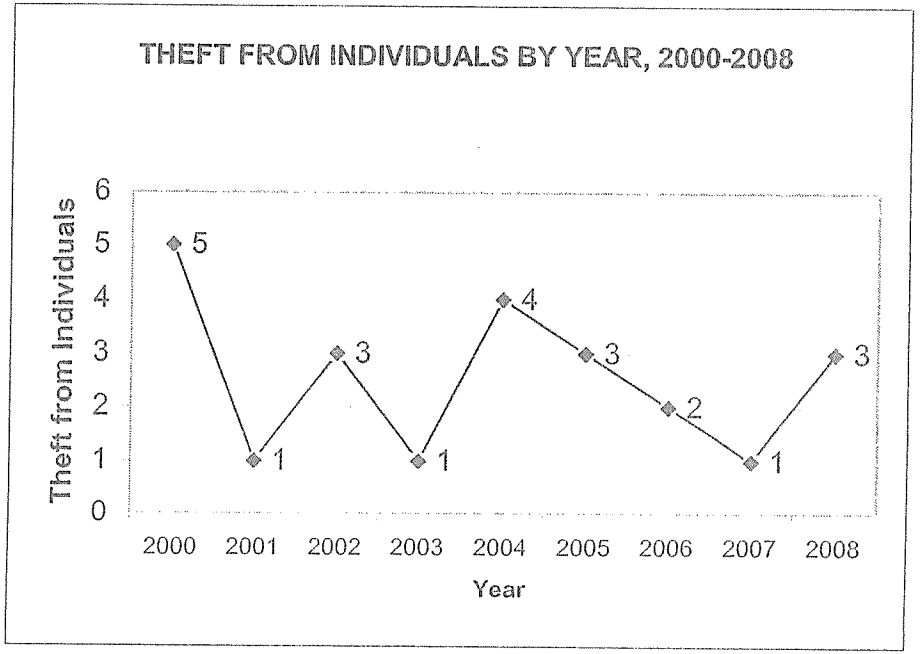
TOTAL REPORTABLE SECURITY INCIDENTS BY YEAR, 2000-2008




REPORTED THEFT OF HOSPITAL EQUIPMENT BY YEAR, 2000-2008
Reported Theft of Hospital Equipment
0
1
2
3
4
0 0 0 3 1 1 0 1 0
2000 2001 2002 2003 2004 2005 2006 2007 2008
Year


BUILDING EXTERIOR/LOT DAMAGE BY YEAR, 2000-2008
Building Exterior/Lot Damage
0
1
2
3
4
5
6
1 0 0 1 1 0 5 1 0
2000 2001 2002 2003 2004 2005 2006 2007 2008
Year


PROBLEMS WITH VISITORS, PUBLIC, PATIENTS BY YEAR, 2000-2008
Problems with Visitors, Public, Patients
0
5
10
15
20
25
20 13 7 6 4 2 3 6 8
2000 2001 2002 2003 2004 2005 2006 2007 2008
Year


THEFT FROM INDIVIDUALS BY YEAR, 2000-2008
Theft from Individuals
0
1
2
3
4
5
6
5 1 3 1 4 3 2 1 3
2000 2001 2002 2003 2004 2005 2006 2007 2008
Year

2008 ANNUAL EDUCATION REPORT

The Educational component of employment at Alameda Hospital is addressed in the Goals in support of the Hospital's Mission Statement:

> "To attract and retain outstanding employees, to foster an environment where employees gain a sense of satisfaction and accomplishment from their work; and to create a safe and pleasant work setting."

The Alameda Hospital Educational program was de-centralized to the various individual departments in January 2008. The Nursing Department Educational program is provided by Nursing Managers, Supervisors, and staff.

The Peri-operative Services department held weekly educational programs for 40 of the 52 calendar weeks in 2008. Approximately 15 staff attended these ½ hour sessions that included use of new equipment, medication errors, and new techniques.

The Emergency Care Center held 5 programs specific to their unit. These included splinting, toxicology, handling patient complaints, and use of disaster triage tags. Approximately 46 staff attended these sessions.

Other classes/in-services included instruction in BLS (Basic Life Support), Respiratory Care, Airway Management, Ergonomics & Suicide Prevention. Additionally off-site training occurred for required certification in ACLS (Advanced Cardiac Life Support) and PALS (Pediatric Advanced Life Support).

The following table displays the number of employees attending some of the classes in 2008:

Class:	**# of Employees Attending:**
Mandatory Annual Training (MAT)	623
C.N.A. Recertification	140
New Employee Orientation	103
Color-Coded Wristbands	98
Non-Violent Crisis Intervention	78
Basic Life Support (BLS)	77
Licensed Nurse Updates	66
Class:	**# of Employees Attending:**
Performance Improvement Collaboration	29
Disaster Management	22
Decontamination Drill Training	12
Rapid Response Team	12
Disaster Preparedness-Emerg. Prep for Care Providers	11
Decontamination-HICS	7

Goal for 2009:

During the 2009 calendar year, it is our goal to obtain, implement and utilize an online education tool that will provide a more comprehensive directory of available educational and training applications to better educate our employees. The program (Healthcare Compliance Strategies) has been selected with an anticipated implementation schedule during the third quarter of the year. This new program will replace, and in some cases

CITY OF ALAMEDA HEALTH CARE DISTRICT
ADMINISTRATIVE POLICY No. 86

TITLE: Identity Theft Prevention Program

PURPOSE: To develop and implement a written Identity Theft Prevention Program

SCOPE: Hospital-wide

POLICY:

It is the policy of Alameda Hospital to provide health care services in a manner that complies with applicable federal and state laws and that meets the high standards of business and professional ethics. To further this policy, and to comply with sections 114 and 315 of the Fair and Accurate Credit Transactions Act of 2003, the Alameda Hospital Board of Directors has developed and approved this Identity Theft Prevention Program designed to detect, prevent and mitigate Identity Theft in connection with the opening of a Covered Account or any existing Covered Account ("Program").

Part I: Definitions:

The following definitions apply for purposes of this Program:

"**Account**" means a continuing relationship established by a person with Alameda Hospital to obtain a product or service for personal, family, household or business purposes.

"**Covered Account**" means:

(1) Any account Alameda Hospital offers or maintains primarily for personal, family or household purposes that involves or is designed to permit multiple payments or transactions; and

(2) Any other account Alameda Hospital offers or maintains for which there is a reasonably foreseeable risk to Patients or to the safety and soundness of Alameda Hospital from Identity Theft.

"**Patient**" means a person that has a Covered Account with Alameda Hospital.

"**Identity Theft**" means a fraud committed or attempted using the Identifying Information of another person without authority.

"**Identifying Information**" means any name or number that may be used, alone or in conjunction with any other information, to identify a specific person, including any name, social security number, date of birth, official State or government issued driver's license or identification number, alien registration number, government passport number, employer or taxpayer identification number; unique biometric data, such as fingerprint, voice print, retina or iris image, or other unique physical representation; unique electronic identification number, address, or routing code; or telecommunication identifying information or access device.

"**Red Flag**" means a pattern, practice, or specific activity that indicates the possible existence of Identity Theft.

"**Service Provider**" means a person or business entity that performs an activity for Alameda Hospital in connection with one or more Covered Accounts.

Part II: Periodic Identification of Covered Accounts

Alameda Hospital shall periodically conduct a risk assessment to determine the types of Covered Accounts the Hospital offers and/or maintains, taking into consideration (1) the methods the Hospital provides to open its Accounts; (2) the methods the Hospital provides to access its Accounts; and (3) the Hospital's previous experiences with Identity Theft.

Part III: Periodic Identification of Relevant Red Flags

Alameda Hospital shall periodically identify and update relevant Red Flags for the Covered Accounts that the Hospital offers or maintains to reflect changes in risks to Patients and to the safety and soundness of Alameda Hospital. Such Red Flags shall be incorporated into the Program. In order to identify relevant Red Flags, Alameda Hospital shall review and consider the types of Covered Accounts that the Hospital offers and/or maintains, the methods the Hospital provides to open Covered Accounts, the methods the Hospital provides to access its Covered Accounts, and the Hospital's previous experiences with Identity Theft.

Part IV: Verification of Patient Identity at Time of Registration

Alameda Hospital staff shall, to the extent feasible, request documentation of the Patient's name, date of birth, residence address and insurance coverage at the time of registration.

1. When a Patient requests an appointment, Alameda Hospital shall request the Patient to bring the following documentation at the time of the appointment:

    a) Valid government-issued ID evidencing current residence address and bearing a photo, such as a driver's license or passport ("Photo ID");
    b) Valid insurance card; and
    c) If the Photo ID does not show the Patient's current residence address, utility bills or other correspondence showing current residence address.

    If the Patient is a minor, the Patient's legally authorized representative must bring the information listed above.

2. When the Patient arrives for the appointment, the Patient must produce all of the documentation listed above.

3. Alameda Hospital shall verify all registration information and request additional documentation of identity if necessary.

4. Exception: If the Patient has come to Alameda Hospital to request evaluation or treatment for an emergency medical condition, the provision of a medical screening examination shall not be delayed to obtain documents verifying identity.

Part V: Detection of Red Flags and Responses

New Accounts

Alameda Hospital staff shall watch for the following discrepancies in documents and Patient Identifying Information that suggest the risk of Identity Theft and that the Hospital has identified as Red Flags associated with the opening of new Accounts.

- The Patient submits any Identifying Information that appears to be altered or forged.

- The photograph on any Identifying Information submitted by the Patient does not resemble the Patient.

- Information on one form of Identifying Information submitted by the Patient is inconsistent with information on another form of Identifying Information, or with information already on file.

- The Social Security Number (SSN) furnished by the Patient has not been issued, is listed on the Social Security Administration's Death Master File, or is otherwise invalid. The following numbers are always invalid:

    - The first three digits are in the 800, 900 or 000 range, are in the 700 range above 772, or are 666;

    - The fourth and fifth digits are 00; and

    - The last four digits are 0000.

- The address given by the Patient does not exist, or is a post office box.

- The phone number given by the Patient is invalid or is associated with a pager or an answering service.

- The Patient fails to provide Identifying Information or documentation.

- Identifying Information given by the Patient is not consistent with Identifying Information on file.

- The Patient's signature does not match the signature on file.

- The Social Security Number or other Identifying Information furnished by the Patient is the same as the Social Security Number or other Identifying Information on file furnished by other individuals.

To prevent and mitigate Identity Theft, if Alameda Hospital staff detects one or more Red Flags in the process of opening a new Covered Account, such staff shall take one or more of the following steps depending on the degree of risk posed by the Red Flag(s):

- Decline to open a new Covered Account; and/or

- Notify the Program Administrator/Board Identity Theft Committee for determination of the appropriate step(s) to take.

Existing Accounts

Alameda Hospital staff shall watch for the following suspicious information that may suggest Identity Theft and that the Hospital has identified as Red Flags associated with the maintenance of existing Covered Accounts.

- A complaint or question from a Patient based on the Patient's receipt of:

    - A bill for another individual;
    - A bill for a product or service that the Patient denies receiving;

    - A bill from a health care provider that the Patient never patronized; and/or
    - A notice of insurance benefits (EOB) for health services never received.

- Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the Patient.

- A complaint or question from a Patient about the receipt of a collection notice from a bill collector.

- A Patient or insurance company report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.

- A complaint or question form a Patient about information added to a credit report by Alameda Hospital or the insurer.

- A dispute of a bill by a Patient who claims to be the victim of any type of Identity Theft.

- A Patient who has an insurance number fails to produce an insurance card or other physical documentation of insurance within five (5)] business days.

- A notice or inquiry from an insurance fraud investigator on behalf of a private insurance company, government program or other payor or a law enforcement agency.

To prevent and mitigate Identity Theft, if Alameda Hospital staff detects one or more identified Red Flags with respect to an existing Covered Account, such staff shall take one or more of the following steps depending on the degree of risk posed by the Red Flag(s):

- Monitor a Covered Account for evidence of Identity Theft;

- Contact the Patient with the Covered Account;

- Change any passwords or other security codes and devices that permit access to a Covered Account;

- Close an existing Covered Account;

- Reopen a Covered Account with a new number;

- Notify law enforcement;

- Follow the steps for an investigation in accordance with Part VI;

- Determine that no response is warranted under the particular circumstances; and/or

- Notify the Program Administrator/Board Identity Theft Committee for determination of the appropriate step(s) to take.

Part VI: Investigation of Potential Identity Theft

1. To prevent and mitigate Identity Theft, when an individual claims to be a victim of Identity Theft, Alameda Hospital shall investigate the claim in accordance with the following guidelines.

   The individual must provide Alameda Hospital with a copy of a police report regarding the claimed Identity Theft.

   The individual must provide Alameda Hospital with one of the following documents:

   - The Identity Theft Affidavit developed by the Federal Trade Commission, including supporting documentation;
   - An Identity Theft Affidavit recognized under state law, including supporting documentation; or
   - A statement signed by the individual that includes the following information:
     - A statement that the individual is a victim of Identity Theft
     - A copy of the individual's valid government-issued Photo ID
     - Any other identification document that supports the statement of Identity Theft
     - Specific facts supporting the claim of Identity Theft
     - Any other evidence that the individual is not the person who incurred the debt
     - Any available correspondence disputing the debt
     - Documentation of the individual's residence address on the date of service, including copies of utility bills, tax statements, or other statements from businesses sent to the individual at his/her residence address
     - A telephone number where the individual can be contacted
     - Any information that the individual may have concerning the person who registered in his/her name
     - A statement that the individual did not authorize the use of his/her Identifying Information for obtaining services
     - A certification that the individual's representations in the statement are true and correct and contain no omissions of fact to the best knowledge, information and belief of the individual submitting the statement.

   The individual must cooperate with Alameda Hospital's investigation.

2. If following the investigation, Alameda Hospital determines that the individual was a victim of Identity Theft, Alameda Hospital shall take the following actions:

   Alameda Hospital shall cease collection on open Accounts that resulted from Identity Theft. If the Accounts had been referred to collection agencies, Alameda Hospital shall instruct the collection agencies to cease collection activities on those Accounts.

Alameda Hospital shall cooperate with any law enforcement investigation relating to the Identity Theft to the maximum extent permitted by law.

If a private insurance company, government program or other payor has made payment on the account, Alameda Hospital shall notify such company, program or payor and refund the amount paid.

If Alameda Hospital has made a report to a consumer reporting agency regarding the Account, Alameda Hospital shall notify the agency that based on Alameda Hospital's investigation, the Account was not the responsibility of the individual.

3. If following the investigation, Alameda Hospital determines that the individual was not a victim of Identity Theft, Alameda Hospital shall, or request the collection agencies to, give written notice to the individual that he/she is responsible for payment of the Account. The notice shall state the basis for Alameda Hospital's determination that the individual was not the victim of Identity Theft.

Part VII: Correction of Errors in Medical Records

Inaccuracies in medical records resulting from Identity Theft shall be corrected as soon as possible and not later than ten (10) business days after detection.

1. If it is confirmed that a Patient medical record was created as the result of Identity Theft, Medical Records staff shall make a notation in the medical record regarding the Identity Theft. All erroneous demographic information shall be removed from the record.

2. Medical Records staff shall determine whether any other medical records are linked to the record found to be created through Identity Theft.

3. Identity Theft may involve an identity thief receiving care under the name of a former Patient. In such case, other files relating to the former Patient shall be reviewed and all erroneous demographic information shall be removed from the record.

4. Alameda Hospital shall comply with applicable Alameda Hospital HIPAA policies and procedures, including those regarding correction and amendment of medical records.

Part VIII. Program Administration

Oversight

The Program Administrator/Board Identity Theft Committee shall be responsible for oversight, development, implementation and continued administration of the Program.

Staff Training

Alameda Hospital staff responsible for implementing the Program shall be trained on an as needed basis in the effective implementation of the Program either by or under the direction of the Program Administrator/Board Identity Theft Committee.

Service Provider Arrangements

If Alameda Hospital engages a Service Provider to perform an activity in connection with one or more Covered Accounts, the Hospital shall exercise appropriate and effective oversight of Service Provider arrangements by requiring the Service Provider, by contract, to perform its activities with respect to Alameda Hospital Covered Accounts in compliance with the terms and conditions of the Program, perform its activities with respect to Alameda Hospital Covered Accounts in compliance with the terms and conditions of the Service Provider's own Identity Theft Prevention Program, and to report promptly to Alameda Hospital in writing if the Service Provider detects an incident of actual or attempted Identity Theft or is unable to resolve one or more Red Flags that the Service Provider detects in connection with an Alameda Hospital Covered Account.

Part IX: Patient Identifying Information and Disclosure

The Identifying Information of Alameda Hospital Patients with Covered Accounts shall be kept confidential and shall be exempt from disclosure to the maximum extent permitted by law. Public disclosure of Alameda Hospital's specific practices to identify, detect, prevent and mitigate Identity Theft may compromise the effectiveness of such practices. Therefore, knowledge of such specific practices shall be limited to the Program Administrator/the Board Identity Theft Committee and Alameda Hospital staff and Service Providers who need to be aware of such practices for the purpose of preventing Identity Theft.

Part X: Program Updates

The Program (including the Red Flags determined to be relevant) shall be periodically updated to reflect changes in risks to Patients and to the safety and soundness of Alameda Hospital from Identity Theft. The Program Administrator/Board Identity Theft Committee shall at least annually consider Alameda Hospital's experiences with Identity Theft, changes in Identity Theft methods, changes in Identity Theft detection and prevention methods, changes in types of Accounts Alameda Hospital maintains and changes in Alameda Hospital's business arrangements with other entities and Service Providers. After considering these factors, the Program Administrator/Board Identity Theft Committee shall determine whether changes to the Program, including the listing of Red Flags, are warranted. If warranted, the Program Administrator/Board Identity Theft Committee shall update and implement the revised Program and present the Program Administrator's/Board Identity Theft Committee's recommended changes to the Board of Directors for review and approval.

City of Alameda Health Care District Policy No. 44		
Action:	**Date:**	**By:**
Created	10/08	Finance
Reviewed/ Revised	5/08	Finance
Approvals	05/08	Management Team
	05/08	Administration
	05/08	District Board

ANNUAL COMPLIANCE REPORT
October 2006 to December 2008

Background

In late 1998, Alameda Hospital adopted a voluntary Compliance Plan which encompassed all of the elements necessary for an effective compliance program. These elements included:

1. Compliance standards of conduct
2. Designation of a Compliance Officer(s) or other appropriate supervision
3. Education and Training Programs
4. Maintenance of a process to receive complaints, maintain complainants' anonymity, and protect complainant from retaliation
5. Enforcement of the plan and disciplinary action against violators
6. Periodic audits and other evaluation techniques
7. Investigation and remediation of problems and the non-employment or retention of sanctioned individuals.

In 2003, the Compliance Plan Document was reviewed and revised by district legal counsel Foley and Lardner. Recommended changes were implemented at that time. In late 2008, the plan was reviewed and revised again. Recommended changes were approved in early November 2008.

DHHS/OIG Work Plan – 2007 and 2008

The mission of the Office of Inspector General (OIG) is to improve Health and Human Services programs and operations and protect them against fraud, waste and abuse. The project areas described in the Work Plan reflect what the OIG believes at the beginning of each year best identifies vulnerabilities of Department of Health & Human Services' programs and activities. The work is planned and performed by the four direct mission components of OIG; the offices of Audit Services (OAS), Evaluation and Inspections (OEI), Investigations (OI), and Counsel to the Inspector General (OCIG).

OAS conducts financial and performance audits to determine whether objectives are being achieved, which aspects of programs need to be performed more efficiently, and to identify systemic weaknesses that give rise to fraud, waste, or abuse. OEI seeks to improve HHS program effectiveness and efficiency by conducting inspections to provide timely, useful, and reliable information and advice to decision makers. OI conducts investigations of fraud and misconduct to safeguard the Department's programs and protect its beneficiaries. OCIG coordinates the OIG's role in the judicial and administrative resolution of fraud and abuse cases involving HHS programs, including the litigation and imposition of administrative sanctions, such as program exclusions and civil monetary penalties and assessments; global settlement of cases arising under the Civil False Claims Act; and the development and monitoring of corporate integrity agreements for certain providers that have settled their False Claim Act liability with the Federal Government.

At Alameda Hospital, each year's OIG Work Plan is used as a guide to focus our efforts to review internal practices, policies, and procedures as they apply to hospital compliance. In conjunction with the Work Plan, an internal listing of areas to be monitored and/or audited is developed each year.

Summary of 2006/2008 Compliance Activity

Compliance Committee

Over the past two years, due to staff turnover, all but three members of the Compliance Committee have changed. In addition, the Board of Directors replaced the Management Company of Delta One Partners with a Chief Executive Officer. During this transition, the activities of the Compliance Committee were curtailed until the new management team was established and oriented.

Joyce Walker, Director of Budget and Hospital Compliance continues to serves as Compliance Officer. The continuing membership of the Compliance Committee, in addition to the Compliance Officer is Janet Dike, Director of Quality Resource Management; Tony Corica, Director of Physician Relations; and Kerry Easthope, Associate Administrator. New members of the committee are Kristy Lugert, Director of Health Information Management; Phyllis Weiss, Director of Human Resources; Robert Lundy-Paine, Director of Information Systems; David Neapolitan, Chief Financial Officer; Leon Dalva, Director of Revenue Cycle; and Mary Bond, Executive Director of Nursing Services.

Kristy Lugert and Robert Lundy-Paine are the co-chairmen of the HIPAA subcommittee. Additional subcommittees are added on an ad-hoc basis to address specific issues that arise throughout the year.

The committee meets on a quarterly basis. Its responsibilities include the development and maintenance of compliance policies, procedures and standards; distribution of the compliance plan and coordination of all training programs; coordination of the investigation and resolution of identified compliance problems or infractions; and communication with the hospital's Board of Trustees.

From time to time certain issues are identified or questions raised that may require further in depth review by legal counsel. Many of these issues are identified from the audits that are performed throughout the year. Others result from investigations and analyses that are proposed by the Centers for Medicare and Medicaid Services and other regulatory agencies.

Standards of Conduct and Training

The Alameda Hospital Compliance Plan contains certain Standards of Conduct with which each employee, contractor and member of the Medical Staff is expected to comply. These standards are summarized under the categories of General Matters (confidentiality, gifts and gratuities, and protection of hospital assets); Discharge and Transfer (correct charging under DRGs, and EMTALA regulations); Contracts with Physicians and Suppliers (kickbacks and referrals); Patient Charts and Billing (medical necessity, correct coding, accurate medical record documentation and correct cost reporting); and Collection of Co-Payments and Deductibles and Refunds of Overpayments.

At each new employee orientation session held over the past year, there has been a section on the Compliance Program at Alameda Hospital. The sessions have included the showing of a short video, which outlines the basics of compliance and how those basics are applied at our facility. In addition, each new employee has received a copy of the document and has been encouraged to read it fully and to be aware of the codes of conduct.

As part of the Deficit Reduction Act of 2005 implemented in February of that year by President Bush, Section 6032 of that law requires any entity that receives or makes payments under Medicaid of at least five million dollars to have established written policies and procedures regarding the Federal and State False Claims Act for their employees, agents and contractors. In the fall of 2008, the Hospital created a new Administrative Policy (#53) that addresses this issue.

Over the past year, there were no reported violations of the codes of conduct.

Reports, Inquiries and Audits

The compliance hotline was established in 2004 to provide a confidential mechanism for employees to report issues, complaints or problems to the Compliance Committee.

The hotline is checked weekly to collect any complaints, problems or issues for review at the next scheduled Compliance Committee meeting.

No major compliance issues or trends were noted on the hotline in the past two years.

Ongoing audits are conducted during the year to address key areas including discharge planning, proper billing and coding; charge entry; emergency care center charging and coding; patient discounts; medical necessity; unclaimed property and bad debts. The results of the audits are presented at the Compliance Committee meetings. If additional review is necessary based upon the audit results, subcommittees of the Compliance group are formed and the follow-up is carried out, with periodic reporting to the committee until resolution of the issue is achieved.

Annually. the hospital complies with the Office of Statewide Health Planning and Development (OSHPD) requirement to file with the office a copy of its charge description master (CDM) each July. In addition, the hospital is required to make a copy of its CDM available for public inspection. An electronic version is available through the Business Services department for public inspection.

The hospital also made necessary coding and billing changes to its CDM and billing software based upon annual revisions published by the Centers for Medicare & Medicaid Services.

Policies and Procedures

The Compliance Committee performs periodic reviews of policies and procedures that address various compliance issues such as billing and coding; bad debts; refunds and rebates; and other cost report issues. Updates and changes to the policies are made as appropriate.

Disciplinary Procedures

No compliance issues have resulted in disciplinary actions.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided for the implementation of Public Law 104-191. This law was intended to guarantee the confidentiality of records by establishing a three-pronged security process including electronic data interchange, privacy of patient health information, and security of patient records.

The first section of HIPAA, privacy of patient health information, was implemented effective April 14, 2003. On-going training in this area is provided annually to all employees and at orientation for all new employees.

Patients are now informed of their rights to privacy and security of their information through Notice of Privacy Practices (NPP), which is distributed to all patients during the registration process.

Working with legal counsel, the hospital reviewed all existing contracts to determine the necessity of Business Associate language. Where necessary, Business Associate agreements were added.

The Hospital upgraded the computer network. This upgrade included the segmentation of the network to increase network security, a new firewall which monitors all inbound and outbound network traffic, and software which monitors network security events and notifies staff in the event of a breach.

The Hospital also contracted with an outside vendor to provide disaster recovery resources including test restoration of the Hospital's backup tapes and assistance for 30 days in the event of a disaster that causes the loss of data storage and access software.

In addition to physical security, all computer network users must comply with frequent password updates which require increased complexity. Multi-user workstations limit users to access to only Meditech and if necessary for business purposes, the internet. The Information Systems department continues to develop systems to better protect Patient Health Information and meet HIPAA requirements.

Medicare Program

In March 2007, Medicare initiated a demonstration program under the Medicare Modernization Act of 2003. PRG Schultz, International, the recovery audit contractor (RAC) for the Medicare program in California, began conducting 100% audits of Medicare one-day inpatient stay records. The purpose of the audits was to identify Medicare overpayments and underpayments and to recoup Medicare underpayments.

At Alameda Hospital, over 100 claims were identified as overpaid and Medicare recouped approximately half of the alleged overpaid amounts. The Hospital appealed all but a small number of the claims and to date believes that we have rights to a refund of the remaining funds. In mid 2008, the demonstration project was put on hold due to the actions of PRG Schultz and to date, no funds have been refunded to the hospital.

Beginning in the fall of 2008, the permanent RAC program will be phased in state by state, with four new RAC contractors. California is scheduled to begin the permanent RAC program in the spring of 2009. Full implementation is to be complete by 2010. In preparation, the Hospital has implemented a RAC Task Force to develop internal audit protocols and identify potential resources to assist in minimizing the financial impact of the program.

Plan Effectiveness

The Alameda Hosptial Compliance Plan continues to be effective. The recommendations identified below will serve to renew the program and make it more visible to the staff.

Recommendations

Re-activate the Compliance Program by establishing a regular meeting schedule, and review and revise all training and education programs regarding compliance for staff, volunteers, medical staff, allied health professionals, board and contractors.

Review and revise the Compliance Plan document. Utilize the expertise of district legal counsel if necessary.

Continue to review, revise and implement internal policies and procedures to keep abreast of changes in reimbursement regulations, to enhance our ability to utilize proper coding and billing practices and to be able to meet increasing reporting requirements by Federal and other agencies.

In compliance with the Federal Trade Commission regulation on identify theft, develop Red Flag Rules and implement a system to identify and mitigate potential identify theft.

Review the OIG 2009 Work Plan to identify and review any issues that may pertain to the hospital's operations.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED

FINANCIAL STATEMENTS

FOR THE

PERIOD ENDING

02/28/09

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

ALAMEDA HOSPITAL

City of Alameda Health Care District
February 28, 2009

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ALAMEDA HOSPITAL

February 28, 2009

The management of the Alameda Hospital (the Hospital) has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending February 28, 2009 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of February 28, 2009

- Total assets on the balance sheet decreased by $103,332 from the prior month as a result of an increase in net accounts receivable of $309,525 offset by a decrease in cash and cash equivalents of $301,184 and other assets of $83,031.

- Total cash and cash equivalents for February decreased by $301,184 which resulted in a decrease in our day's cash on hand from the prior month's 10.5 to 8.7 February 28, 2009. This decrease was the result of the use of 1/12 of our annual parcel tax proceeds and was offset by increase average daily collections of $170,846 versus the prior months $128,885.

- Net patient accounts receivable increased in February by $309,525 compared to an increase of $1,287,695 in January. Days in outstanding receivables decreased to 56 as compared to 57 in January. This decrease in days outstanding receivables at month end was the result of a slight increase ($48,000) in the average daily revenue for the three month period used to calculate this metric.

- Total liabilities decreased by $138,200 compared to a decrease of $244,232 in the prior month. This decrease was the result of a decrease of $450,326 in other liabilities. This decrease was offset by an increase of $204,608 in payroll and benefit related accruals and $119,214 in accounts payable and other accrued liabilities.

- Current portion of long term debt decreased by $1,863,999 while debt borrowings, net of current maturities increased by $1,852,304 as a result of the successful conversion of our demand note payable with the Bank of Alameda to a five (5) year note payable at fixed interest rate of 4.8%.

- Accounts payable at February 28th was $6,236,322, which represents a increase of $119,214 from the prior month. Despite this slight increase in outstanding payables from January, days in accounts payable remained at 84.

- Payroll and benefit related accruals increased by $204,608 from the prior month. This increase was primarily the result of an increase in accrued vacation of $80,360, accrued employee health expenses of $78,865 and accrued payroll of $30,638.

- Other liabilities decreased by $450,326 as a result of the amortization of one month's deferred revenue related to the 2008/2009 parcel tax revenues.

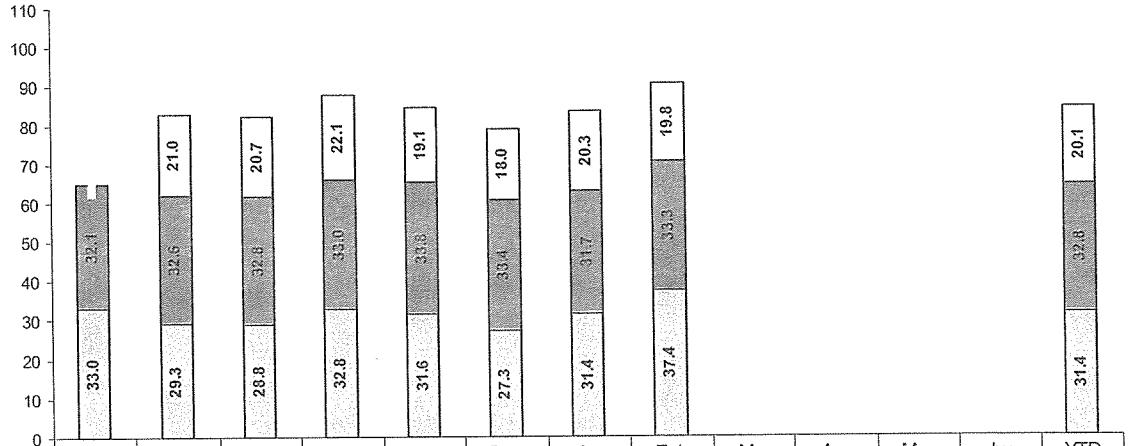
- Combined total revenue was less than budget by $155,000 or 0.7% and net patient revenue was unfavorable to budget by $50,000 or 1.0%. Inpatient revenue, excluding South Shore, was less than budgeted by 0.5% while outpatient revenue, excluding South Shore, also less than budgeted by 1.6%. On an adjusted patient day basis total revenue, excluding South Shore, was $6,705 compared to a budgeted amount of $6,844.

- Total patient days were 2,532 and included 554 patient days from the South Shore facility as compared to the prior month's total patient days of 2,582 (628 South Shore days included) and the prior year's 1,913 total patient days. The average daily acute care census was 37.4 compared to a budget of 36.0 and an actual average daily census of 31.4 in the prior month; the average daily Sub-Acute census was 33.3 versus a budget of 33.5 and 31.7 in the prior month and the South Shore unit had an average daily census of 19.8 versus a budget of 23.0 and prior month census of 20.3, respectively.

- ER visits were 1,389 or 3.9% less than the budgeted 1,445 visits but were down from the prior year's visits of 1,616.
- Total surgery cases were 13.6% greater than budget, with Kaiser surgical cases making up 335 or 71.6% of the total cases. Alameda physician surgical cases declined from the past several months 140+ cases to 133 cases in February.
- Combined excess revenues over expense (profit) for February was $19,000 versus a combined budgeted excess of expenses over revenue of (loss) of $5,000. This brings the year-to-date excess of revenues over expenses (profit) to $130,000 or $198,000 better than budgeted.

Volumes

Overall actual daily census was 90.5 versus a budget of 92.6. Acute average daily census was 37.4 versus a budget of 36.0, Sub-Acute average daily census was 33.3 versus a budget of 33.5 and the South Shore unit had an average daily census of 19.8 versus a budget of 23.0.

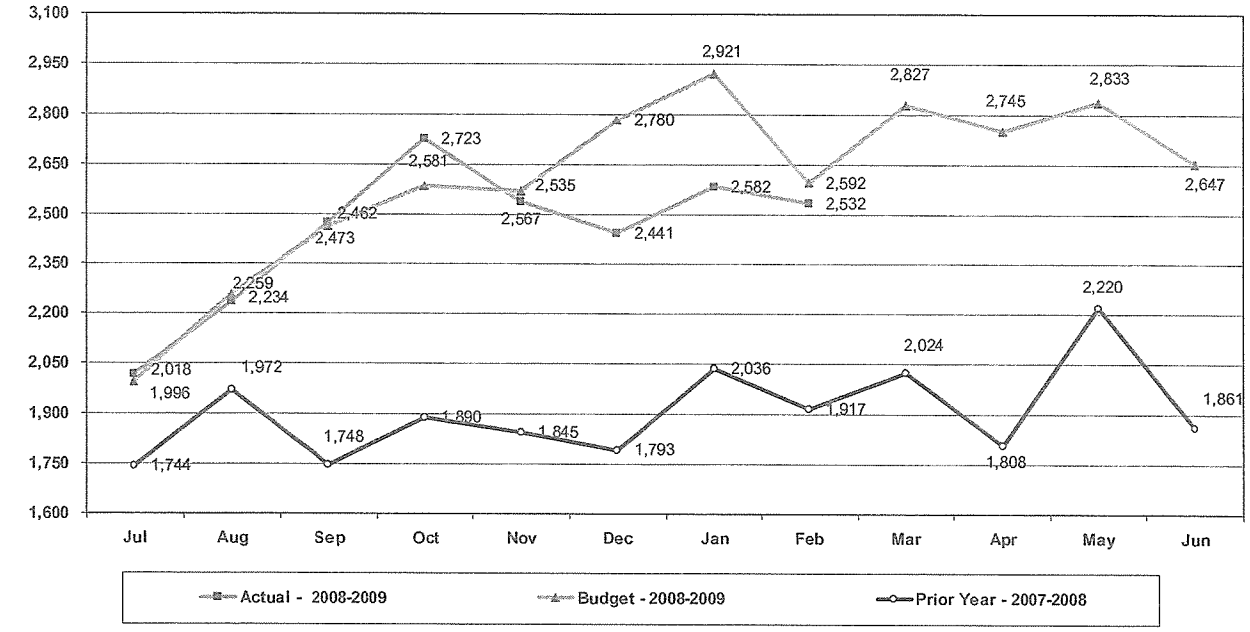


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Actual SNF		21.0	20.7	22.1	19.1	18.0	20.3	19.8					20.1
Actual Sub-Acute	32.1	32.6	32.8	33.0	33.8	33.4	31.7	33.3					32.8
Actual Acute	33.0	29.3	28.8	32.8	31.6	27.3	31.4	37.4					31.4

Actual	65.1	82.9	82.3	87.9	84.5	78.7	83.3	90.5					84.3
Budget	64.4	83.2	82.1	83.3	85.6	89.7	94.2	92.6					87.2

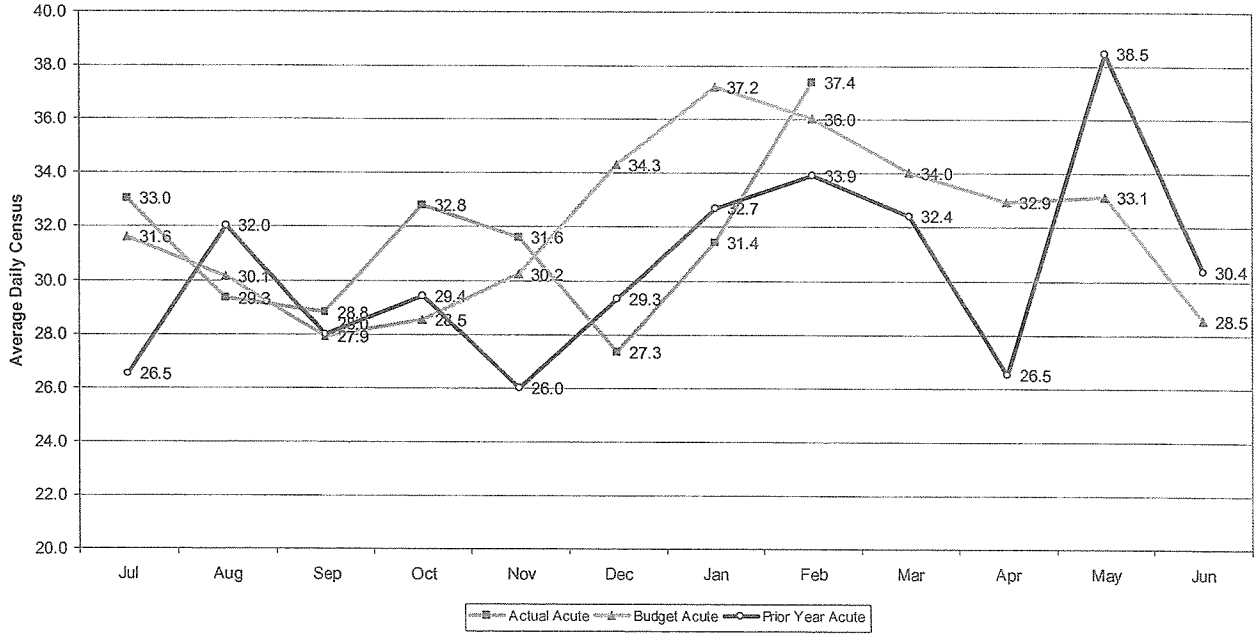
Total patient days in February were 2.1% less than budgeted and were 3.4% better than the prior year after removing the South Shore patient days from the current year total patient day count. The graph on the following page shows the total patient days by month for fiscal year 2009 including South Shore.

Total Patient Days

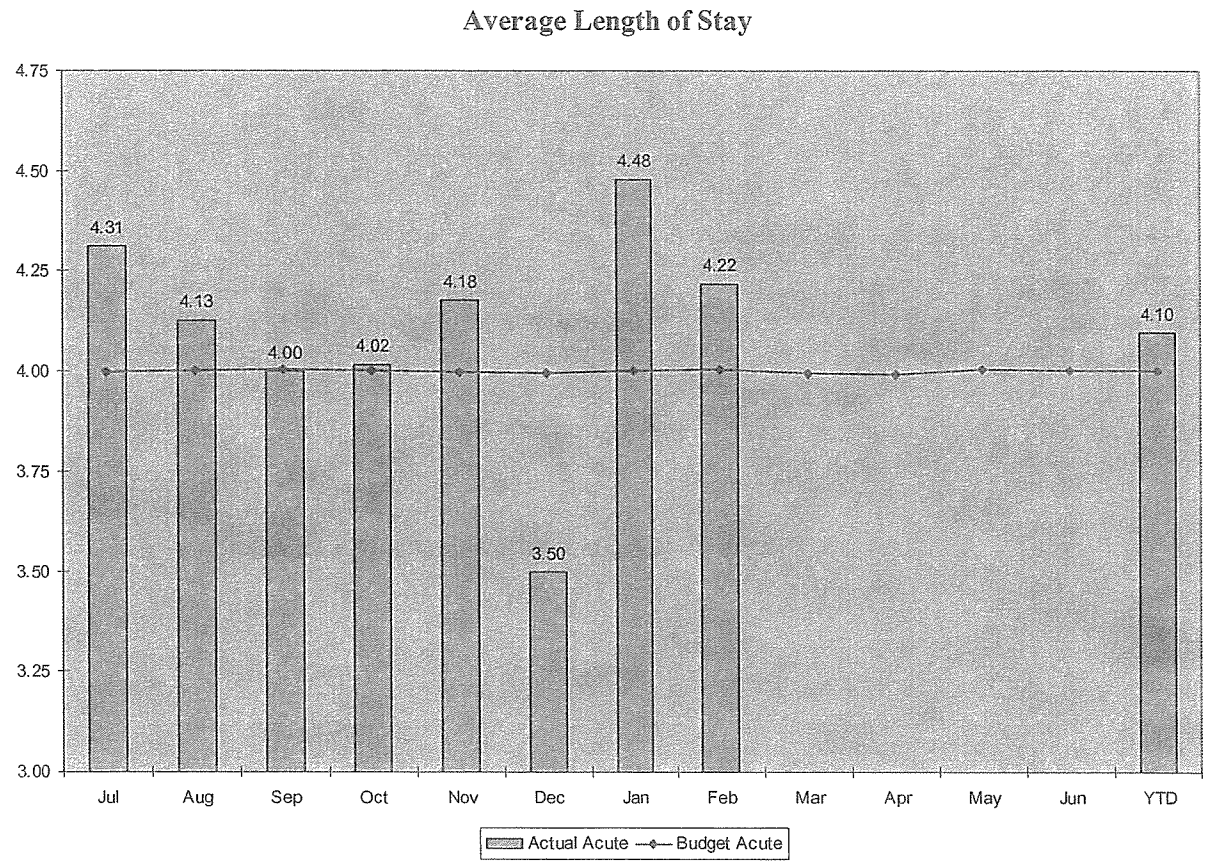


As we look at the various components of our volumes for the month of February we see that the acute care patient days were 3.7% (37 days) better than budgeted and 10.3% better than the prior year's average daily census.

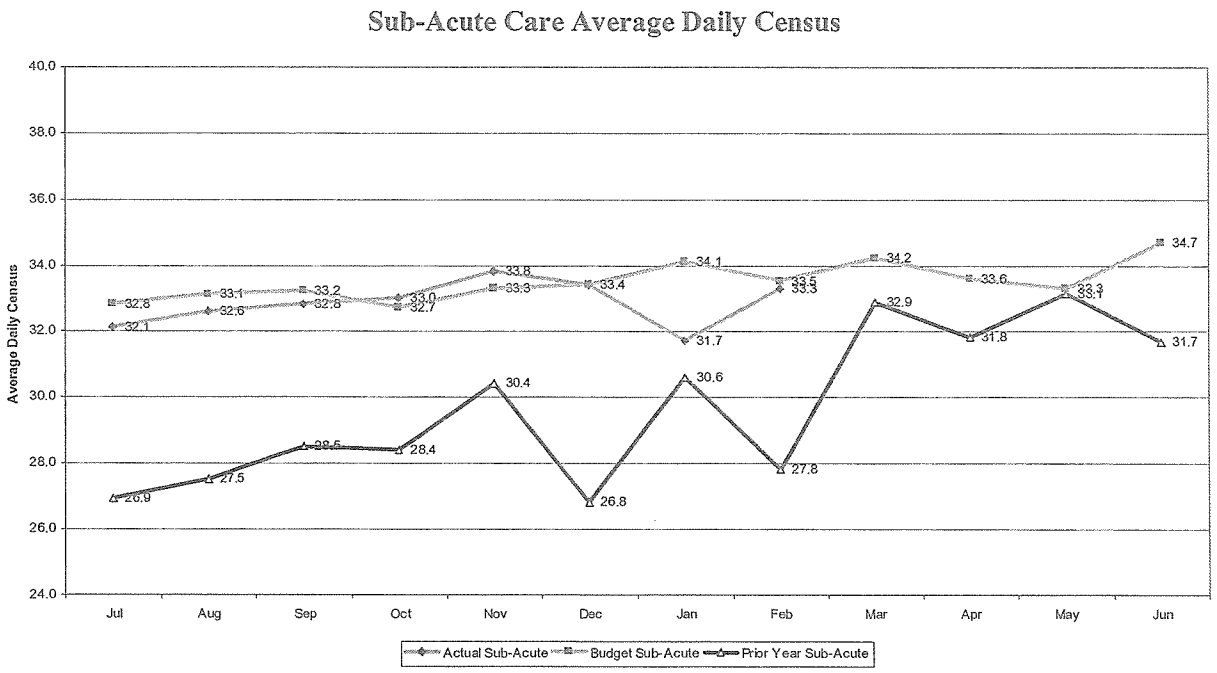
Inpatient Acute Care Average Daily Census



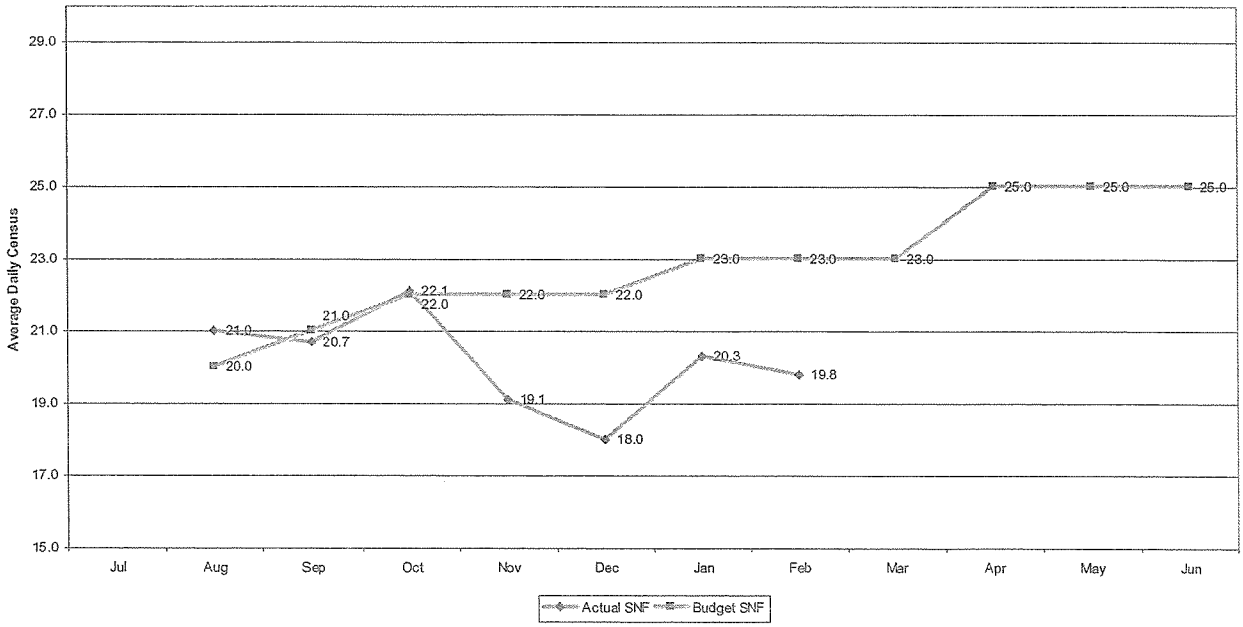
Our year to date average length of stay (ALOS) remains very close to budgeted levels at 4.10. However, in January and February our ALOS has been influenced by acute care accounts that had longer than normal length of stays. Had these accounts (one in February and two in January) been removed from the statistics for those months the ALOS would have approximated 4.13 and 4.05, respectively, versus the ALOS for our acute care population shown below.

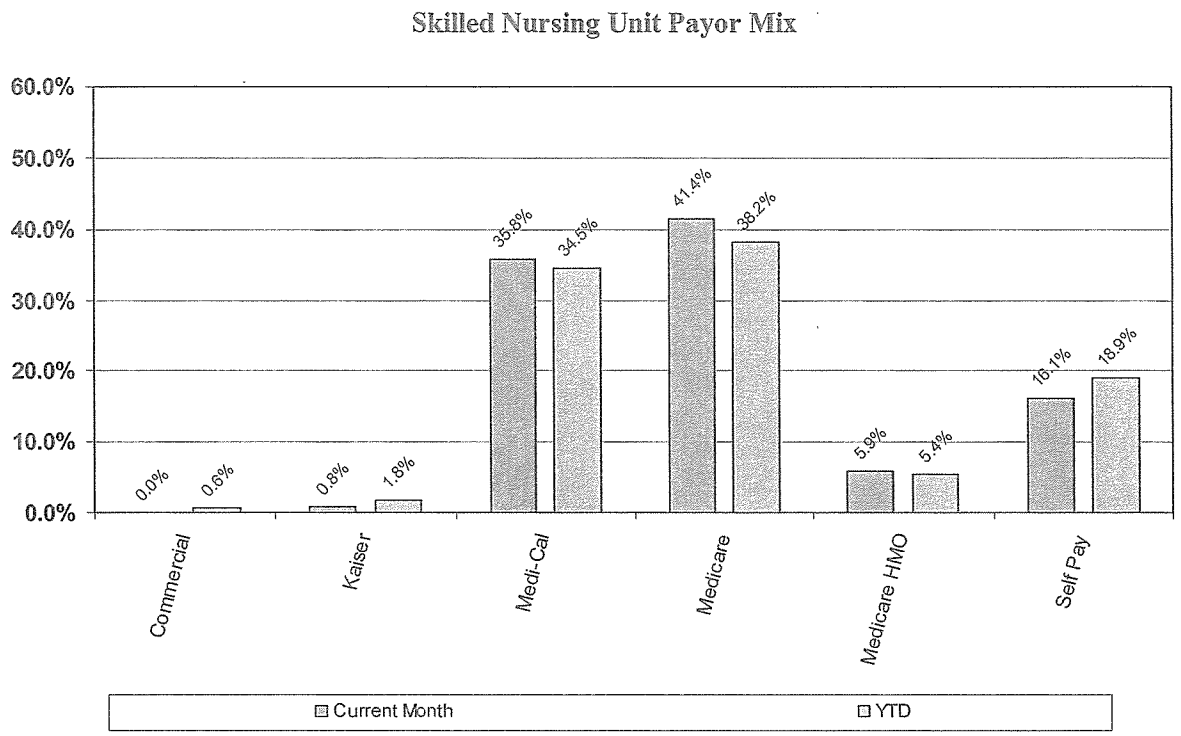


Sub-Acute patient days were only 0.7% below budget or 7 days and continue to exceed the prior year performance. The graph on the following page shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

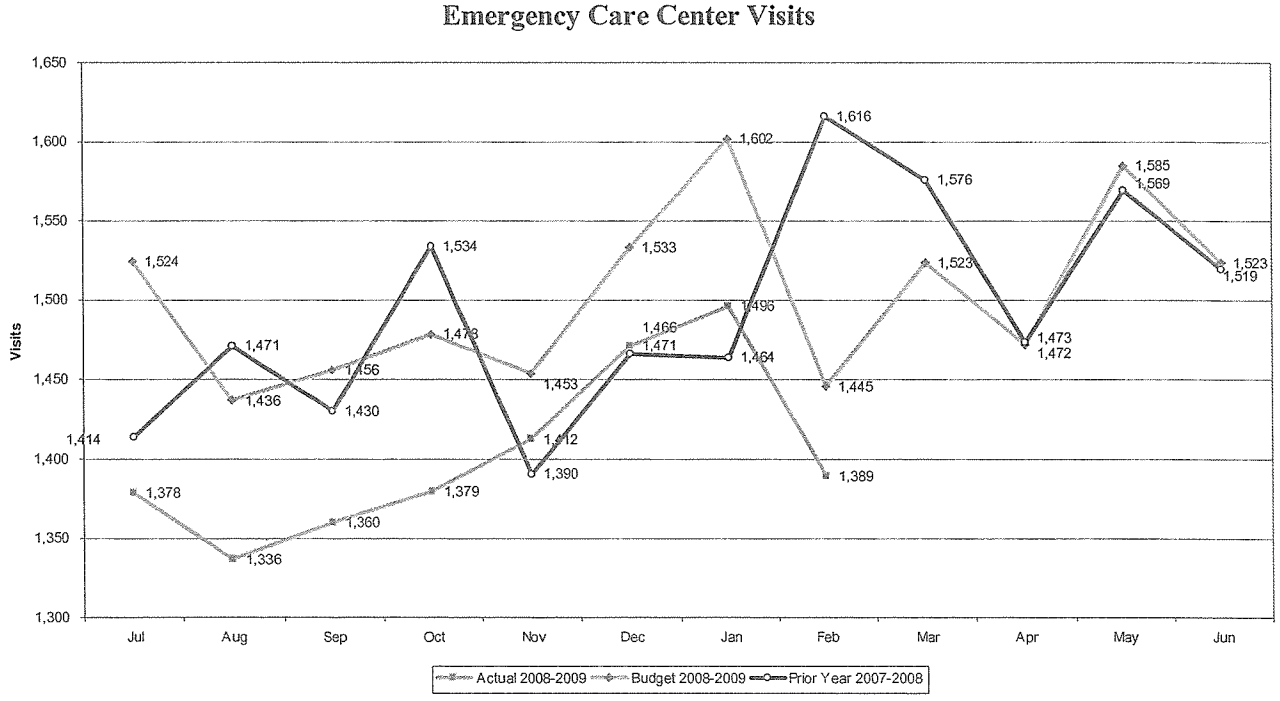


The Skilled Nursing Unit (South Shore) patient days were 14.0% less than budgeted for the month of February and are 8.8% less than budgeted for the first seven months (August 17th through February 28th) of operations. This unfavorable variance from our budgeted patient day expectations continues to be the result of shorter length of stay cases. While this has negatively impacted our volume measure (patient days) we have experienced a higher level of net reimbursement as we move from custodial care type patients to patients requiring a higher level of skilled nursing and ancillary care. The following graphs show the Skilled Nursing Unit average daily census as compared to budget by month and the payor mix experienced during the current month and year-to-date.

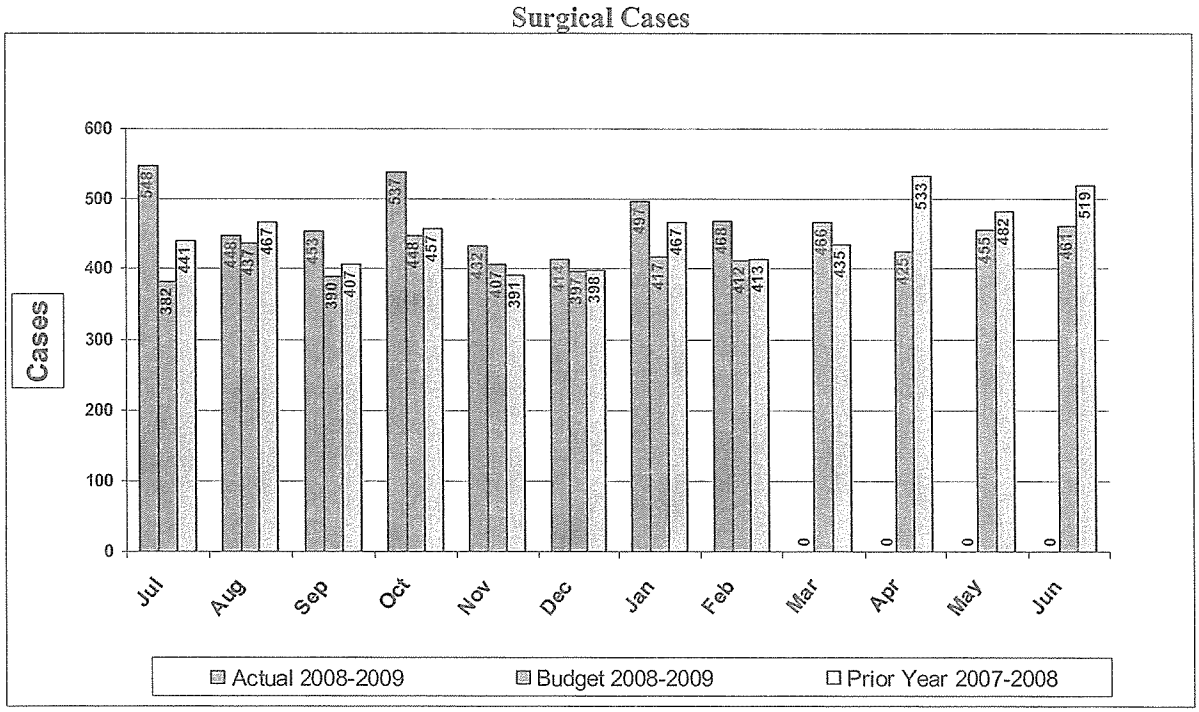




February ER visits were 3.9% less than budgeted but were 227 less than the prior year's activity of 1,616.



Surgery cases were 468 versus the 412 budgeted and 413 in the prior year. In February, Alameda physician cases declined to 133 cases versus 143 in the prior month. Kaiser related cases in February decreased slightly to 335 as compared to the 347 cases performed in January. Despite this decrease in the number of cases Kaiser Same Day Surgery revenue increased by $106,357 over the prior month. As a result of this months activity our reimbursement for Kaiser Outpatient cases in February decreased to 18.3% as compared to 18.8% of gross charges in January.

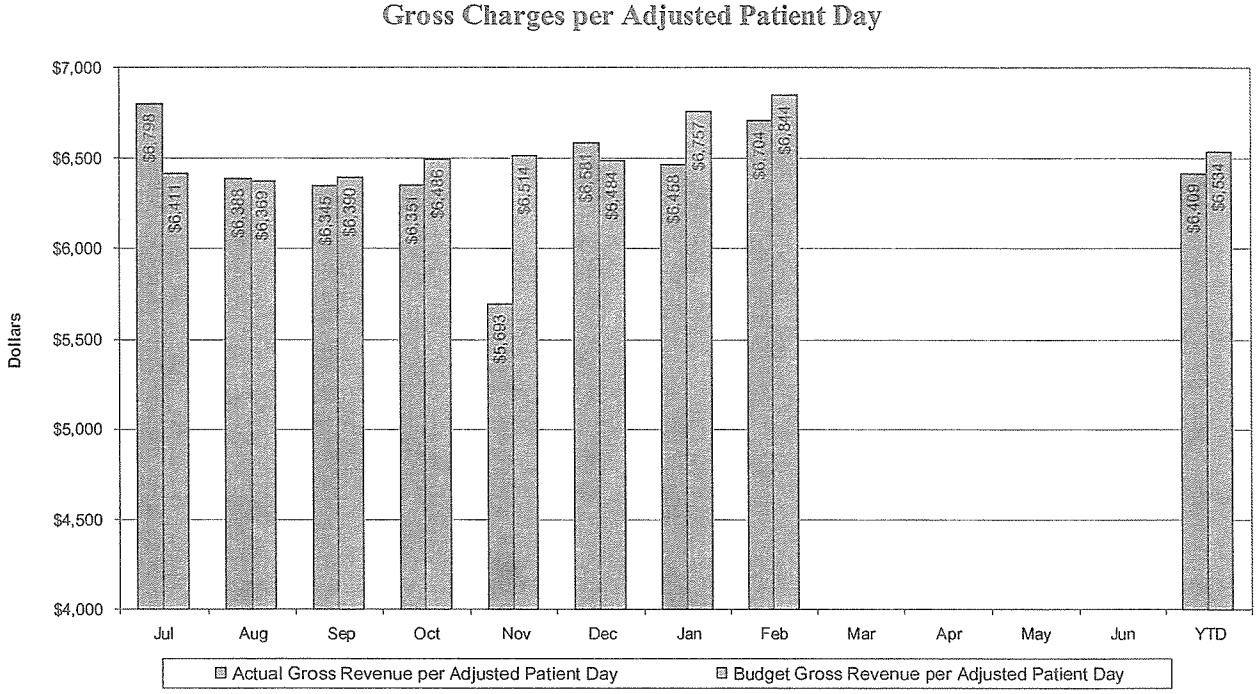


Income Statement – Hospital Only

Gross Patient Charges

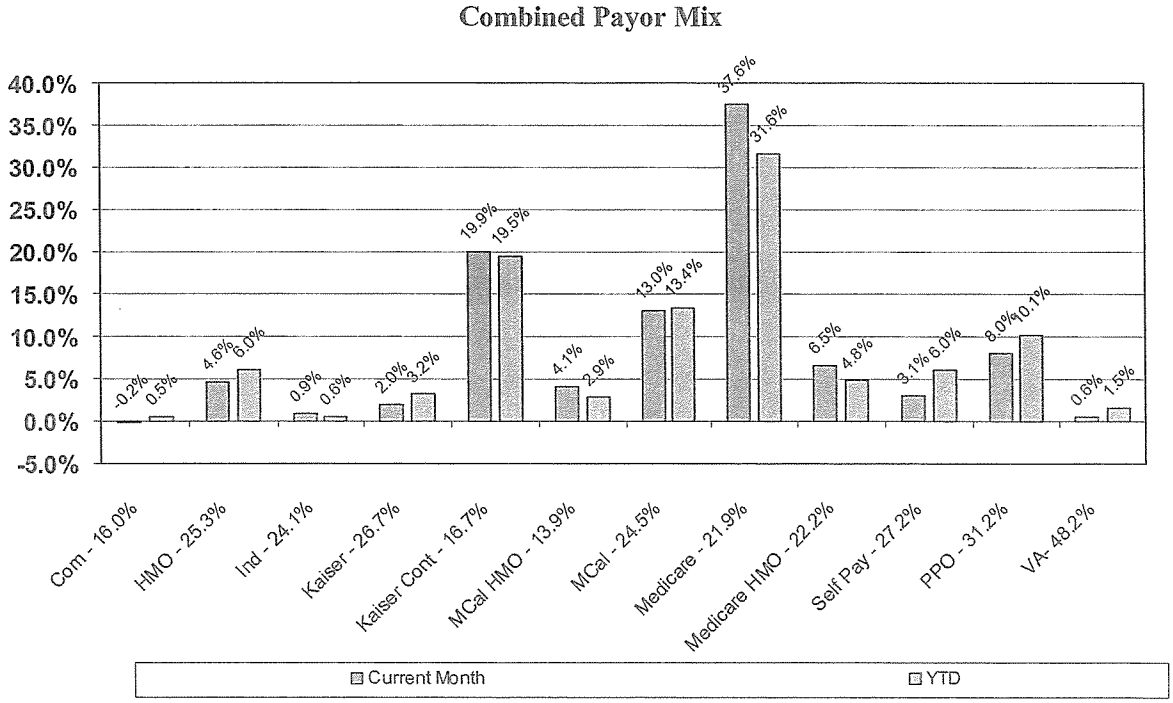
Gross patient charges in February were less than budgeted by $219,000 and were comprised of unfavorable variances in both inpatient and outpatient services of $71,000 and $148,000, respectively. On an adjusted patient day basis total patient revenue was $6,705 versus the budgeted $6,844 or a 2.0% favorable variance from budget (See graph on next page).

The unfavorable variance from budgeted gross inpatient revenues was driven by the delay in implementing the January 1, 2009, budgeted 5% price increase to March 1, 2009. This delay was necessary as a result of difficulties in capturing accurate data from the Meditech application that would allow us to evaluate the impact of our pricing strategies across the organizations revenue cycle. However, despite the two month delay we were able to strategically increase prices to mitigate the impact of this delay to only one month and thereby keep the impact on net patient revenue to a minimum.



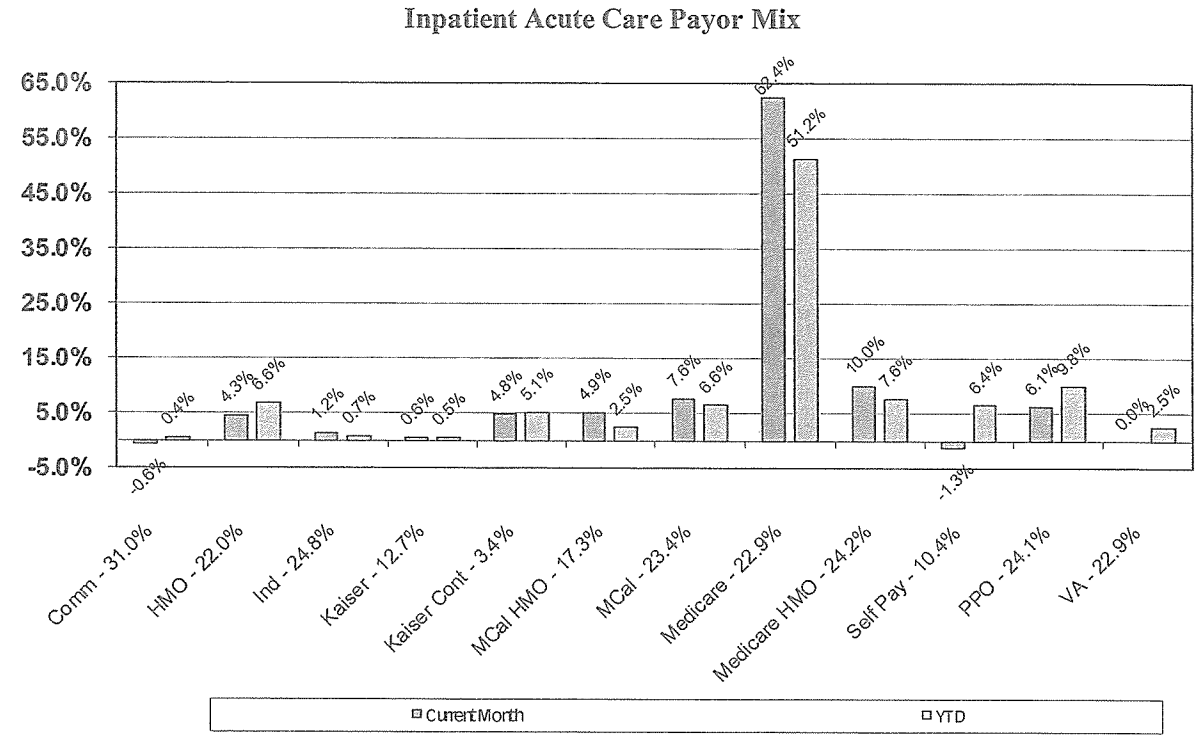
Payor Mix

Medicare total gross revenue in February made up 37.6% our total gross patient charges up from 29.0% in the prior month. Kaiser was again the second largest source of gross patient revenues at 21.99%. The graph on the following page shows the percentage of revenues generated by each of the major payors for the current month and year-to-date as well as the current months expected reimbursement for each.

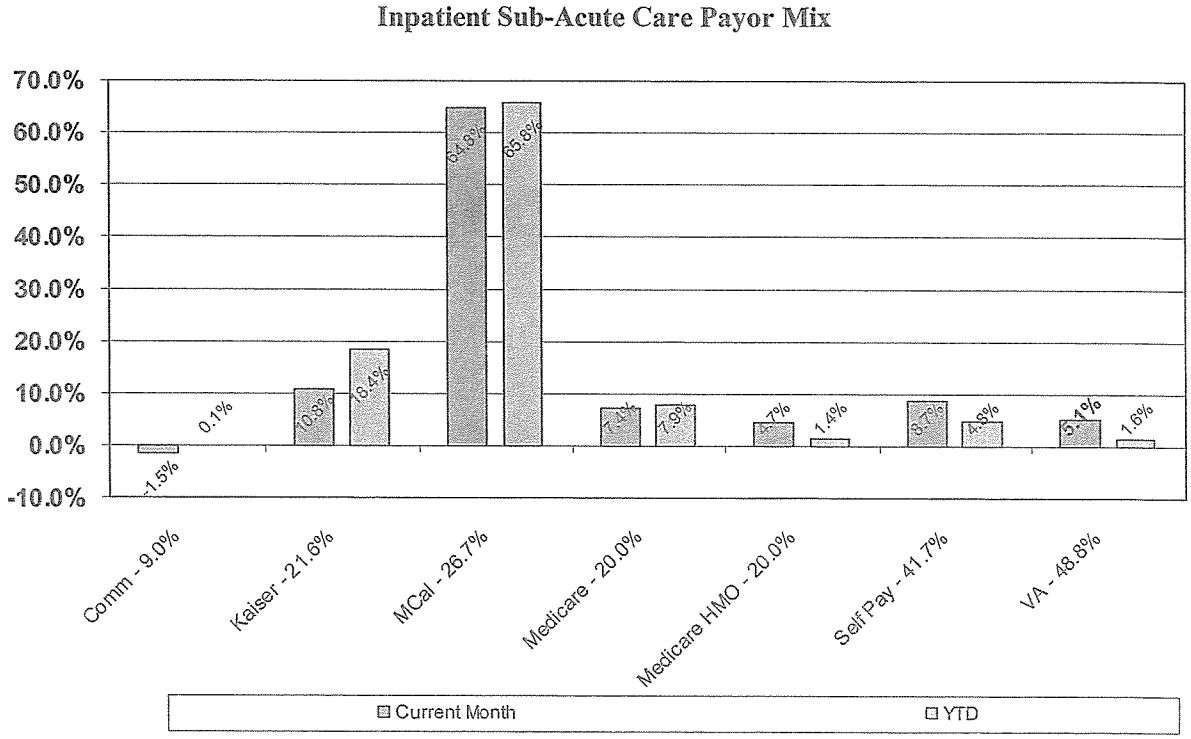


On the Hospital's inpatient acute care business, current month gross Medicare charges soared to 62.4% of our total inpatient acute care gross revenues bringing the year-to-date average to 51.2%. However, despite four (4) cases that hit the outlier threshold and an increase in the Medicare Case Mix Index (CMI) to 1.3137 from 1.2448 in January,

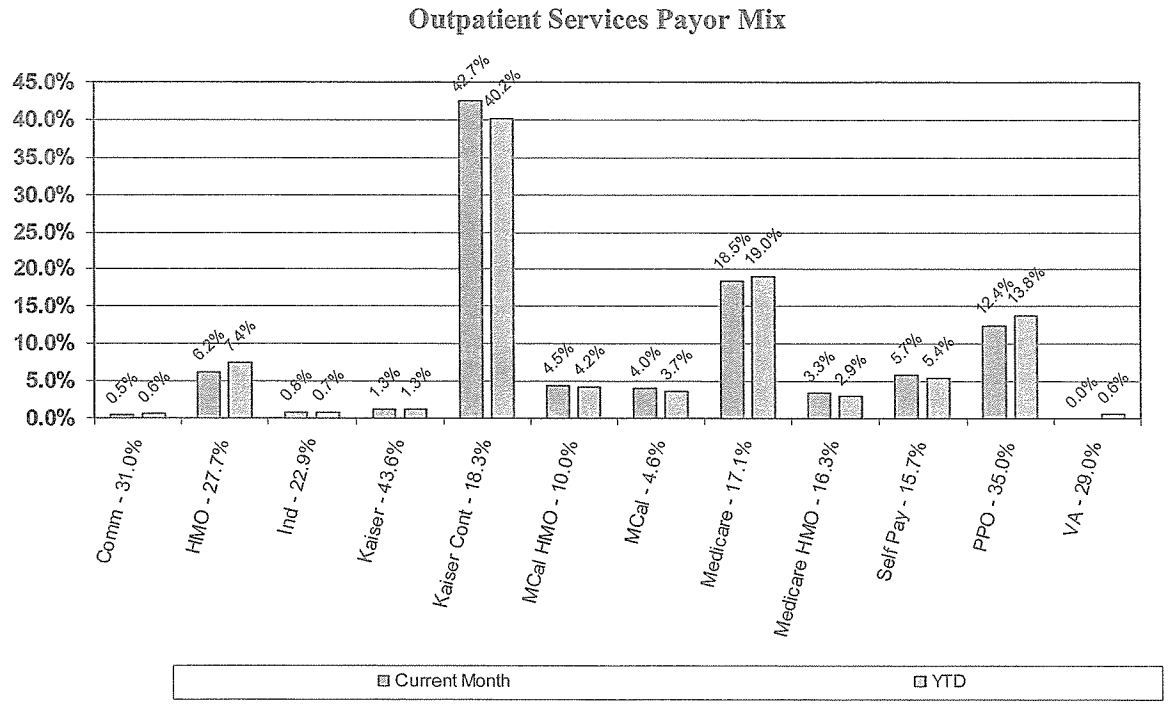
our expected reimbursement for Medicare inpatient cases was estimated to be 22.9% which is 1.7% lower than January's estimate. This decline in the estimated Medicare reimbursement percentage was primarily driven by the outlier cases which had an estimated overall reimbursement percentage of 19.4% versus the other 116 Medicare cases that had an estimated reimbursement percentage of 24.5%



In February the Sub-Acute care program was again was dominated by Medi-Cal utilization of 64.8% based on gross revenue.



Outpatient gross revenue payor mix for February was comprised of 43.9% Kaiser, 18.5% Medicare, 12.4% PPO and 6.2% HMO and is shown on the following graph.



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.

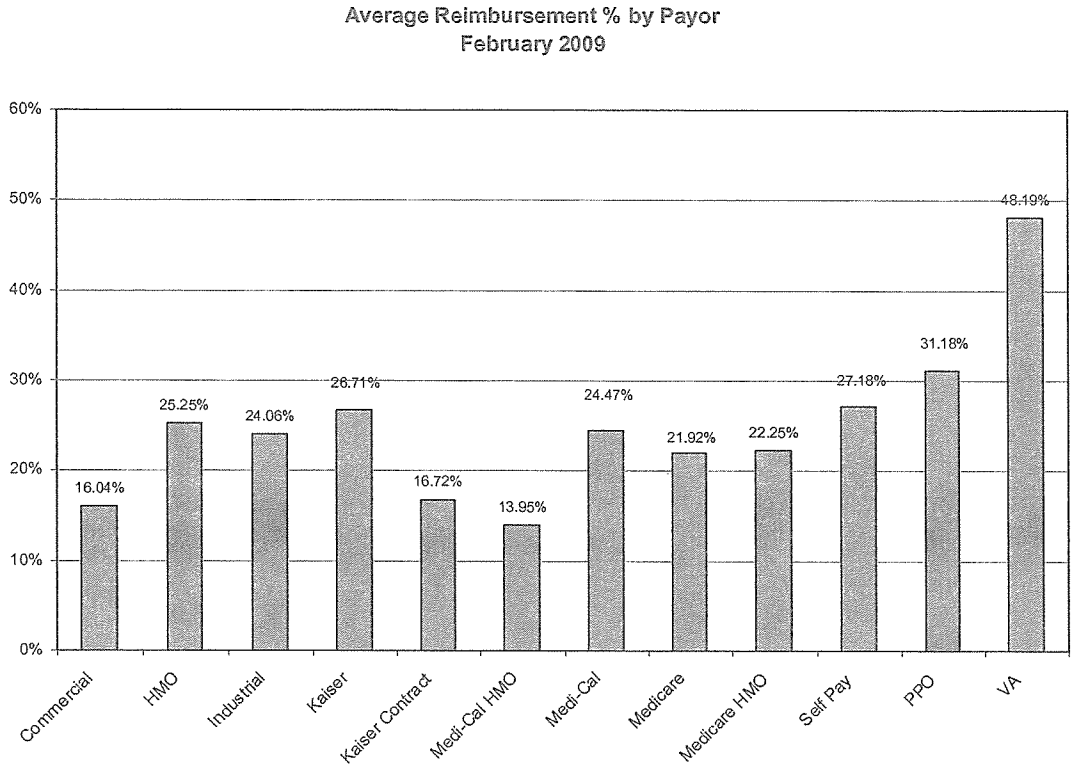
In the month of February contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 78.5% versus the budgeted 78.5%. Contractual reserves in the month of February include additional reserves attributable to recently enacted legislation, AB 1183, the Health Budget Trailer Bill, which requires a reduction to the interim payment for inpatient services provided by hospitals that do not participate in the Selective Provider Contracting Program (commonly known as non-contract hospitals), unless the hospital meets exemption criteria contained in the bill. Effective October 1, 2008, AB 1183 requires the Department of Health Care Services (DHCS) to limit the amount paid to non-contract hospitals for inpatient services to the lesser of the interim per diem rate (28% of gross Medi-Cal patient charges) reduced by 10%, or the applicable regional average per diem contract rate for tertiary and non-tertiary hospitals ($1,682 per Medi-Cal patient day) reduced by 5%. This resulted in additional contractual reserves of approximately $56,000.

In February there were again no DRG "take backs" associated with the Recovery Audit Contractor (RAC) project. The new National Recovery Audit program is to be phased in state-by-state starting in the fall of 2008. A new RAC contractor has been selected by CMS for California, HealthDataInsights, Inc., with California RAC audits slated to resume some time in the Spring of 2009. It is anticipated that we will begin to see requests for information under this program in the upcoming months and are working on developing appropriate mechanisms to ensure compliance with our rights to ensure timely responses to these requests.

Net Patient Service Revenue

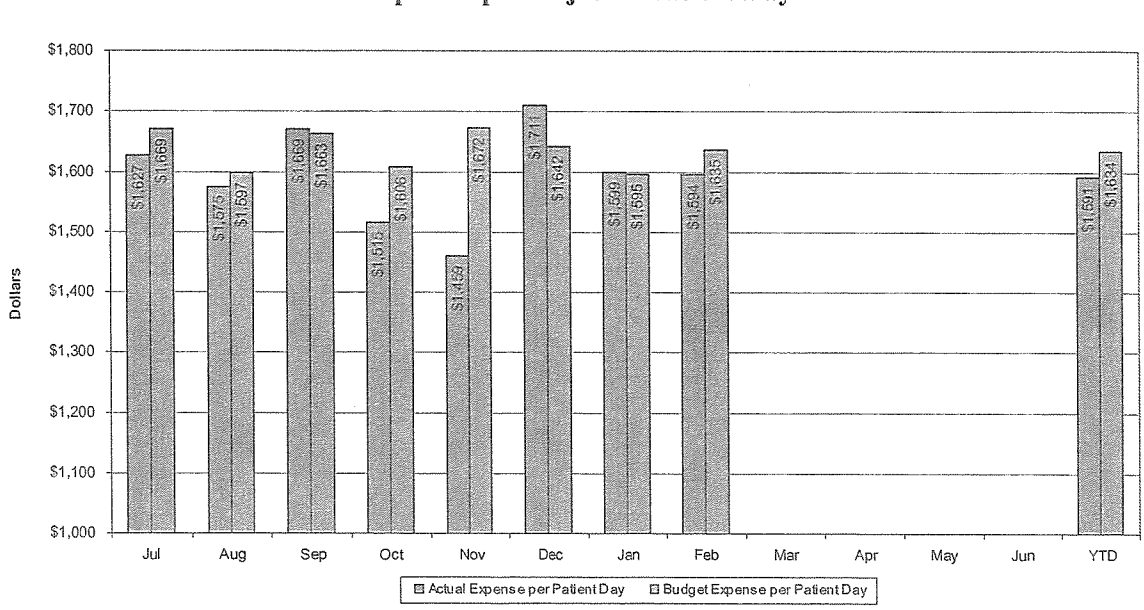
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is to receive for the services

provided. The graph below shows the level of estimated reimbursement that the Hospital has estimated for the current month of fiscal year 2009 by major payor category.



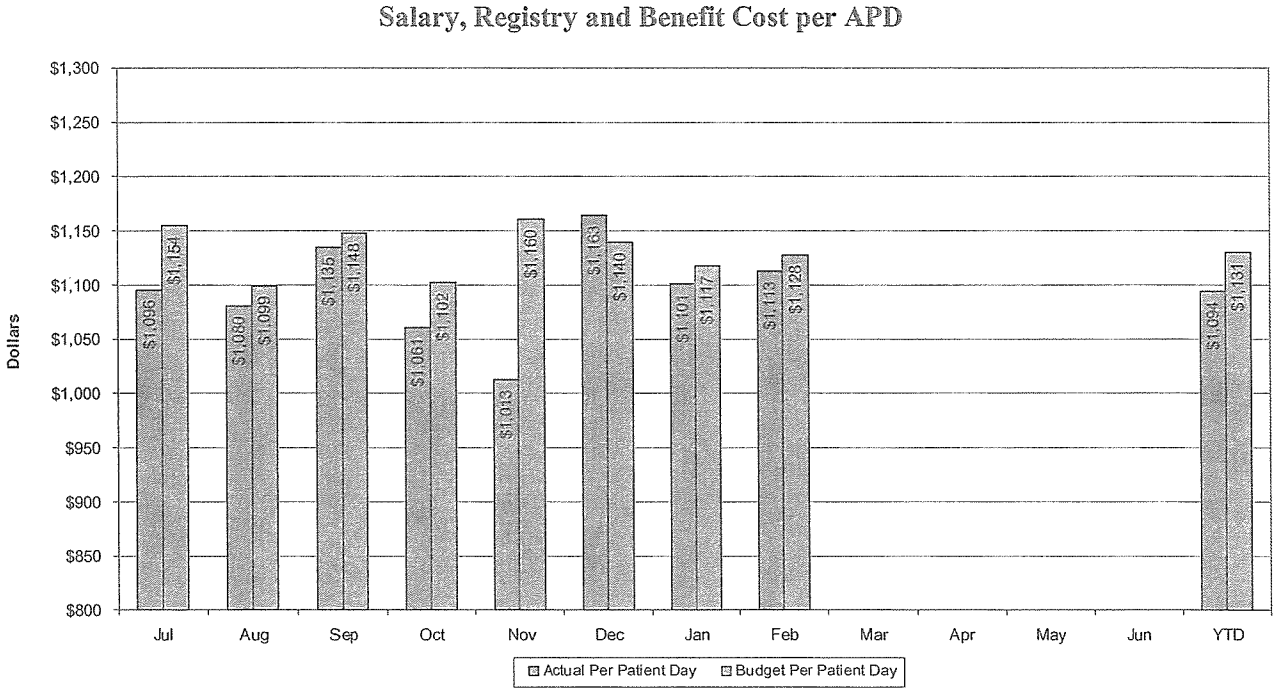
Total Operating Expenses

Total operating expenses were less than the fixed budget by $72,000 or 1.3%. On an adjusted patient day basis, our cost per adjusted patient day decreased to $1,592 for the month which was only slightly higher than budgeted. On a year to date basis our cost per adjusted patient day is 2.6% better than budgeted. The graph below shows the hospital operating expenses on an adjusted patient day basis for the 2009 fiscal year by month and is followed by explanations of the significant areas of variance.

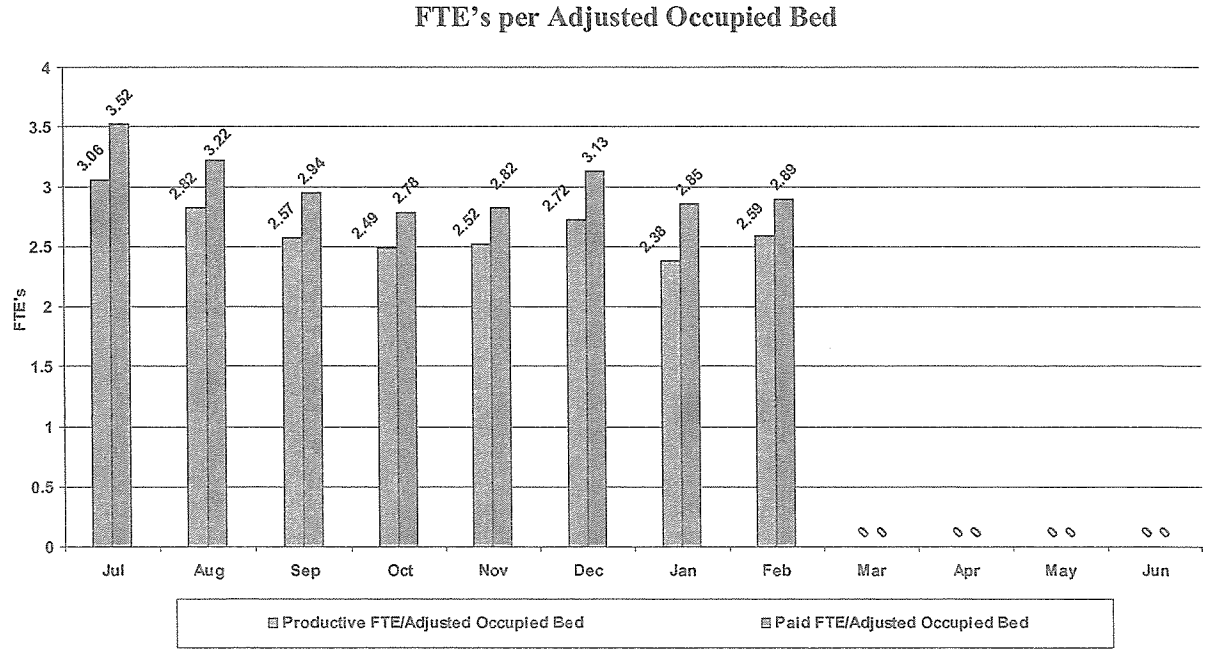


Salary and Registry Expenses

Salary and registry costs combined were again favorable to the fixed budget by $33,000 and $1 per adjusted patient day favorable to budget in February. For the eight months ending February 28, 2009, the hospital is $131,000 favorable to the fixed budget and $18 per adjusted patient day favorable to budgeted expectations as seen on the graph of the next page.



Combined productive FTE's per adjusted occupied bed was 2.58 in February versus the budgeted 2.44. The graph below shows the combined (Hospital including South Shore) productive and paid FTE's per adjusted occupied bed for FY 2009.



Benefits
For the month of February benefit costs were unfavorable to budget by $30,000 as a result of the unfavorable adjustment of our health insurance IBNR ($26,100) to the latest lag analysis which increased to $726,748.

Professional Fees
Professional fees were favorable to budget by $87,000 primarily as a result of the reversal of expense accruals for legal fess associated with the settlement of one of two employee related matters ($73,000) which actual expenses had been expensed in previous months but the accrual was not reversed.

Insurance
Insurance costs continue to be under budget as result of the favorable experience in our professional liability insurance program. We expect that for FY 2009 a savings of approximately 25% will be achieved in professional liability insurance rates over that of the prior year due to improved loss experience.

Other Operating Expenses
This category was unfavorable to budget by $38,000 as a result the initial payment to Webcore for the Crestcom management training program, $28,000, and the payment of $25,000 to settle the employee related matter mentioned in the Professional Fees section of this report.

ALAMEDA HOSPITAL
Balance Sheet
February 28, 2009

	February 29, 2009	January 31, 2009	Audited June 30, 2008
Assets			
Current assets:			
Cash and cash equivalents	$ 1,563,919	$ 1,865,103	$ 4,520,156
Net Accounts Receivable	10,147,803	9,838,278	7,944,522
Net Accounts Receivable %	23.55%	23.65%	20.17%
Inventories	1,021,287	1,014,263	1,048,503
Est.Third-party payer settlement receivable	518,042	507,957	245,115
Other assets	3,867,436	3,950,467	7,270,116
Total Current Assets	17,118,487	17,176,068	21,028,412
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate	556,369	546,916	602,817
Total fixed assets, net of accumulated depreciation	7,014,105	7,069,309	7,450,244
Total Assets	$ 24,688,961	$ 24,792,293	$ 29,081,473
Liabilities and Net Assets			
Current Liabilities:			
Current portion of long term debt	$ 477,046	$ 2,341,045	$ 2,744,870
Accounts payable and accrued expenses	6,236,322	6,117,108	7,057,073
Payroll and benefit related accruals	4,343,076	4,138,468	3,133,574
Est.Third-party payer settlement payable	502,229	502,229	441,409
Other liabilities	3,503,697	3,954,023	8,190,530
Total Current Liabilities	15,062,369	17,052,873	21,567,456
Long-Term Liabilities:			
Debt borrowings net of current maturities	1,904,289	51,985	80,992
Total Long-Term Liabilities	1,904,289	51,985	80,992
Total Liabilities	16,966,658	17,104,858	21,648,448
Net Assets			
Unrestricted Funds	7,165,934	7,140,519	6,830,209
Restricted Funds	556,369	546,916	602,817
Net Assets	7,722,304	7,687,435	7,433,025
Total Liabilities and Net Assets	$ 24,688,961	$ 24,792,293	$ 29,081,473

City of Alameda Health Care District

Statements of Operations - Combined

February 28, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 13,714	$ 13,721	$ (7)	-0.1%	$ 12,128	$ 102,884	$ 106,167	$ (3,282)	-3.1%	$ 107,731
Gross Outpatient Revenues	9,338	9,486	(148)	-1.6%	9,276	77,533	74,658	2,874	3.9%	51,883
Total Gross Revenues	23,051	23,207	(155)	-0.7%	21,404	180,417	180,825	(408)	-0.2%	159,614
Contractual Deductions	17,442	17,603	161	0.9%	16,930	133,588	134,175	587	0.4%	120,812
Bad Debts	530	477	(53)	-11.1%	7	4,897	4,321	(576)	-13.3%	2,707
Charity and Other Adjustments	25	22	(2)	-11.1%	(44)	792	772	(19)	-2.5%	658
Net Patient Revenues	5,055	5,105	(50)	-1.0%	4,510	41,140	41,556	(416)	-1.0%	35,436
Net Patient Revenue %	21.9%	22.0%			21.1%	22.8%	23.0%			22.2%
Other Operating Revenue	10	10	0	2.4%	9	124	80	43	54.0%	80
Total Revenues	**5,066**	**5,115**	**(50)**	-1.0%	**4,519**	**41,264**	**41,637**	**(373)**	-0.9%	**35,517**
Expenses										
Salaries	2,728	2,917	189	6.5%	2,549	22,848	23,829	981	4.1%	21,673
Registry	247	112	(136)	-121.6%	103	1,682	925	(757)	-81.9%	964
Benefits	890	875	(16)	-1.8%	619	6,499	7,033	534	7.6%	5,715
Professional Fees	202	282	81	28.6%	227	2,411	2,258	(153)	-6.8%	2,602
Supplies	717	725	8	1.1%	726	5,968	5,940	(28)	-0.5%	5,617
Purchased Services	344	345	1	0.3%	310	2,692	2,760	68	2.5%	2,390
Rents and Leases	58	55	(3)	-4.8%	41	477	428	(49)	-11.5%	376
Utilities and Telephone	73	69	(4)	-6.2%	74	573	590	18	3.0%	544
Insurance	50	61	11	17.9%	60	338	490	152	31.0%	477
Depreciation and amortization	117	113	(4)	-3.1%	131	971	906	(65)	-7.2%	1,264
Other Opertaing Expenses	104	65	(39)	-61.0%	44	605	531	(75)	-14.1%	418
Total Expenses	**5,530**	**5,618**	**88**	1.6%	**4,883**	**45,064**	**45,689**	**625**	1.4%	**42,040**
Operating gain (loss)	(464)	(503)	39	7.7%	(364)	(3,800)	(4,052)	252	-6.2%	(6,524)
Net Non-Operating Income / (Expense)	483	498	(15)	-3.0%	493	3,930	3,985	(54)	-1.4%	4,100
Excess of Revenues Over Expenses	$ 19	$ (5)	$ 24	-499.4%	$ 129	$ 130	$ (67)	$ 198	-292.9%	$ (2,424)

City of Alameda Health Care District

Statements of Operations - Hospital Only

February 28, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 13,262	$ 13,333	$ (71)	-0.5%	$ 12,128	$ 100,106	$ 103,571	$ (3,464)	-3.3%	$ 107,731
Gross Outpatient Revenues	9,338	9,486	(148)	-1.6%	9,276	77,533	74,658	2,874	3.9%	51,883
Total Gross Revenues	22,600	22,818	(219)	-1.0%	21,404	177,639	178,229	(590)	-0.3%	159,614
Contractual Deductions	17,185	17,406	221	1.3%	16,930	131,967	132,859	892	0.7%	120,812
Bad Debts	530	477	(53)	-11.1%	7	4,897	4,321	(576)	-13.3%	2,707
Charity and Other Adjustments	25	22	(2)	-11.1%	(44)	792	772	(19)	-2.5%	658
Net Patient Revenues	4,861	4,914	(53)	-1.1%	4,510	39,984	40,277	(294)	-0.7%	35,436
Net Patient Revenue %	21.5%	21.5%			21.1%	22.5%	22.6%			22.2%
Other Operating Revenue	10	10	0	2.4%	9	124	80	43	54.0%	80
Total Revenues	**4,871**	**4,924**	**(53)**	-1.1%	**4,519**	**40,107**	**40,358**	**(250)**	-0.6%	**35,517**
Expenses										
Salaries and Benefits	2,640	2,808	169	6.0%	2,549	22,208	23,096	888	3.8%	21,673
Registry	247	112	(136)	-121.6%	103	1,682	925	(757)	-81.9%	964
Benefits	872	842	(30)	-3.6%	619	6,428	6,818	389	5.7%	5,715
Professional Fees	182	269	87	32.3%	227	2,268	2,152	(116)	-5.4%	2,602
Supplies	709	715	6	0.8%	726	5,891	5,875	(16)	-0.3%	5,617
Purchased Services	331	344	13	3.7%	310	2,645	2,751	106	3.8%	2,390
Rents and Leases	50	47	(2)	-5.3%	41	424	378	(46)	-12.3%	376
Utilities and Telephone	68	67	(2)	-2.3%	74	553	574	21	3.7%	544
Insurance	50	60	10	16.9%	60	333	485	152	31.4%	477
Depreciation and Amortization	116	112	(4)	-3.2%	131	966	900	(66)	-7.3%	1,264
Other Operating Expenses	102	63	(38)	-60.5%	44	594	523	(71)	-13.6%	418
Total Expenses	**5,367**	**5,439**	**72**	1.3%	**4,883**	**43,992**	**44,474**	**483**	1.1%	**42,040**
Operating Gain / (Loss)	**(495)**	**(515)**	**20**	3.8%	**(364)**	**(3,884)**	**(4,117)**	**232**	-5.6%	**(6,524)**
Net Non-Operating Income / (Expense)	**483**	**498**	**(15)**	**-3.0%**	**493**	**3,930**	**3,985**	**(54)**	**-1.4%**	**4,100**
Excess of Revenues Over Expenses	**$ (12)**	**$ (17)**	**$ 5**	-29.1%	**$ 129**	**$ 46**	**$ (132)**	**$ 178**	-134.9%	**$ (2,424)**

City of Alameda Health Care District

Statements of Operations - South Shore

February 28, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 452	$ 388	$ 63	16.3%	$ -	$ 2,778	$ 2,596	$ 182	7.0%	$ -
Gross Outpatient Revenues	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Gross Revenues	452	388	63	16.3%	-	2,778	2,596	182	7.0%	-
Contractual Deductions	257	197	(60)	-30.5%	-	1,621	1,316	(304)	-23.1%	-
Bad Debts	-	-	-	0.0%	-	-	-	-	0.0%	-
Charity and Other Adjustments	-	-	-	0.0%	-	-	-	-	0.0%	-
Net Patient Revenues	195	191	3	1.7%	-	1,157	1,279	(122)	-9.6%	-
Net Patient Revenue %	43.1%	49.3%			0.0%	41.6%	49.3%			0.0%
Other Operating Revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Revenues	**195**	**192**	**3**	1.6%	**-**	**1,157**	**1,280**	**(123)**	-9.6%	**-**
Expenses										
Salaries	88	108	21	18.9%	-	640	734	93	12.7%	-
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	18	33	14	43.9%	-	71	215	144	67.2%	-
Professional Fees	20	13	(6)	-46.5%	-	143	106	(37)	-34.9%	-
Supplies	8	10	2	17.8%	-	77	65	(12)	-18.7%	-
Purchased Services	13	1	(12)	-785.7%	-	47	10	(38)	-392.5%	-
Rents and Leases	8	8	(0)	-1.8%	-	53	50	(3)	-5.5%	-
Utilities and Telephone	5	3	(3)	-108.9%	-	20	16	(3)	-21.1%	-
Insurance	0	1	1	89.0%	-	5	6	0	1.5%	-
Depreciation and amortization	1	1	0	12.7%	-	6	6	1	12.5%	-
Other Operating Expenses	2	1	(1)	-88.1%	-	11	7	(4)	-51.7%	-
Total Expenses	**164**	**179**	**16**	8.8%	**-**	**1,073**	**1,215**	**142**	11.7%	**-**
Opertaing Gain / (Loss)	**31**	**12**	**19**	-152.3%	-	**84**	**65**	**19**	29.8%	-
Net Non-Operating Income / (Expense)	-	-	-	**0.0%**	-	-	-	-	**0.0%**	-
Excess of Revenues Over Expenses	**$ 31**	**$ 12**	**$ 19**	152.3%	**$ -**	**$ 84**	**$ 65**	**$ 19**	29.8%	**$ -**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day - Combined

February 28, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,222	$ 3,130	$ 92	2.9%	$ 3,592	$ 3,004	$ 3,092	$ (89)	-2.9%	$ 4,922
Gross Outpatient Revenues	2,194	2,164	30	1.4%	2,747	2,263	2,175	89	4.1%	2,370
Total Gross Revenues	5,416	5,294	123	2.3%	6,340	5,267	5,267	0	0.0%	7,292
Contractual Deductions	4,098	4,015	(83)	-2.1%	5,014	3,900	3,908	8	0.2%	5,519
Bad Debts	124	109	(16)	-14.4%	2	143	126	(17)	-13.6%	124
Charity and Other Adjustments	6	5	(1)	-14.4%	(13)	23	22	(1)	-2.8%	30
Net Patient Revenues	1,188	1,165	23	2.0%	1,336	1,201	1,210	(9)	-0.8%	1,619
Net Patient Revenue %	21.9%	22.0%			21.1%	22.8%	23.0%			22.2%
Other Operating Revenue	2	2	0	5.5%	3	4	2	1	54.3%	4
Total Revenues	**1,190**	**1,167**	**23**	2.0%	**1,339**	**1,205**	**1,213**	**(8)**	-0.7%	**1,623**
Expenses										
Salaries	641	685	44	6.5%	599	667	694	27	3.9%	990
Registry	58	26	(32)	-121.6%	24	49	27	(22)	-82.3%	44
Benefits	209	206	(4)	-1.8%	145	190	205	15	7.4%	261
Professional Fees	47	64	17	26.4%	67	70	66	(5)	-7.0%	119
Supplies	169	165	(3)	-1.9%	215	174	173	(1)	-0.7%	257
Purchased Services	81	81	0	0.3%	73	79	80	2	2.2%	109
Rents and Leases	14	13	(1)	-7.9%	12	14	12	(1)	-11.7%	17
Utilities and Telephone	17	16	(1)	-9.4%	22	17	17	0	2.8%	25
Insurance	12	14	2	15.4%	18	10	14	4	30.9%	22
Depreciation and Amortization	27	26	(2)	-6.2%	39	28	26	(2)	-7.4%	58
Other Operating Expenses	24	15	(10)	-65.8%	13	18	15	(2)	-14.3%	19
Total Expenses	**1,299**	**1,311**	**11**	0.9%	**1,227**	**1,316**	**1,331**	**15**	1.1%	**1,921**
Operating Gain / (Loss)	**(109)**	**(144)**	**35**	24.2%	**112**	**(111)**	**(118)**	**7**	-6.0%	**(298)**
Net Non-Operating Income / (Expense)	**114**	**114**	**(0)**	**0.0%**	**146**	**115**	**116**	**(1)**	**-1.1%**	**187**
Excess of Revenues Over Expenses	**$ 5**	**$ (30)**	**$ 35**	-115.5%	**$ 258**	**$ 4**	**$ (2)**	**$ 6**	-330.8%	**$ (111)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day - Hospital Only

February 28, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,934	$ 3,999	$ (65)	-1.6%	$ 3,592	$ 3,616	$ 3,798	$ (182)	-4.8%	$ 4,922
Gross Outpatient Revenues	2,770	2,845	(75)	-2.6%	2,747	2,801	2,738	63	2.3%	2,370
Total Gross Revenues	6,705	6,844	(140)	-2.0%	6,340	6,417	6,536	(119)	-1.8%	7,292
Contractual Deductions	5,098	5,221	123	2.3%	5,014	4,767	4,872	105	2.2%	5,519
Bad Debts	157	143	(14)	-9.9%	2	177	158	(18)	-11.6%	124
Charity and Other Adjustments	7	7	(1)	-9.9%	(13)	29	28	(0)	-1.0%	30
Net Patient Revenues	1,442	1,474	(32)	-2.2%	1,336	1,444	1,477	(33)	-2.2%	1,619
Net Patient Revenue %	21.5%	21.5%			21.1%	22.5%	22.6%			22.2%
Other Operating Revenue	3	3	0	1.3%	3	4	3	2	51.7%	4
Total Revenues	**1,445**	**1,477**	**(32)**	-2.2%	**1,339**	**1,449**	**1,480**	**(31)**	-2.1%	**1,623**
Expenses										
Salaries	783	842	59	7.0%	755	802	847	45	5.3%	990
Registry	73	33	(40)	-119.2%	30	61	34	(27)	-79.2%	44
Benefits	259	253	(6)	-2.4%	183	232	250	18	7.1%	261
Professional Fees	54	81	27	33.1%	67	82	79	(3)	-3.8%	119
Supplies	210	214	4	1.9%	215	213	215	3	1.2%	257
Purchased Services	98	103	5	4.7%	92	96	101	5	5.3%	109
Rents and Leases	15	14	(1)	-4.1%	12	15	14	(1)	-10.6%	17
Utilities and Telephone	20	20	(0)	-1.2%	22	20	21	1	5.1%	25
Insurance	15	18	3	17.8%	18	12	18	6	32.4%	22
Depreciation and Amortization	34	34	(1)	-2.1%	39	35	33	(2)	-5.7%	58
Other Operating Expenses	30	19	(11)	-58.8%	13	21	19	(2)	-11.9%	19
Total Expenses	**1,592**	**1,631**	**39**	2.4%	**1,446**	**1,589**	**1,631**	**42**	2.6%	**1,921**
Operating Gain / (Loss)	**(147)**	**(154)**	**7**	4.9%	**(108)**	**(140)**	**(151)**	**11**	-7.1%	**(298)**
Net Non-Operating Income / (Expense)	143	149	(6)	-4.0%	146	142	146	(4)	-2.8%	187
Excess of Revenues Over Expenses	$ (3)	$ (5)	$ 2	-30.8%	$ 38	$ 2	$ (5)	$ 7	-140.7%	$ (111)

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day - South Shore

February 28, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 815	$ 603	$ 212	35.2%	$ -	$ 706	$ 602	$ 104	17.3%	$ -
Gross Outpatient Revenues	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Gross Revenues	815	603	212	35.2%	-	706	602	104	17.3%	-
Contractual Deductions	464	306	(158)	-51.7%	-	412	305	(107)	-35.0%	-
Bad Debts	-	-	-	0.0%	-	-	-	-	0.0%	-
Charity and Other Adjustments	-	-	-	0.0%	-	-	-	-	0.0%	-
Net Patient Revenues	351	297	54	18.2%	-	294	297	(3)	-0.9%	-
Net Patient Revenue %	43.1%	49.3%			0.0%	41.6%	49.3%			0.0%
Other Operating Revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Revenues	**352**	**298**	**54**	18.1%	-	**295**	**297**	**(3)**	-0.9%	-
Expenses										
Salaries	159	196	37	18.9%	-	163	170	7	4.3%	-
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	33	59	26	43.9%	-	18	50	32	64.0%	-
Professional Fees	35	21	(15)	-70.3%	-	36	25	(12)	-47.8%	-
Supplies	15	16	1	4.5%	-	20	15	(5)	-30.1%	-
Purchased Services	24	3	(21)	-785.7%	-	12	2	(10)	-439.8%	-
Rents and Leases	14	12	(2)	-18.4%	-	13	12	(2)	-15.6%	-
Utilities and Telephone	10	4	(6)	-142.8%	-	5	4	(1)	-32.8%	-
Insurance	0	1	1	87.2%	-	1	1	(0)	-8.0%	-
Depreciation and amortization	2	2	(0)	-1.5%	-	1	2	0	4.1%	-
Other Operating Expenses	4	2	(2)	-118.7%	-	3	2	(1)	-66.3%	-
Total Expenses	**295**	**315**	**19**	6.2%	-	**273**	**282**	**9**	3.2%	-
Operating Gain / (Loss)	56	(17)	73	434.0%	-	22	15	6	40.8%	-
Net Non-Operating Income / (Expense)	-	-	-	**0.0%**	-	-	-	-	**0.0%**	-
Excess of Revenues Over Expenses	$ 56	$ (17)	$ 73	-434.0%	$ -	$ 22	$ 15	$ 6	40.8%	$ -

ALAMEDA HOSPITAL
KEY STATISTICS
February, 2009

	ACTUAL FEBRUARY 2009	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	FEBRUARY 2008	YTD FEBRUARY 2009	YTD FIXED BUDGET	VARIANCE	%	YTD FEBRUARY 2008
Discharges:										
Total Acute	248	252	(4)	-1.6%	278	1,860	1,941	(81)	-4.2%	1,896
Total Sub-Acute	2	2	-	0.0%	1	27	16	11	68.8%	11
Total Skilled Nursing	13	9	4	44.4%	3	81	58	23	39.7%	59
	263	263	-	0.0%	282	1,968	2,015	(47)	-2.3%	1,966
Patient Days:										
Total Acute	1,046	1,009	37	3.7%	1,052	7,623	7,762	(139)	-1.8%	7,345
Total Sub-Acute	932	939	(7)	-0.7%	857	7,978	8,085	(107)	-1.3%	6,833
Total Skilled Nursing	554	644	(90)	-14.0%	4	3,933	4,311	(378)	-8.8%	596
	2,532	2,592	(60)	-2.3%	1,913	19,534	20,158	(624)	-3.1%	14,774
Average Length of Stay										
Total Acute	4.22	4.00	0.21	5.3%	3.78	4.10	4.00	0.10	2.5%	3.87
Average Daily Census										
Total Acute	37.36	36.04	1.19	3.3%	36.28	31.37	31.94	(0.57)	-1.8%	30.10
Total Sub-Acute	33.29	33.54	(0.23)	-0.7%	29.55	32.83	33.27	(0.44)	-1.3%	28.00
Total Skilled Nursing	19.79	23.00	(2.90)	-12.6%	0.14	20.07	21.99	(1.93)	-8.8%	2.44
	90.43	92.57	(1.94)	-2.1%	65.97	84.27	99.37	(1.01)	-1.0%	60.55
Emergency Room Visits	1,389	1,445	(56)	-3.9%	1,616	11,221	11,927	(706)	-5.9%	11,785
Outpatient Registrations	2,298	2,525	(227)	-9.0%	2,432	19,740	20,442	(702)	-3.4%	21,038
Surgery Cases:										
Inpatient	54	56	(2)	-3.6%	62	447	454	(7)	-1.5%	448
Outpatient	414	356	58	16.3%	351	3,350	2,836	514	18.1%	2,993
	468	412	56	13.6%	413	3,797	3,290	507	15.4%	3,441
Kaiser Inpatient Cases	10	-	10	-	7	70	-	70	-	37
Kaiser Eye Cases	168	123	45	36.6%	100	1,258	973	285	29.3%	1,037
Kaiser Outpatient Cases	157	133	24	18.0%	155	1,248	1,011	237	23.4%	1,037
Total Kaiser Cases	335	256	79	30.9%	262	2,576	1,984	592	29.8%	2,111
% Kaiser Cases	71.6%	62.1%			63.4%	67.8%	60.3%			61.3%
Adjusted Occupied Bed	152.00	155.59	3.59	2.3%	116.42	140.97	141.32	(0.35)	-0.2%	105.76
Productive FTE	393.20	379.36	(13.84)	-3.6%	350.92	369.80	362.16	(7.64)	-2.1%	347.65
Total FTE	439.78	443.19	3.41	0.8%	401.89	422.19	424.41	2.22	0.5%	404.39
Productive FTE/Adj. Occ. Bed	2.59	2.44	(0.15)	-6.1%	3.01	2.62	2.56	(0.06)	-2.4%	3.29
Total FTE/ Adj. Occ. Bed	2.89	2.85	(0.04)	-1.6%	3.45	2.99	3.00	0.01	0.3%	3.82

ALAMEDA HOSPITAL

12 MONTH CASH PROJECTION

PERIOD COVERED: 3/1/09 THRU 2/28/10

	COLLECTIONS		PROPERTY	W/C REFUND	OTHER	FY 2008		EST.	
MONTH	NON-KAISER	KAISER -USE	TAX[1]	NET		AB 915	TRANSFERS	DISBURSEMENTS	BALANCE[2]
FEB 09	3,980,352	760,000	477,000		98,565			5,176,021	(385,391)
MAR 09	4,742,355	760,000	477,000		50,000		100,000	5,584,002	159,962
APR 09	4,200,000	790,000	477,000		50,000		(250,000)	5,271,513	155,449
MAY 09	4,710,000	790,000	477,000		50,000		800,000	6,862,505	119,945
JUNE 09	4,620,000	790,000	477,000		50,000	180,000	(700,000)	5,411,170	125,775
JULY 09	4,840,000	790,000	477,000		50,000		(100,000)	6,017,752	165,023
AUG 09	4,620,000	790,000	477,000		50,000		75,000	6,017,752	159,271
SEP 09	4,725,000	790,000	477,000		50,000			6,017,752	183,519
OCT 09	4,950,000	790,000	477,000		50,000		(200,000)	6,099,854	150,665
NOV 09	4,370,000	790,000	477,000		50,000		350,000	6,017,752	169,913
DEC 09	5,060,000	790,000	477,000		50,000		(350,000)	6,017,752	179,161
JAN 10	5,060,000	790,000	477,000		50,000		(350,000)	6,017,752	188,409
TOTALS	51,897,355	8,660,000	5,247,000	0	912,256	180,000	(34,812.00)	76,111,366	

Notes:

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

12 Month Cash Projection - Disbursement Detail

PERIOD COVERED: 3/1/09 THRU 2/28/10

	DISBURSEMENTS								TOTAL CASH
			10%						
MONTH	PAYROLL	PENSION	PAYROLL RELATED	Total Payroll	Health expense	Refund	A/P	Debt Service	OUTLAYS
FEB 09	2,750,801	60,500	253,536	3,064,837	230,759	2,273	1,829,641	48,511	5,176,021
MAR 09	2,749,099	60,500	276,403	3,086,002	278,000	20,000	2,137,441	62,559	5,584,002
APR 09	2,749,099	60,500	263,914	3,073,513	278,000	20,000	1,851,707	48,293	5,271,513
MAY 09	4,177,924 a	85,500	401,081	4,664,505	278,000	20,000	1,855,987	44,013	6,862,505
JUNE 09	2,785,283	60,500	267,387	3,113,170	278,000	20,000	1,955,933	44,067	5,411,170
JULY 09	3,338,734	60,500	320,518	3,719,752	278,000	20,000	1,955,891	44,109	6,017,752
AUG 09	3,338,734	60,500	320,518	3,719,752	278,000	20,000	1,955,842	44,158	6,017,752
SEP 09	3,338,734	60,500	320,518	3,719,752	278,000	20,000	1,955,788	44,212	6,017,752
OCT 09	5,008,100 a	85,500	480,778	3,801,854	278,000	20,000	1,955,744	44,256	6,099,854
NOV 09	3,338,734	60,500	320,518	3,719,752	278,000	20,000	1,955,690	44,310	6,017,752
DEC 09	3,338,734	60,500	320,518	3,719,752	278,000	20,000	1,957,912	42,088	6,017,752
JAN 10	3,338,734	60,500	320,518	3,719,752	278,000	20,000	1,957,870	42,130	6,017,752
TOTALS	42,936,373	840,697	4,124,175	46,128,721	0 3,673,761	225,273	25,482,489	601,122	0 76,111,366

a) 3 pay periods in the month

TCA Partners, LLP

A Certified Public Accountancy Limited Liability Partnership
1111 East Herndon Avenue, Suite 211, Fresno, California 93720
Voice: (559) 431-7708 Fax: (559) 431-7685 Email: rictcpa@aol.com

March 26, 2009

City of Alameda Health Care District
2070 Clinton Avenue
Alameda, CA 94501

To the Board of Directors:

We are pleased to confirm our understanding of the services we are to provide for the City of Alameda Health Care District (the Hospital) for the year ended June 30, 2009. We will audit the balance sheet of the City of Alameda Health Care District as of June 30, 2009 and the related statements of revenues, expenses and changes in net assets, and cash flows for the year then ended.

Our audit will be made in accordance with U.S. generally accepted auditing standards and will include tests of the accounting records of the Hospital and other procedures we consider necessary to enable us to express an unqualified opinion that the financial statements are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. If our opinion is other than unqualified, we will fully discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit, we will not issue a report as a result of the respective year and engagement.

Our procedures will include tests of documentary evidence that support the transactions recorded in the accounts, tests of the physical existence of inventories, and direct confirmation of cash, investments, and certain other assets and liabilities by correspondence with customers, creditors, and financial institutions. Also, we will request written representations from your attorneys as part of the engagement, and they may bill you for responding to that inquiry. At the conclusion of our audit, we will also request certain written representations from you about the financial statements and related matters.

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. Our audit is designed to provide reasonable, not absolute, assurance about whether the financial statements are free of material misstatement, whether due to

error, fraudulent financial reporting, misappropriation of assets, or violations of laws or governmental regulations. Because of this concept of reasonable assurance and because we will not examine all transactions, there is a risk that material misstatements may exist and may not be detected by us. The Hospital's management is responsible for establishing and maintaining a sound system of internal controls, which is the best means of preventing or detecting errors, fraudulent financial reporting, misappropriation of assets, or violations of laws or governmental regulations. Our responsibility as auditors is limited to the period covered by our audit and does not extend to matters that might arise during any later periods for which we are not engaged as auditors.

Our audit is not specifically designed to provide assurance on internal controls and cannot be relied on to disclose reporting conditions; that is, significant deficiencies in the design or operation of the internal controls. However, during the audit, if we become aware of such reportable conditions or ways that we believe management practices can be improved, we will communicate them to you in a separate letter.

We understand that you will provide us with the basic information required for our audit and that you are responsible for the accuracy and completeness of that information. We will advise you about appropriate accounting principles and their application and will assist in the preparation of your financial statements, but the responsibility for the financial statements remains with you. This management responsibility includes: (a) establishing and maintaining adequate records and related internal control policies and procedures, (b) selecting and applying accounting principles, (c) safeguarding assets, and (d) identifying and ensuring that the entity complies with applicable laws and regulations applicable to its activities.

Management is also responsible for adjusting the financial statements to correct material misstatements and for confirming to us in the management representation letter that the effects of any uncorrected misstatements, resulting from errors or fraud, aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole. In addition, management is responsible for: (a) the design and implementation of programs and controls to prevent and detect fraud, (b) for informing us about any fraud or suspected fraud affecting the entity involving management, employees who have significant roles in internal control, or others where the fraud could have a material effect on the financial statements, and (c) for informing us about allegations of fraud or suspected fraud affecting the entity received in communications from employees, former employees, analysts, regulators, short sellers, or others.

We understand that your employees will locate any documents or invoices selected by us for testing.

If you intend to publish or otherwise reproduce the financial statements and make reference to our firm, you agree to provide us with printers' proofs or masters for our review and approval before printing. You also agree to provide us with a copy of the final reproduced material for our approval before it is distributed.

The timing of our audit may be scheduled for performance for the year and completion as follows:

	Begin	*Complete*
Document internal controls and preliminary tests	May	June
Mail confirmations	June	June
Perform year-end audit procedures	July	August
Issue audit report	September	September

Our fees are based on the amount of time required at various levels of responsibility, plus actual out-of-pocket expenses. Invoices will be rendered periodically and are payable upon presentation. Based upon the proposal accepted, our fees for the June 30, 2009 audit will be $34,250. All travel and out-of-pocket expenses, estimated at $4,500 for the June 30, 2009 audit, will be billed separately.

We will notify you immediately of any circumstances we encounter that could significantly affect these fees. Whenever possible, we will attempt to use the Hospital's personnel to assist in the preparation of schedules and analyses of accounts. This effort helps to reduce time requirements and facilitate the timely conclusion of the audit.

During the course of the audit we may observe opportunities for economy in, or improved controls over, your operations. We will bring such matters to the attention of appropriate level of management, either orally or in writing.

If the foregoing is in accordance with your understanding, please indicate your agreement by signing the final page of this letter and returning it to us. If you have any questions, please let us know.

We appreciate the opportunity to be your certified public accountants and look forward to working with you and your staff.

Very truly yours,

TCA Partners, LLP

TCA Partners, LLP

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RESPONSE:

This letter correctly sets forth the understanding of the City of Alameda Health Care District.

Approved by:_____

Title:_____

Date:_____

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

CONTINUING MEDICAL EDUCATION PROGRAM OF THE MEDICAL STAFF

MISSION STATEMENT

GOALS:

The Medical Staff of Alameda Hospital is committed to providing Category I continuing medical education consistent with established accreditation standards which will update physicians' scientific knowledge, clinical knowledge and skills, practice efficiency, professional ethics, and knowledge and understanding of medical staff leadership. A coordinated linkage between quality improvement activities and the CME program will continue to generate opportunities for sustained improvements in clinical practice.

SCOPE:

The scope of the CME Program shall include:

- Health care issues related to patients admitted to Alameda Hospital as well as health care issues relative to our community patient population;
- Medico-legal topics, bioethics, behavioral education, socioeconomic and public health issues.
- Quality improvement, performance improvement, and utilization review

Except as may be exempt by State law, all courses shall include the appropriate cultural and linguistic competencies.

ADMINISTRATION:

The Chairman of the Continuing Medical Education Committee shall be responsible for overseeing all CME activities of Alameda Hospital.

Membership of the CME Committee shall include a broad physician representation of the physician constituency of the Medical Staff as well as representatives from Nursing, Quality Improvement and the Medical Library and other relevant professionals as may be appropriate. Members shall serve staggered terms to ensure continuity of the program.

ACTIVITIES:

The CME Program offers hospital-based conferences of one or two hours duration and may, based on need, offer courses lasting up to one or more days. Teaching methodology will include didactic, interactive, demonstration of techniques and panels.

EXPECTED RESULTS:

It is expected that participation in the CME activities at Alameda Hospital will result in improved medical knowledge, enhanced skills, practice improvement and overall ability to better provide the quality care expected by patients. **It is expected that a significant number of learners will report that learning objectives have been met and/or that the learner intends to make a change in practice.**

AUDIENCE:

Characteristics of potential participants in the CME Program shall include physicians who range in degree of specialization from tertiary care to specialists to primary care as well as other healthcare professionals.

>><<

Approved by: CME Committee: 04/15/09
Medical Executive Committee: 04/24/09
Board of Directors: 05/04/09

ALAMEDA HOSPITAL
ALAMEDA, CALIFORNIA

APPLICATION FOR MEDICAL PRIVILEGES

NAME: _____ SPECIALTY: _____

BOARD: _____

BOARD: _____

- Your request for clinical/surgical privileges will be evaluated on the basis of your **current** competence, including education, training, experience, demonstrated professional competence and judgment, recent clinical performance, and the documented results of patient care and other quality review and monitoring. Applicants who use the hospital infrequently may be asked to provide documented evidence of current competence from his/her primary hospital.

- *In the case of an emergency, any individual who is a member of the Medical Staff or who has been granted clinical/surgical privileges is permitted to do everything possible within the scope of his/her license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.*

- Procedures not listed on the attached application form must be requested on a separate form to determine the availability of sufficient space, equipment, technology and staffing to support each requested procedure. Please contact the Medical Staff Office at 510-814-4035 for the application forms. All requests for new technology/procedures must be approved prior to applying for the technology/procedure(s).

- Please check below the category of privileges you are requesting.

____ **CATEGORY 1:** Physicians with these privileges may render emergency care and care of the most primary nature. Further management must then be provided by an appropriate qualified physician.

____ **CATEGORY 2:** Physicians with these privileges are expected to request consultation in all cases in which doubt exists as to the diagnosis, where expected improvement is not soon apparent, and when specialized therapeutic or diagnostic techniques are indicated.

____ **CATEGORY 3:** Physicians with Category 3 privileges are expected to have training and/or experienced and competence on a level commensurate with that provided by specialty training such as in the broad field on internal or family medicine, although not necessarily at the level of the subspecialist. Physicians with Category 3 privileges may act as consultants to other and may be expected to request consultation when (1) diagnosis and/or managements remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness; (2) unexpected complications arise which are outside this level of competence; (3) specialized treatment or procedures are contemplated with which the physician is not familiar.

____ **CATEGORY 4:** Physicians with Category 4 privileges have the highest level competence within a given field, on a par with that considered appropriate for a subspecialist. Physicians with Category 4 privileges are qualified to act as consultants and should request consultation from within or from outside the hospital staff whenever needed.

NAME: _____

MEDICAL SPECIALTY AREA(S)

Please indicate below your medical specialty area(s) for which you will be requesting privileges.

___ Allergy/Immunology	___ Hematology/Oncology	___ Psychiatry
___ Cardiology	___ Infectious Diseases	___ Pulmonary Medicine
___ Critical Care Medicine	___ Internal Medicine	___ Radiation Oncology
___ Dermatology	___ Nephrology	___ Radiology
___ Endocrine/Metabolic	___ Neurology	___ Rheumatology
___ Family Medicine	___ Nuclear Medicine	___ Other: _____
___ Gastroenterology	___ Occupational Medicine	
___ General Medicine	___ Pathology (Anatomic)	
___ Geriatric Medicine	___ Pathology (Clinical)	

GENERAL PRIVILEGES

	REQUESTED	APPROVED
Hospital Admitting/Attending	_____	_____
Medical Consultation	_____	_____

SPECIAL PROCEDURES

Documentation of appropriate training and/or recent experience is required.

PROCEDURAL SEDATION MANAGEMENT

To apply for sedation privileges, please contact the Medical Staff Office., 510-814-4035. A separate application will be sent to you.

RADIOLOGICAL SAFETY

Fluoroscopy Criteria: *Practitioner must submit evidence with this application of a current California Fluoroscopy Operator's Permit.*

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at Alameda Hospital. I acknowledge that my professional liability insurance extends to all privileges I have requested.

_____ _____

SIGNATURE – APPLICANT DATE

MEDICAL STAFF RECOMMENDATION

_____ _____

SIGNATURE/APPROVAL - CHAIRMAN, MEDICAL COMMITTEE DATE

_____ _____

SIGNATURE/APPROVAL – PRESIDENT, MEDICAL STAFF DATE

GENERAL PROCEDURES 1.00	Requested	Number Performed Past 2 Years	Approved
Lumbar Puncture			
Thoracentesis			
Paracentesis			
CVP Peripheral			
Subclavian/Int. Jug. Central IV Catheter Fermoral Line Central IV Catheter			
Arthrocentesis			
History and Physical			
Thrombolytic Therapy (standard protocol)			
IV Conscious Sedation – Contact the Medical Staff Office @ (510)814-4035			

CARDIOLOGY PROCEDURES 2.00	Requested	Number Performed Past 2 Years	Approved
Right heart catherization: Percutaneous			
Right heart catherization: Cutdown			
Arterial line placement			
Cardioversion, elective			
Pacemaker implantation: Temporary			
Pacemaker implantation: Permanent			
EKG interpretation with report			
Stress testing & report			
Echocardiogram interpretation with report			
Thrombolytic Therapy (standard protocol)			
Intracardiac Defibrillator Implant			

PULMONARY PROCEDURES 3.00	Requested	Number Performed Past 2 Years	Approved
Bronchoscopy with biopsy			
Bronchoscopy (therapeutic)			
Transthoracic needle biopsy			
Thoracostomy: Percutaneous			
Thoracostomy: Open			
Pulmonary function tests complete with report			
Spirometry with report			

GASTROENTEROLOGY PROCEDURES 4.00	Requested	Number Performed Past 2 Years	Approved
Liver biopsy			
Upper GI endoscopy			
Colonoscopy			
ERCP			
Endoscopic sclerotherapy			
Flexible sigmoidoscopy			
Therapeutic upper endoscopy			
Therapeutic lower endoscopy			
Sphincterotomy			

HEMATOLOGY PROCEDURES 5.00	Requested	Number Performed Past 2 Years	Approved
Bone marrow aspiration & biopsy			
Bone marrow interpretation			
Chemotherapy			

NEPHROLOGY PROCEDURES 6.00	Requested	Number Performed Past 2 Years	Approved
Hemodialysis: Acute			
Hemodialysis: Chronic			
Peritoneal dialysis			
Renal biopsy			
Continuous AV-Hemofiltration			
Continuous AV-Hemofiltration w/dialysis			

DERMATOLOGY PROCEDURES 7.00	Requested	Number Performed Past 2 Years	Approved
Skin biopsy			
Resection of skin lesions			
Dermabrasion			
Simple cryotherapy			
Skin biopsy interpretation			

NEUROLOGY PROCEDURES 8.00	Requested	Number Performed Past 2 Years	Approved
EEG interpretation			
EMG/NCS			
Tensilon Tests			
Transcranial Doppler (TCD)			
Neurologic Consultations			

ENDOCRINE/METABOLISM PROCEDURES 9.00	Requested	Number Performed Past 2 Years	Approved
TPN			
Fine needle biopsy thyroid			
Continuous AV-Hemofiltration			
Continuous AV-Hemofiltration with dialysis			

RADIOLOGY PROCEDURES 10.00	Requested	Number Performed Past 2 Years	Approved
Fine needle biopsy organs			
Arteriography			
Sonographic interpretation & report			
CT interpretation & report			
MRI interpretation & report			
Routine radiologic procedures, other			
Interpretation of nuclear medicine studies			
CT, US, NM, PF, MRI preliminary interpretations			
Paracentesis (US OR CT Guidance)			
Mammography			
Computer Tomography			
Ultrasound including Doppler, but excluding cardiac			
Magnetic Resonance Imaging (MRI			
General Fluoroscopic Exams (UGI, BE)			
Fluroscopy			
Radiation Consultation			
NUCLEAR MEDICINE PROCEDURES 12.00	Requested	Number Performed Past 2 Years	Approved
Diagnostic			
Therapeutic			
Cisternogram			
PATHOLOGY PROCEDURES 11.00	Requested	Number Performed Past 2 Years	Approved
Anatomic pathology			
Clinical pathology			

PROPOSED AMENDMENT:

ALAMEDA HOSPITAL
MEDICAL STAFF RULES & REGULATIONS

TITLE:	EFFECTIVE DATE:
ARTICLE 16: MEDICAL RECORDS	06/12/01 05/24/05 05/31/06 03/02/09
	PAGE: 1 of 3

A. Medical Record Pertinence

The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the course and results accurately.

B. Patient Record Content

The format, forms, and abbreviations used in the medical record are approved by the appropriate Medical Staff Service Committees and the Medical Executive Committee.

1. Identification data and medical record number
2. Medical history of the patient
3. As appropriate, a summary of the patient's psychosocial needs.
4. Reports of relevant physical examination
5. Diagnostic and therapeutic orders; verbal orders must be countersigned within 48 hours.
6. Appropriate informed consents.
7. Clinical observations, including results of therapy (progress notes)
8. Reports of procedures, tests and their results
9. Conclusions at termination of hospitalization or evaluation/treatment.

C. History and Physical Exam

A medical history and physical examination must be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

1. A durable, legible copy of a history and physical examination recorded in the physician's office within thirty (30) days prior to admission may be accepted. An interval medical history and physical examination must be performed and recorded at the time of admission, but prior to surgery or a procedure requiring anesthesia services, if the H&P was completed more than 24 hours prior to admission or surgery. The updated examination of the patient, including any changes in the patient's

condition, must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

2. For readmissions within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes is acceptable, provided the original information is readily available. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. In all cases involving surgery or a procedure requiring anesthesia services, the update must be completed and documented within 24 hours prior to the surgery or procedure.

D. History & Physical Exam - Content

1. Complete H&P

A complete H&P has the following components: History, physical examination, assessment and treatment plan as indicated.

a) History includes:

- **Presenting diagnosis/condition (chief complaint/reason for the visit**
- **Description of symptoms**
- **Current medications and biologicals**
- **Drug allergies**
- **Co-morbid conditions/significant past medical & surgical history**
- **Review of systems**
- **Significant family history**
- **Psychosocial status**
- **For surgery or invasive procedure requiring moderate sedation or anesthesia:**

  1) Indications
  2) Proposed procedure(s)

b) Physical examination (should include as appropriate an examination of body areas/organ systems) and:

- **Vital signs, weight and height**
- **Allergies**
- **Medications**

c. Assessment

2. Interval H&P

An interval H&P must update any components of the patient's current medical status, regardless of whether or not there were any changes. The Interval

H&P must contain either the changes in medical history or physical exam, or a statement indicating that no changes have occurred.

3. History & Physical Examination for Non-Inpatient Services

The outpatient history & physical, *Short Form History and Physical Exam* form may be used for outpatient surgery or procedures. The short form history and physical should contain the following elements:

a. Indications/reasons for procedure
b. Planned procedure
c. Brief history relevant to the procedure
d. Prior anesthesia/sedation complications
e. History of drug or alcohol abuse
f. Medications
g. Allergies
h. Pertinent physical
i. Relevant laboratory tests

If the patient is admitted, a dictated or written history and physical exam must be performed within the time periods established by applicable regulatory standards.

>><<

TITLE:	EFFECTIVE DATE:
ARTICLE 34: MEDICAL STAFF PROFESSIONAL PRACTICE EVALUATION ▪ Ongoing Professional Practice Evaluation (OPPE) ▪ Focused Professional Practice Evaluation (FPPE) ▪ Disruptive Behavior	
	PAGE: 1 of 6

PURPOSE

The purpose of this policy is two-fold:

1. To establish a systematic process for the Medical Staff to evaluate, assess and confirm the ongoing and current professional practice and competence of its members' performance of clinical privileges granted to them at Alameda Hospital as well as the current professional practice and competence of practitioners who have been granted privileges through the credentialing process for allied health professionals.

2. To use the results of the evaluations and assessments to improve professional competency, practice and the system of patient care.

POLICY

It is the Policy of Alameda Hospital to conduct appropriate monitoring of the care delivered to patients by its Medical Staff and Allied Health Professionals. It is further the policy of Alameda Hospital to comply with statutory, regulatory and the standards of the accrediting bodies regarding Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE).

For purposes of clarification, the phrase "Professional Practice Evaluation" is synonymous with the traditional phrase "Peer Review." This policy refers to the records and proceedings of the Medical Staff, which has the responsibility of evaluating and improving the quality of care rendered in this institution. The records and proceedings of the Medical Staff that relate to this policy in any way are protected from discovery pursuant to California Evidence Code, Section 1157 and any other protections afforded by the State and Federal law.

DEFINITIONS

1. Ongoing Professional Practice Evaluation (OPPE)

   OPPE is a process that allows the Medical Staff to identify professional practice trends and systems issues that may affect the delivery of quality of care and patient safety. This process includes:

   a. Identification of issues which may impair optimal provision of care or which do not adequately protect the care process against foreseeable human error.

   b. Evaluation of an individual practitioner's professional performance, including opportunities to improve care based on recognized standards.

2. Focused Professional Practice Evaluation (FPPE)

FPPE is a time-limited period during which the Medical Staff evaluates and determines a practitioner's professional performance of privileges, including patterns of care, outcomes, complications, behavior or other indicators associated with the practitioner's practice. FPPE is not considered an investigation as defined in the Medical Staff Bylaws and is not subject to regulations afforded in the investigation process. If a FPPE results in an action plan to perform an investigation, the process set forth in the Medical Staff bylaws will be followed. The FPPE process will apply to the following:

a. When a member is initially appointed to the Medical Staff or a practitioner is granted Allied Health Professional status.

b. The proctoring program as set forth in the Medical Staff Bylaws;

c. When questions arise regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

d. When a currently credentialed member of the Medical Staff or a practitioner granted Allied Health Professional status requests privileges to perform a new procedure.

* * *

A. Ongoing Professional Practice Evaluation (OPPE)

1. Responsibility

It is the responsibility of the Chairman of each Medical Staff Service Committee to coordinate the Ongoing Professional Practice Evaluation (OPPE) and to review the performance data of each Service Committee member.

a. This responsibility may be delegated to another member if, in the opinion of the Chairman, the member is equally or more qualified to conduct the ongoing review.

2. Frequency of Data Review

The frequency of each member's OPPE will occur every six (6) months. The information collected during this period will be forwarded to the member and, if appropriate, feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

3. Data Collection

Refer to Section B, Data Collection and Assessment. of the CI Program Integration Plan, a copy of which is attached to this policy.

Data may be collected from multiple sources of information, including review of individual cases, the review of aggregate data (including rate comparisons against established benchmarks or norms) compliance with clinical standards, periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing and administrative personnel, Bylaws, Rules and Regulations of the Medical Staff and relevant hospital policies.

a. Aggregate Data Collection

Aggregate data reports and information that are included in OPPE consist of:

1) Admission activity
2) Length of Stay data
3) Mortality Data
4) Blood Use
5) Readmissions
6) Procedures and tests
7) Use of ancillary services and prsonnel
6) Risk related occurrences
7) Quality indicator related occurrences (Service Committee specific)
8) Outcomes as a result of the above occurrences
9) Medical Records suspensions
10) Behavior related events

b. The data collected will be compiled and documented in each member's/ practitioner's credentials file and used in the assessment and evaluation process for determining competency.

4. Information Produced by Data

The information resulting from the ongoing data accumulation will be forwarded to the appropriate Service Committee(s) for review and analysis. If the data is determined by the Service Committee Chair to be favorable, no further action will be necessary. If a determination is made by the Service Committee Chair that he data is unfavorable, it will be forwarded to the Service Committee for further review. Members will be asked to determine:

a. if the practitioner is performing well or within the desired expectations and that no further action is warranted;

b. if any issues exist that require a focused evaluation, e.g., referral for FPPE;

c. if there is evidence to suggest a recommendation to the Medical Executive Committee that one or more privileges/procedures be suspended, revised, or revoked;

5. OPPE Review

a. Rule and Rate Based Indicators

1) Rule and rate based indicators are determined by each Service Committee and approved by the Medical Executive Committee.

2) Predetermined thresholds for each indicator are identified as appropriate.

3) When a threshold is exceeded by a member, the Service Committee Chair determines whether additional review is required. If the threshold pertains to the Service Committee Chair, the Committee Vice Chair will make the determination.

b. Individual Case Reviews

Cases for individual case review will be based on significant clinical events described in the CI Program Plan Integration, Section A, Risk Management, a copy of which is attached to this policy.

6. OPPE Review Process

The process by which the review process for OPPE is conducted is set forth in the Continuous Improvement Program Integration, Section C, Physician Peer Review. A copy of the Plan is attached to these minutes.

B. Focused Professional Practice Evaluation (FPPE)

1. Responsibility

It is the responsibility of the Chairman of each Medical Staff Service Committee to coordinate the Focused Professional Practice Evaluation (FPPE) review. FPPE is not considered a formal Medical Staff investigation, and is not subject to regulations afforded in the investigation process.

a. This responsibility may be delegated to another member if, in the opinion of the Chairman, the member is equally or more qualified to coordinate the FPPE.

2. Indications for FPPE

a. Any single egregious case or sentinel event as judged by the relevant Service Committee Chairman or Service Committee as a whole, the Medical Executive Committee or the President of the Medical Staff may be referred to the appropriate Service Committee for consideration of a FPPE.

b. When indicator thresholds are exceeded within the agreed upon time:

1) The number of cases rated "Negative" exceeds the threshold approved by the Service Committee.

2) A rate or rule based indicator exceeds a predetermined threshold defined by the appropriate Service Committee.

c. When, in the opinion of the Service Committee a summary of trend cases of an individual member suggests the need for further review.

These indications do not result in an automatic FPPE. The Service Committee Chair will determine if a referral to the Service Committee is warranted based on individual circumstances.

3. FPPE Process

The FPPE process will essentially parallel the OPPE process, including:

a. Any FPPE (with the exception of routine proctoring) will be performed by the appropriate Service Committee.

b. Review is not restricted to individual cases, rates and rules, but may extend to all areas of practice, as determined by the Service Committee.

c. The MEC will receive regular summaries of such focused reviews, including major findings, conclusions, recommendations and required actions, at least annually.

C. Disruptive Behavior

1. Definition

Disruptive behavior is considered by the Medical Staff to be a quality of care issue. It is defined as behavior that diminishes morale, communication, teamwork and other elements necessary for the provision of optimal care. Disruptive behavior includes, but is not limited to:

- Conduct that interferes with the provision of quality patient care;
- Conduct that constitutes sexual harassment;
- Conduct that creates a "hostile work environment" for hospital employees or other medical staff members.
- Making or threatening reprisals for reporting disruptive behavior;
- Shouting or using vulgar, profane or abusive language;
- Abusive behavior toward patients or staff;
- Physical assaults;
- Intimidating behavior; and/or
- Refusal to cooperate with other Medical Staff members or hospital staff;
- Conduct that adversely affects the community's confidence in the hospital's ability to provide quality patient care;
- Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, impugning the quality of care in the hospital or attacking specific individuals;

2. Disruptive Behavior Process

a. Reports of disruptive behavior of Medical Staff members and practitioners who have been granted Allied Health Professional status shall be handled in a manner that essentially parallels the OPPE process.

b. The Service Committee will be responsible for tracking these episodes and documenting that each incident is assessed and resolved.

c. The Service Committee may elect to track the physician's behavior for a reasonable period of time or may elect to make a referral to the Medical Staff Well-Being Committee.

d. If the alleged misbehavior is determined by the President of the Medical Staff to be egregious and threatening to the safety of patients, families and/or other staff members, immediate action may be taken including:

1) Summary suspension of privileges

2) Mandatory referral to the Medical Staff Well Being Committee.

3) Such other action as may be deemed appropriate.

D. External Professional Practice Evaluation

External practice evaluation may take place under the following circumstances when deemed appropriate by the Service Committee Chair, the Medical Executive Committee or the President of the Medical Staff:

1. When dealing with ambiguous, vague or conflicting recommendations from internal reviewers and the conclusions from the review will directly affect the practitioner's privileges.

2. When no one of the Medical Staff has adequate expertise in the specialty or specific issues under review.

3. When the only practitioners on the Medical Staff with the expertise required to conduct the review are determined to have a conflict of interest regarding the practitioner under review.

4. When the Medical Staff needs an expert witness for a fair hearing, to evaluate a credentials file, or for assistance in developing a benchmark for quality monitoring.

5. The President of the Medical Staff will inform the Medical Executive Committee when there is a request for an external professional practice evaluation. Input from the relevant Service Committee and/or Service Committee Chair, as well as the practitioner being reviewed, shall be solicited and considered prior to engaging external evaluation.

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Attachment: CI Program Plan Integration

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: April 20, 2009

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

FROM: Deborah E. Stebbins, CEO

SUBJECT: Recommendation for Approval of SEIU, Collective Bargaining Agreement

Hospital Management is hereby recommending to the City of Alameda Health Care District, Board of Directors that it accepts and approves renewal of the Memorandum of Understanding between the District and the Service Employees International Union (SEIU).

The District and SEIU have been operating, by mutual agreement, under the existing Memorandum of Understanding that had a termination date of April 30, 2008. District representatives and the SEIU bargaining team began active negotiations in November 2008. Negotiations were delayed in January and February as the result of significant organizational changes between national SEIU and the local chapter United Healthcare Workers West. Fortunately, this disruption was abbreviated and we were able to resume negotiation with SEIU in March 2009.

Once meetings resumed, negotiations were productive and progressively moved forward. On April 7th the District and SEIU were able to reach a Tentative Agreement on a new contract. This new contract was ratified by the members of SEIU on April 17th.

A summary of the key provisions and changes in the new agreement are as follows:

- The term of the agreement is four years May 1, 2008 – April 30, 2012.

- Modifications to the employee Health Plan beginning in June 2009 including:
  - Employee Contributions for all coverage levels except employees only.
  - A $500 increase in the annual maximum out-of-pocket on coinsurance.
  - Addition of several preventative health tests and screenings when performed at Alameda Hospital.
  - Adding a Flexible Spending Account plan option for employees.
  - Annual cap on hospital contribution to the Cooks Kaiser premiums (allows for a 5% annual increase cap).

- Modest increases in the amount of pension contributions and shift differential pay in Years 2, 3 & 4 (no retro).

- Language modifications to several sections of the agreement that provide for improved operational efficiency and verbiage revisions that provide for better clarification of existing contract language.

- Greater Flexibility for employees with regards to use of Bereavement Leave.

- Increase in annual Wages as follows:

    - Year 1 3% (retro year)
    - Year 2 2.5% / 2.5%
    - Year 3 2.5% / 2.5%
    - Year 4 2.5% / 2.5%

Hospital Management is pleased with this new agreement and appreciates SEIU's willingness to work collaboratively with the District to be able to reach an agreement that satisfactorily achieved both party's objectives in what we feel is a win-win agreement.

Management is available to answer any specific questions regarding the new Memorandum of Understanding.

Alameda Hospital

Swine Influenza Update

April 28, 2009

Alameda Hospital is partnering with the Alameda County Public Health Department to address the evolving swine flu virus. We are also receiving regular updates and guidance from the Centers for Disease Control and Prevention (CDC) in order to remain current with this evolving situation.

No Alameda County cases of swine flu have been identified as of yet. This is subject to change; please check for updates. Updates will be provided on Alameda Hospital's web site:

www.alamedahospital.org

There are every day actions that can help prevent the spread of germs that cause respiratory disease like influenza.

- Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
- Wash your hands often with soap and water, especially after you cough or sneeze. Alcohol-based hand cleaners are also effective.
- Avoid touching your eyes, nose or mouth. Germs spread this way.
- Try to avoid close contact with sick people.
- Do not go to work or school if you are sick. CDC recommends that you limit contact with others to keep from infecting them.

Links:
Alameda County Public Health Department
www.acphd.org

Center for Disease Control and Prevention
www.cdc.gov/swineflu

Swine Influenza Information

Provided by the Alameda County Public Health Department

What is Swine Flu?

- Swine Influenza (swine flu) is a respiratory disease of pigs caused by type A influenza viruses. People do not normally get swine flu, but human infections can and do happen. Swine flu viruses have been reported to spread from person-to-person, but in the past, this transmission was limited and not sustained beyond three people.

- Influenza is always serious—each year, in the United States, seasonal influenza results, on average, in an estimated 36,000 dying from flu-related causes.

- This swine outbreak poses the potential to be a least as serious as seasonal flu if not more so.

- Because this is a new virus, most people will not have immunity to it and so illness may be more severe and widespread as a result.

- The virus is transmitted mainly from person to person through coughing or sneezing of people with influenza. Sometimes people may become infected by touching something with flu viruses on it and then touching their mouth or nose. There is no risk of infection from this virus from consumption of pork and pork products.

www.acphd.org

Alameda Hospital Foundation

2009 Action Plan

Annual Giving: $45,000

- Direct Mail Appeal to Discharged Patients
  Letter from Medical Staff Pres. – approximately 5,000 per year.
- Direct Mail Appeal to Non-donor data base
  Letter from President to approximately 1000 target mailing in February and October.
- Direct Mail to Partners in Health for renewal
  Letter from Dev. Chair sent at beginning of each month.
- Direct Mail to Guardian Angels for renewal
  Letter from Dev. Chair sent at beginning of each month.
- Employee Payroll Deduction program
  Foundation table at benefits fair and staff presentation during new employee orientation.
  Employee appreciation breakfast. Personal solicitation of new managers.

Events: $110,000

- Spring Tea and Fashion Show – May 16
- Fall Gala – September 12

Major Gifts: $30,000

- Develop case for support of ventilator system – February
- Identify and solicit lead/matching gift of $15,000 – February
- Identify and solicit 9 prospect at $5,000 each – February – May

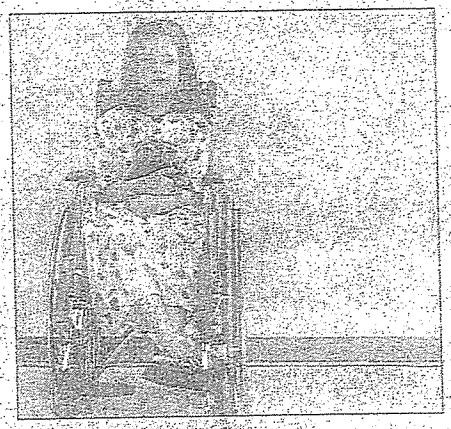
Planned Gifts: $175,000

- Direct Mail newsletter with report from President to donor data base – approximately 800 sent out in March, July, November.
- Bi-monthly e-newsletter with Foundation heading – sent to 113 email addresses.
- Weekly e-newsletter and personal visits with professional advisors
- Maintain planned giving web site – which gets 5,500 looks a month

Stewardship:

- Woman of Distinction presented at Tea – recognition from Congressional Representative
- Creedon Award presented at Gala – plaque place in Hospital
- Wall of Honor listings – 26 names added in 2008
- Birthday and Holiday cards to Board and key donors
- Acknowledgement letters to every donor

SAVE SAN LEANDRO HOSPITAL



Where Will We Go?

What Will We Do?

Sutter Health Corporation is trying to close San Leandro Hospital — depriving our community of a vital resource that has served our community for almost 50 years. 20,000 patients use the emergency room annually, and many thousands more use the acute-care services offered. Despite their healthy profits, Sutter Corp hopes to dump these patients into the public health system, or drive them to Eden Campus in Castro Valley.

Alameda County can't let that happen. As Sutter Corp themselves say: "San Leandro Hospital has a long-standing commitment to the central Alameda County community." Sutter's plan is to close San Leandro Hospital on June 30, and to get approval from the Alameda County Boerd of Supervisors for a rebuild of Eden Medical Center in Castro Valley. **Sutter needs to know: Alameda County Supervisors will NEVER abet their efforts to close San Leandro Hospital!**

Here's What You Can Do

1. **Call the Alameda County Board of Supervisors and tell them to SAVE SAN LEANDRO HOSPITAL!**

   Alice Lai-Bitker, President of Board of Supervisors 510-272-6693;
   Scott Haggerty 510-272-6691; Gail Steele 510-272-6692;
   Nate Miley 510-272-6694; Keith Carson 510-272-6695

2. **Call George Bischelaney, the CEO of San Leandro Hospital, and Eden, and tell him that the community of San Leandro will not allow him to close their hospital! 510-727-2703**

Any questions? Call Mike Brannah at 510-273-2268 or visit www.SaveSanLeandroHospital.com

InsideBayArea.com

Alameda County, Sutter Health in talks about San Leandro Hospital

One proposal: Link San Leandro with Highland

By Karen Holzmeister
The Daily Review

Posted: 04/28/2009 05:23:09 PM PDT

Updated: 04/28/2009 07:21:29 PM PDT

SAN LEANDRO — Could San Leandro Hospital, with its many vacant patient beds and bustling emergency room, become Alameda County's next public hospital?

County officials are in private and ongoing talks with Sutter Health, which operates San Leandro Hospital, to use the centrally located medical complex as a backup to Oakland's Highland Hospital.

Half of the 27,000 patients who come yearly to San Leandro Hospital's ER are Oakland residents, county Health Care Services Agency Director Dave Kears said two weeks ago.

George Bischalaney, chief executive officer of Eden Medical Center in Castro Valley, a Sutter Health affiliate, said the county has made "an expression of interest in the San Leandro campus, if decisions made in the future result in its being available."

Discussions "are occurring" between the county and Sutter, acknowledged Ruben Briones, deputy chief of staff to county Supervisor Alice Lai-Bitker, whose district includes San Leandro.

Neither man would disclose whether the county is interested in buying or leasing San Leandro Hospital, or contracting with Sutter for services.

Sutter has the first option to buy the hospital at East 14th Street and 138th Avenue, which, as far as the general community knows, is in limbo.

Sutter Health and Eden Medical Center operate San Leandro Hospital through June 2010 under a contract with the Eden Township Healthcare District, which owns San Leandro Hospital. San Leandro residents and local medical workers, who fear Sutter will convert San Leandro Hospital for other uses if it buys the facility, are lobbying local and county-elected representatives to keep the 122-bed hospital and its ER open.

The county now is reviewing plans for a new Eden Medical Center. The residents and medical workers want approval of that complex linked to a requirement that Sutter continue to subsidize operating costs at San Leandro Hospital, where Kears said only 40 percent of the beds are filled, on average. Income from insurance and patient payments also don't cover the bills.

"What will happen if there is a disaster?" San Leandro resident Gloria Pineo asked the San Leandro City Council on Monday. "What if we cannot get to Eden?"

About 50 health care workers and former San Leandro Hospital patients picketed the county administration building in Oakland on Tuesday, where supervisors postponed discussion of the Eden plan until May 12.

Most comments on keeping San Leandro Hospital open focus on Sutter as the operator.

The San Leandro council, with Councilman Bill Stephens abstaining, on Monday passed a carefully

worded statement that merely requested Sutter, the county and the health care district keep San Leandro Hospital and its ER open.

Staff writer Chris Metinko contributed to this story. Reach Karen Holzmeister at 510-293-2478.

IF YOU GO WHAT: Regional health care forum on changes in San Leandro Hospital's medical services WHEN: 6:30 p.m. today WHERE: San Leandro City Hall, 835 E. 14th St.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

American Recovery and Reinvestment Act of 2009

Following is a summary of the hospital- and health care-related provisions of the Conference Agreement.

Federal Medical Assistance Percentage (FMAP) [Section 5001]

- Spends a total of $86.5 billion nationwide, a 6.2% temporary increase to the base FMAP rate for all states beginning October 1, 2008, and ending December 31, 2010.
- Includes a bonus increase based on the state's increase in unemployment rate in addition to the base FMAP increase.
- Includes maintenance of effort on eligibility.
- ***California Impact: The 6.2% increase will bring $5.6 billion in new federal spending to California; the unemployment rate bonus is expected to bring another $5.23 to California for a total of $11.23 billion over 27 months.***

Disproportionate-Share Hospitals (DSH) [Section 5003]

- Increases states' FY 2009 annual DSH allotments by 2.5%.
- Increases states' FY 2010 by 2.5% above FY 2009 DSH allotment (with the adjustment).
- ***California Impact: Approximately $25 million per year.***

Medicaid and Medicare Regulations [Section 5003 and Section 4301]

- Extends moratoria on Medicaid regulations for targeted case management, provider taxes and school-based administration and transportation services through June 30, 2009.
- Adds moratorium on Medicaid regulation for hospital outpatient service payments through June 30, 2009.
- Includes a Sense of Congress that the Secretary of HHS should not promulgate regulations concerning intergovernmental transfers, graduate medical education and rehabilitative services
- Blocks a FY 2009 Medicare payment reduction to teaching hospitals related to capital payments for indirect medical education.
- ***California Impact: More than $23 million for California's teaching hospitals and hundreds of millions for California's safety-net providers.***

Coverage [Section 3001]

- Subsidizes COBRA premiums for workers with annual incomes below $125,000 (single) or $250,000 (couples) at 65% of the premium for 9 months.

Health Information Technology (HIT) [Sections 13101-13411 and 4102]

- Provides $19 billion funding for HIT — $17 billion for Medicare and Medicaid incentives, and $2 billion for HIT grants.
- Provides temporary bonus payments up to $11 million for individual hospitals that meaningfully use electronic health records (EHRs). Physicians are eligible for payments as well.
- Provides Medicare and Medicaid incentive payments for Critical Access Hospitals, federally qualified health centers, rural health clinics and children's hospitals.

- Phases in Medicare payment penalties beginning in FY 2015 for physicians and hospitals not using EHRs.
- Provides $2 billion in immediate funding for HIT infrastructure, training, dissemination of best practices, telemedicine, inclusion of HIT in clinical education and state grants to promote HIT.
- Expands current federal privacy protections for health information, such as requiring an individual be notified if there is an unauthorized disclosure or use of his/her health information and requiring a patient's permission to use his/her personal health information for marketing purposes.
- Provides an opportunity to opt out of fundraising. Any written fundraising communication made by a hospital must provide an opportunity for the recipient to opt out of receiving any further such communication. Once such an opt-out is elected, hospitals will not be able to send fundraising solicitations to that patient again. No signed authorization is required to contact patients, nor is a form required at admission; patients will have to sign and return a form included with a fundraising letter to stop any additional fundraising letters. The HHS Secretary must issue a rule to implement this provision, but there is no statutory date by which that rule must be issued and the effective date is one year from date of enactment of the bill. [Section 13406]
- Codifies the Office of the National Coordinator for Health Information Technology (ONCHIT) and establishes a process to develop national standards by 2010 for secure electronic exchange of health information.

Hospital Bond Financing [Section 1502]

- Expands incentives to purchase hospitals' tax-exempt bonds by allowing banks to deduct 80 percent of the cost of buying and holding hospital bonds up to $30 million per hospital.

Medicare Payments to Long–Term-Care Hospitals [Section 4302]

- Makes technical corrections to the Medicare, Medicaid and the SCHIP Extension Act of 2007 related to Medicare payments for long-term-care hospitals.

Broadband Technology [Section 6001]

- Includes $7.2 billion to increase broadband access and usage in unserved and underserved areas.

Workforce*

- Provides $500 million to support the National Health Service Corps, including training of primary-care physicians and nurses, and to repay loans.

Health and Wellness*

- Includes $10 billion to conduct biomedical research in areas such as cancer, Alzheimer's, heart disease and stem cells, and to improve NIH facilities.
- Includes $1.1 billion to the Agency for Healthcare Research and Quality and others to evaluate the relative effectiveness of different health care services and treatment options.
- Includes $1 billion for a new Prevention and Wellness Fund to fight preventable diseases and conditions with evidence-based strategies.

* Specific section numbers not available at press time.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED

FINANCIAL STATEMENTS

FOR THE

PERIOD ENDING

03/31/09

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

ALAMEDA HOSPITAL
City of Alameda Health Care District
March 31, 2009

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ALAMEDA HOSPITAL

March 31, 2009

The management of the Alameda Hospital (the Hospital) has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending March 31, 2009 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of March 31, 2009

- Total assets on the balance sheet decreased by $197,010 from the prior month as a result of an increase in net accounts receivable of $638,575 offset by a decrease in cash and cash equivalents of $678,886, other assets of $73,598 and net fixed assets of $97,744.

- Total cash and cash equivalents for March decreased by $678,886 which resulted in a decrease in our day's cash on hand from the prior month's 8.7 to 4.9 at March 31, 2009. This decrease was the result of the use of 1/12 of our annual parcel tax proceeds ($477,000) and a delay in receipt of the April Kaiser prepayment for contracted services. This slight delay was the result Kaiser's need to update their automatic transfer of funds request to reflect the increase in monthly payments from $760,000 to $800,000. The April prepayment was received on Thursday, April 2nd. Had this been received before the end of the month our days cash on hand would have increased slightly from the prior month to 9.3.

- Net patient accounts receivable increased in March by $638,575 compared to an increase of $309,525 in February. Days in outstanding receivables decreased to 51.2 as compared to 56.3 in February. This decrease in day's outstanding receivables at month end was the result of an increase ($51,000) in the average daily revenue for the three month period used to calculate this metric and collections of $4.8 million which is the second highest collection month dating back to July 2006.

- Total liabilities decreased by $270,410 compared to a decrease of $138,200 in the prior month. This decrease was the result of a decrease of $493,140 in other liabilities, $110,864 in accounts payable and other expenses and $48,082 in long term debt. This decrease was offset by an increase of $381,675 in payroll and benefit related accruals.

- Accounts payable at February 28th was $6,125,458, which represents a decrease of $110,864 from the prior month. As a result of this decrease from February days in accounts payable decreased to 83.

- Payroll and benefit related accruals increased by $381,675 from the prior month. This increase was primarily the result of an increase in accrued vacation of $95,162 and seventeen (17) days of accrued payroll amounting to $278,579 at March 31, 2009.

- Other liabilities decreased by $493,140 as a result of the amortization of one month's deferred revenue related to the 2008/2009 parcel tax revenues.

- Combined total revenue was greater than budget by $686,000 or 2.7%. However net patient revenue was unfavorable to budget by $54,000 or 1.0%. Inpatient revenue, excluding South Shore, was less than budgeted by 0.9% while outpatient revenue, excluding South Shore, was greater than budgeted by 5.9%. On an adjusted patient day basis total gross revenue, excluding South Shore, was $6,946 compared to a budgeted amount of $6,882.

- Total patient days were 2,770 and included 695 patient days from the South Shore facility as compared to the prior month's total patient days of 2,532 (554 South Shore days included) and the prior year's 2,024 total patient days. The average daily acute care census was 33.0 compared to a budget of 34.0 and an actual average daily census of 37.4 in the prior month; the average daily Sub-Acute census was 33.9 versus a budget of 34.2 and 33.3 in the prior month and the South Shore unit had an average daily census of 22.4 versus a budget of 23.0 and prior month census of 19.8, respectively.

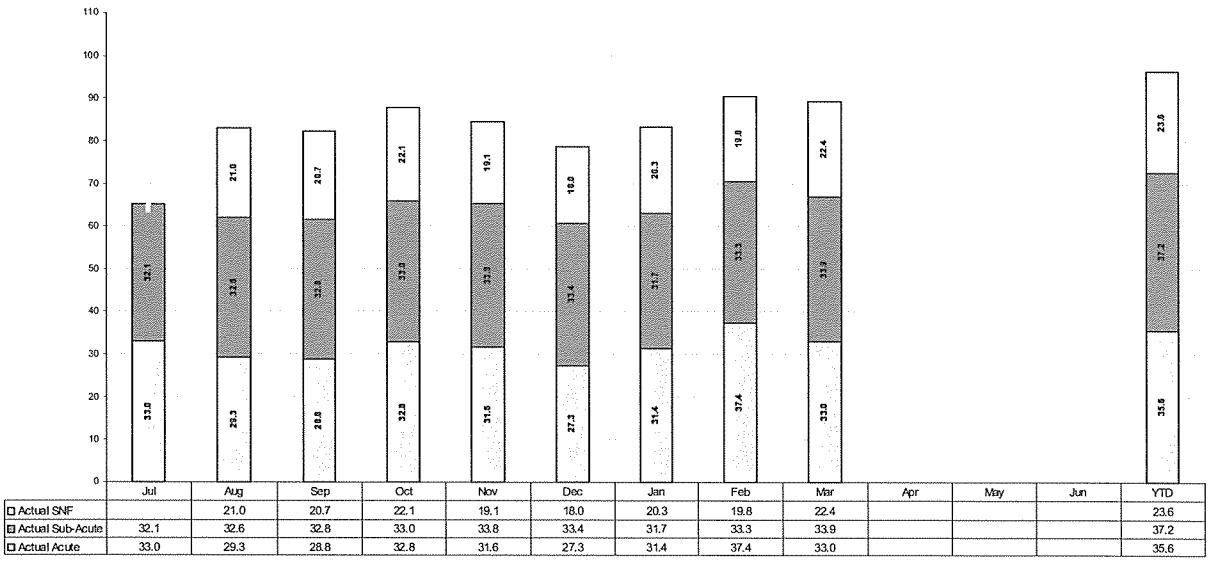
- ER visits were 1,507 or 1.1% less than the budgeted 1,523 visits but were down from the prior year's visits of 1,576.

- Total surgery cases were 10.96% greater than budget, with Kaiser surgical cases making up 359 or 69.4% of the total cases. Alameda physician surgical cases increased to 158 cases as compared to 133 cases in February.

- Combined excess revenues over expense (profit) for March was $62,000 versus a combined budgeted excess of revenues over expense of (profit) of $145,000. This brings the year-to-date excess of revenues over expenses (profit) to $192,000 or $115,000 better than budgeted.

Volumes

Overall actual daily census was 89.4 versus a budget of 91.2. The Acute care average daily census was 33.0 versus a budget of 34.0, Sub-Acute average daily census was 33.9 versus a budget of 34.2 and the South Shore unit had an average daily census of 22.4 versus a budget of 23.0.

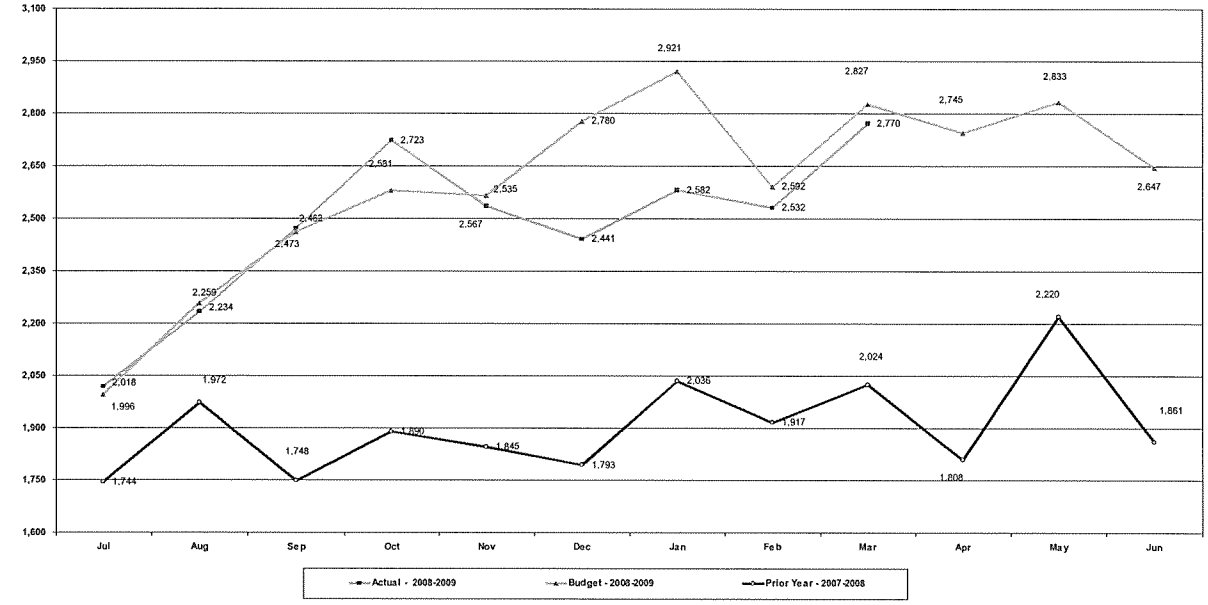


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Actual SNF		21.0	20.7	22.1	19.1	18.0	20.3	19.8	22.4				23.6
Actual Sub-Acute	32.1	32.6	32.8	33.0	33.8	33.4	31.7	33.3	33.9				37.2
Actual Acute	33.0	29.3	28.8	32.8	31.6	27.3	31.4	37.4	33.0				35.6

Actual	65.1	82.9	82.3	87.9	84.5	78.7	83.3	90.5	89.4				84.7
Budget	64.4	83.2	82.1	83.3	85.6	89.7	94.2	92.6	91.2				87.5

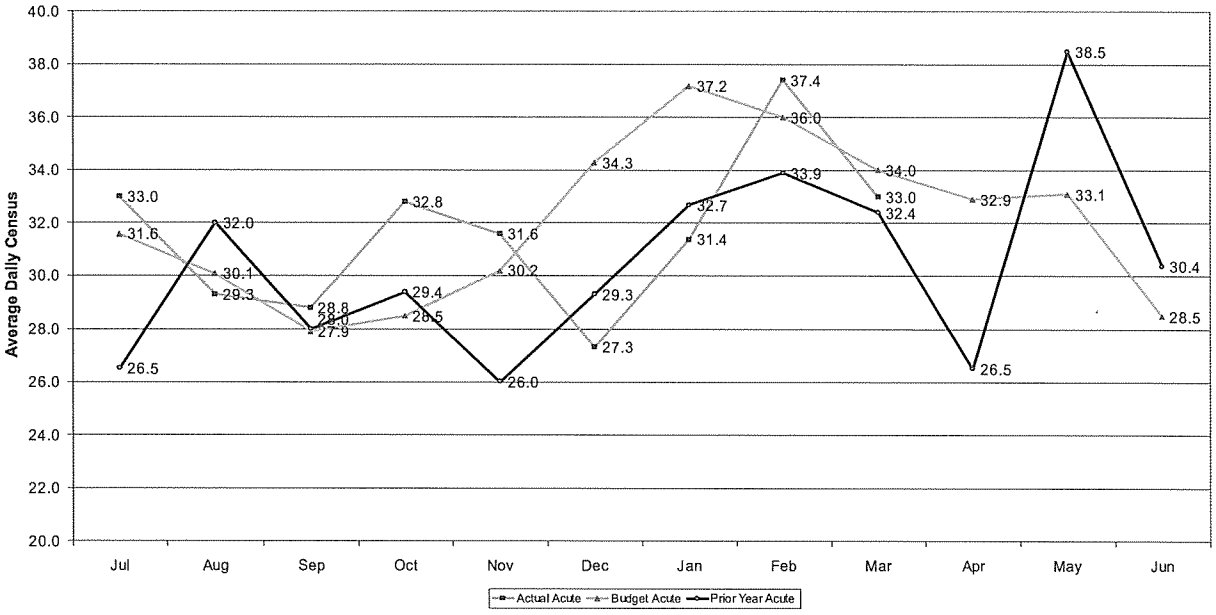
Total patient days in March were 2.0% less than budgeted and were 2.5% better than the prior year after removing the South Shore patient days from the current year total patient day count. The graph on the following page shows the total patient days by month for fiscal year 2009 including South Shore.

Total Patient Days



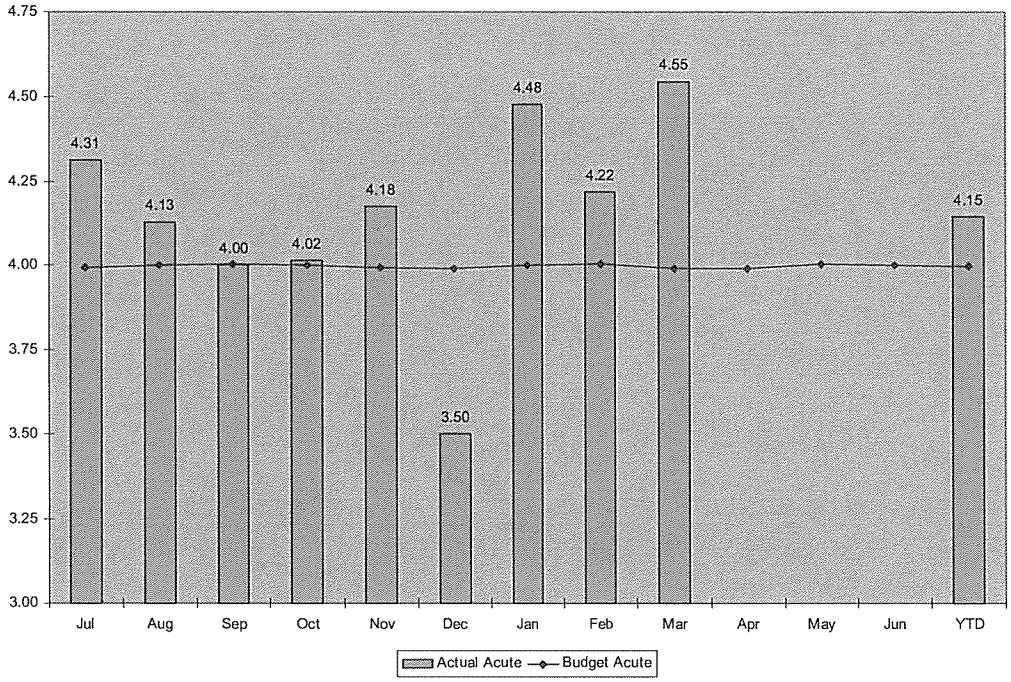
As we look at the various components of our volumes for the month of March we see that the acute care patient days were 2.9% (31 days) less than budgeted and 1.9% better than the prior year's average daily census.

Inpatient Acute Care Average Daily Census



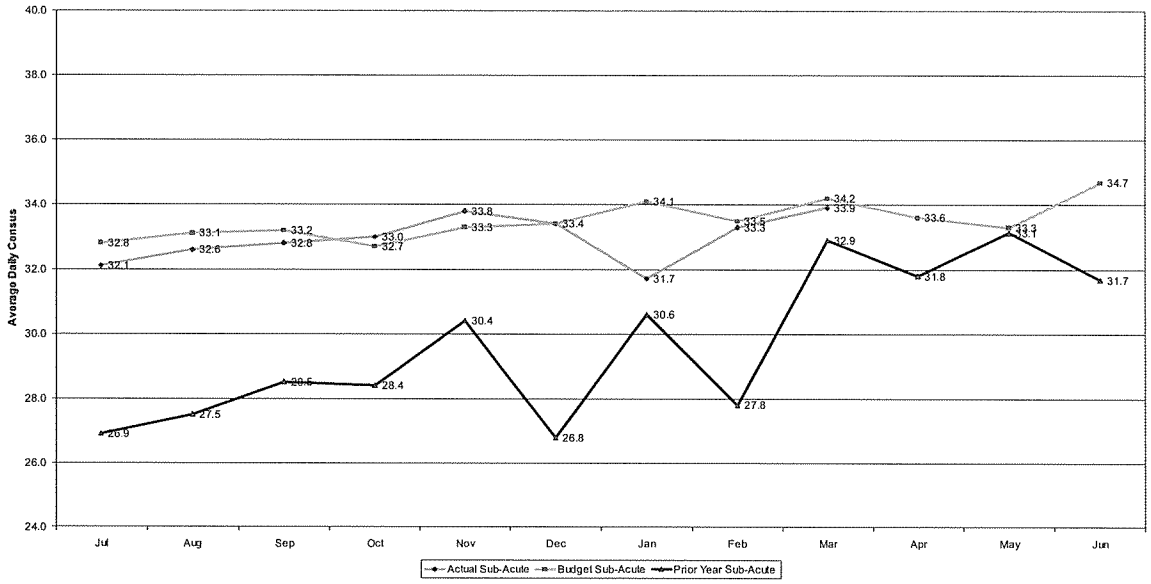
Our year to date average length of stay (ALOS) remains very close to budgeted levels at 4.15. However, the first quarter of calendar 2009 our ALOS has been influenced by twenty-three (23) acute care accounts that length of stays that exceeded fifteen (15) days. Had these accounts (eight in March, eight in February and three in January) been removed from the statistics for those months the ALOS would have approximated 4.28, 3.43 and 3.84, respectively, versus the ALOS for our acute care population shown below.

Average Length of Stay



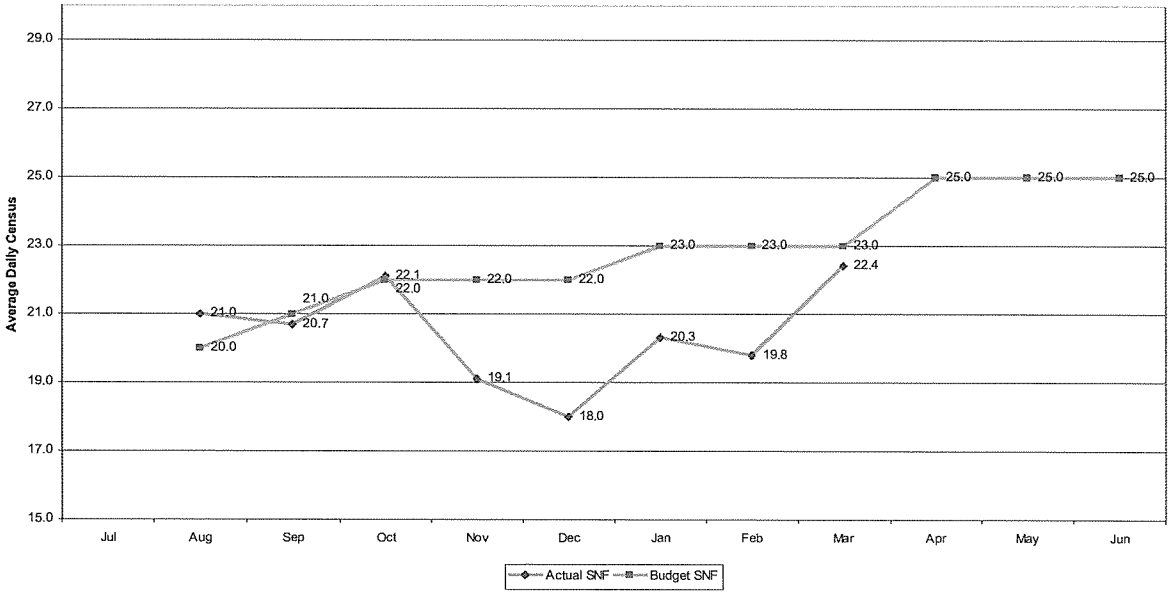
Sub-Acute patient days were only 0.8% below budget or 8 days and continue to exceed the prior year performance. The graph on the following page shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

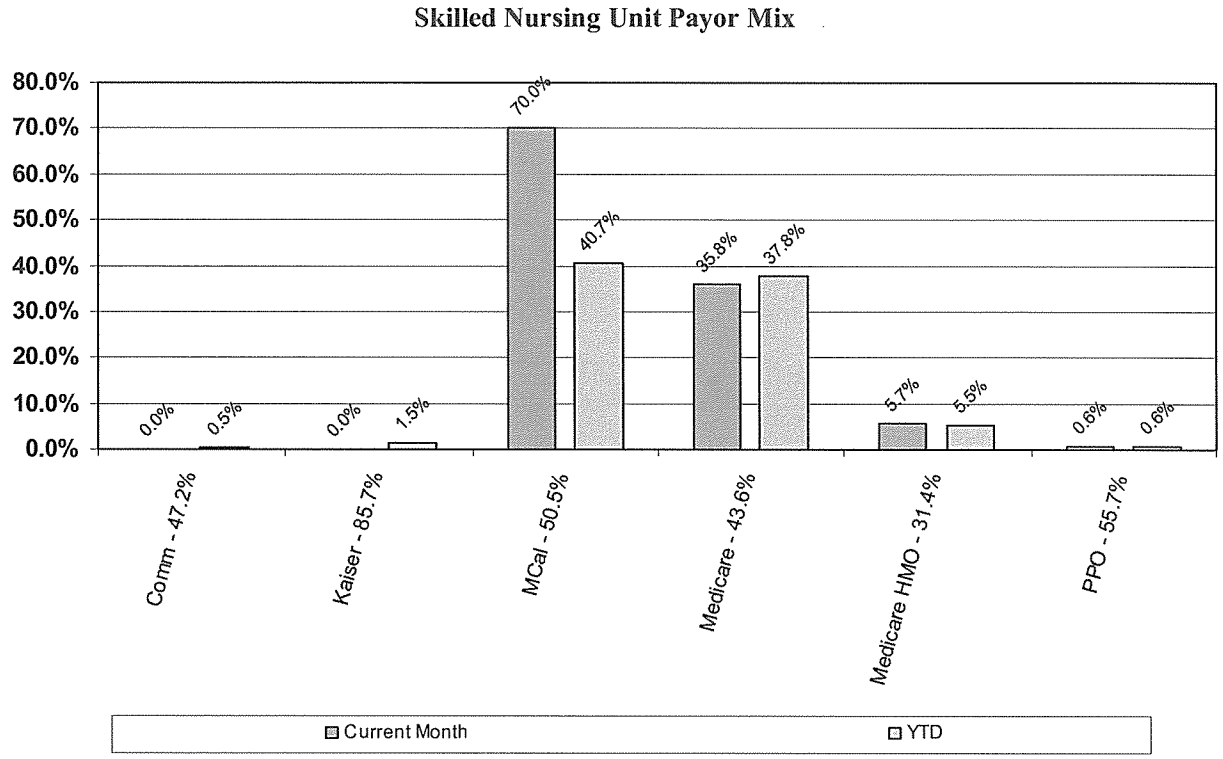
Sub-Acute Care Average Daily Census



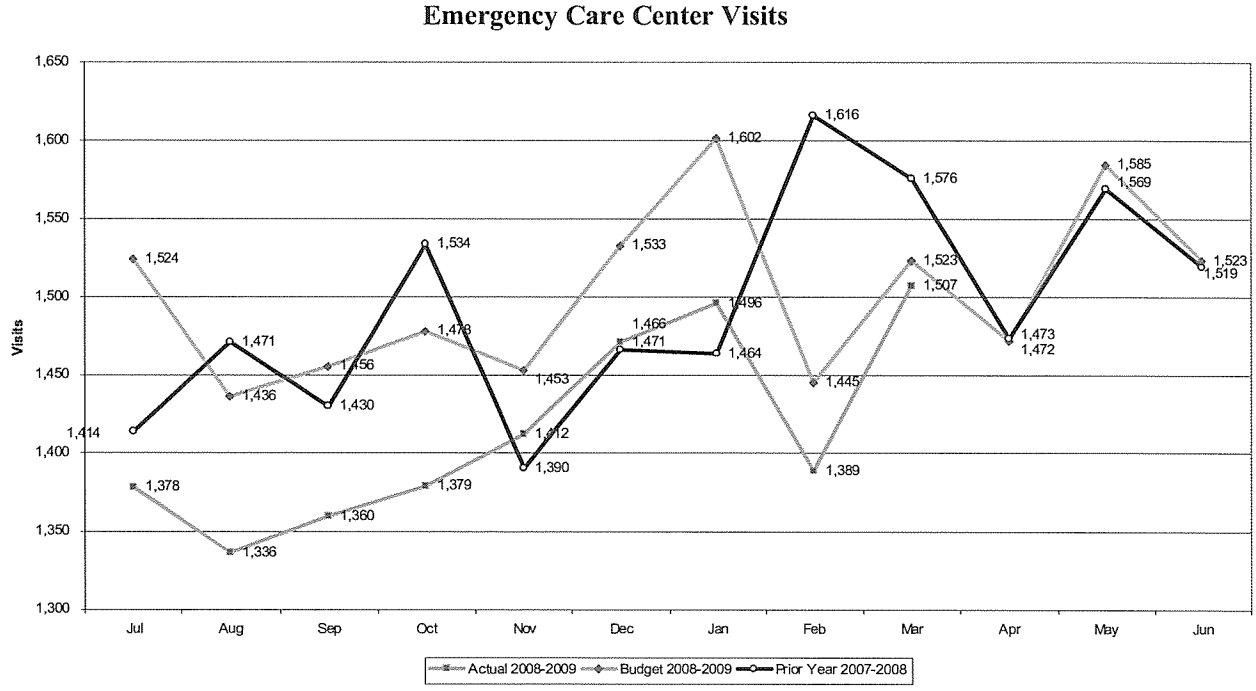
The Skilled Nursing Unit (South Shore) patient days were 2.5% less than budgeted for the month of March and are 7.9% less than budgeted for the first eight months (August 17th through March 31st) of operations. The following graphs show the Skilled Nursing Unit average daily census as compared to budget by month and the payor mix experienced during the current month and year-to-date.

Skilled Nursing Unit Average Daily Census



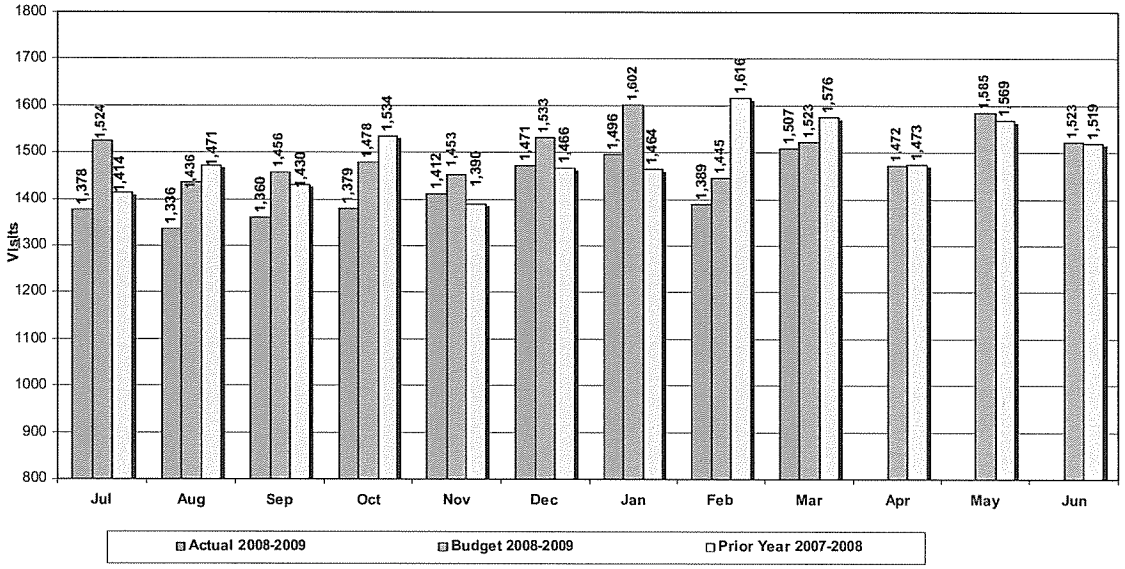


March ER visits were 1.1% less than budgeted but were only 69 less than the prior year's activity of 1,576.



Surgery cases were 517 versus the 466 budgeted and 435 in the prior year. In March, Alameda physician cases increased to 158 cases versus 133 in the prior month. Kaiser related cases in March increased to 359 as compared to the 335 cases performed in February. Despite this increase in the number of cases Kaiser Same Day Surgery revenue increased by $41,751 over the prior month. As a result of this months activity our reimbursement for Kaiser Outpatient cases in March decreased to 18.1% as compared to 18.3% of gross charges in February.

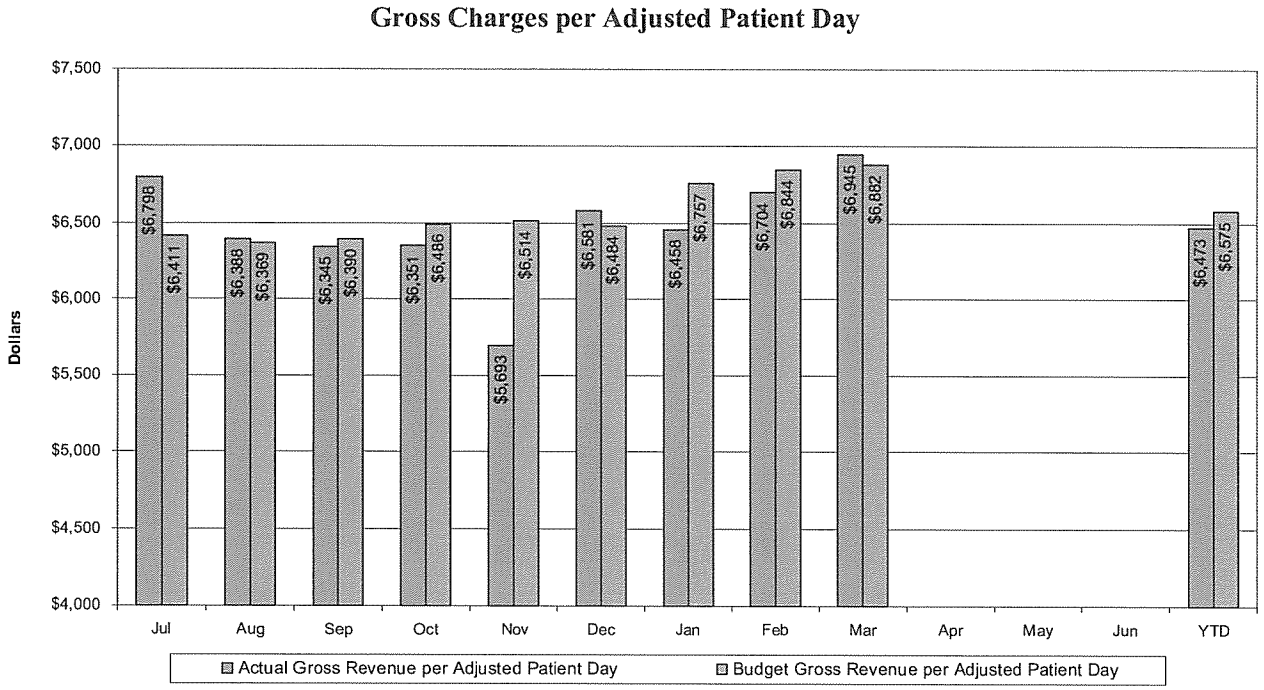
Surgical Cases



Income Statement – Hospital Only

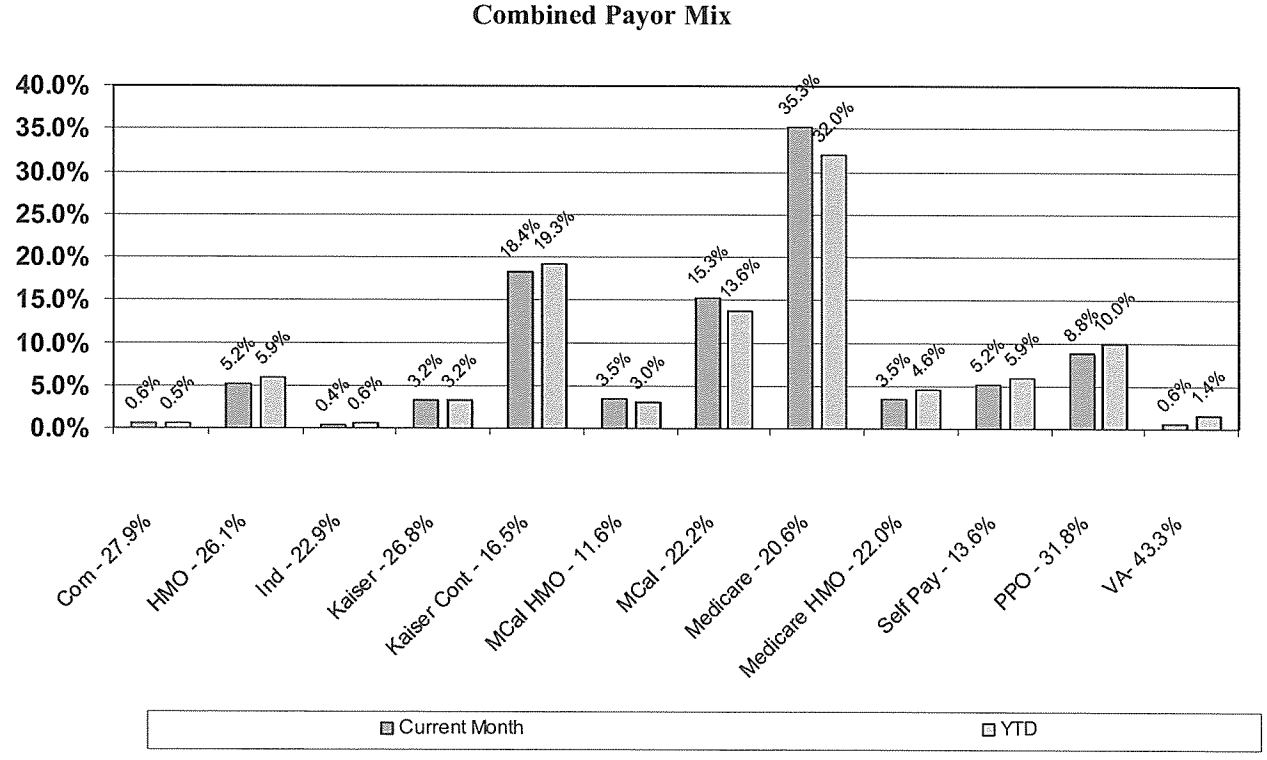
Gross Patient Charges

Gross patient charges in March were greater than budgeted by $496,000 and were comprised of an unfavorable variance in inpatient services of $135,000 and a favorable variance of $631,000 in outpatient services. On an adjusted patient day basis total patient revenue was $6,946 versus the budgeted $6,882 or a 0.9% favorable variance from budget (See graph on next page).



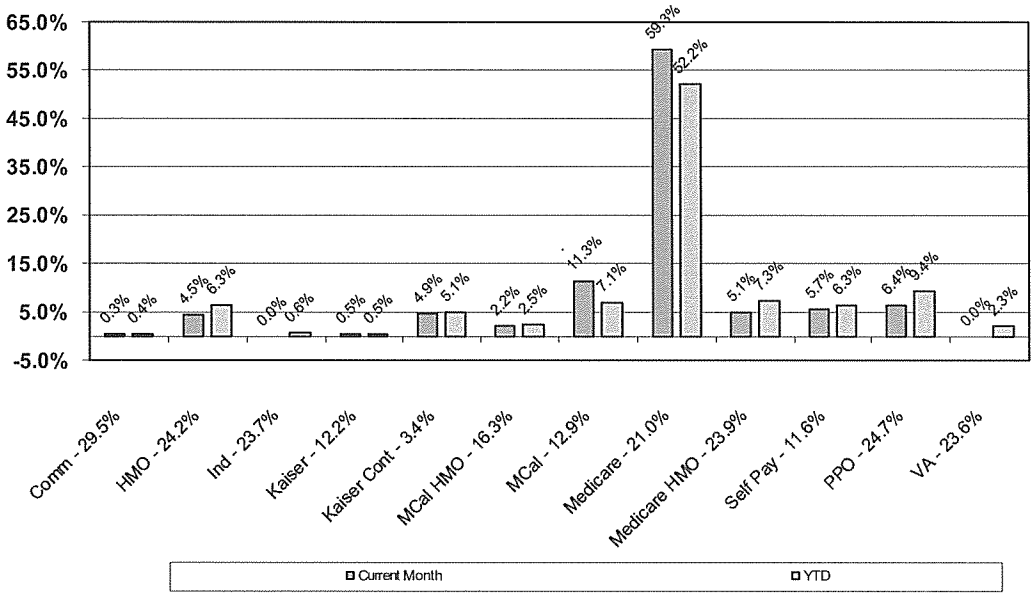
Payor Mix

Medicare total gross revenue in March made up 35.3% our total gross patient charges down from 37.6% in the prior month. Kaiser was again the second largest source of gross patient revenues at 21.6%. The graph on the following page shows the percentage of revenues generated by each of the major payors for the current month and year-to-date as well as the current months expected reimbursement for each.



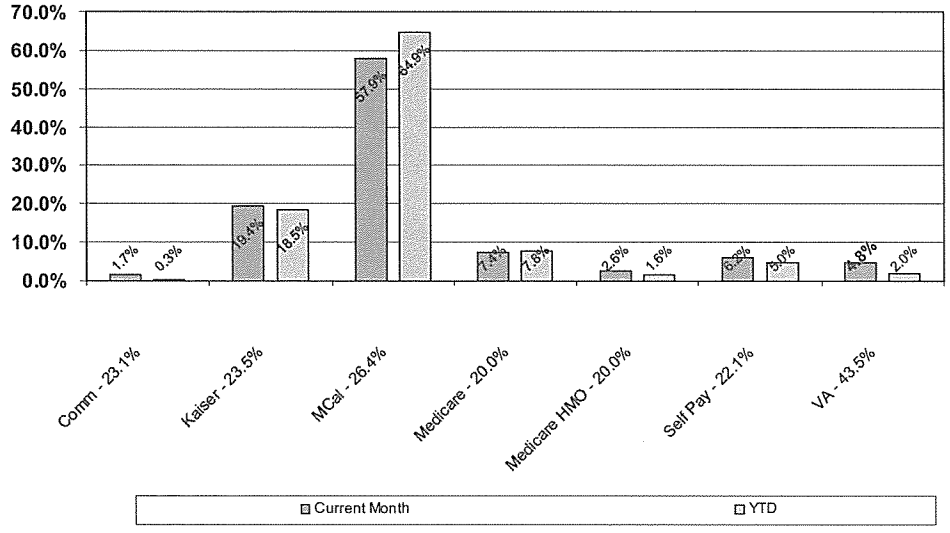
On the Hospital's inpatient acute care business, current month gross Medicare charges were 59.3% of our total inpatient acute care gross revenues bringing the year-to-date average to 52.2%. However, despite three (3) cases that hit the outlier threshold and an increase in the Medicare Case Mix Index (CMI) to 1.3577 from 1.3137 in February, our expected reimbursement for Medicare inpatient cases was estimated to be 21.0% which is 1.9% lower than February's estimate. This decline in the estimated Medicare reimbursement percentage was primarily driven by the outlier cases which had an estimated overall reimbursement percentage of 17.8% versus the other 120 Medicare cases that had an estimated reimbursement percentage of 22.1%. Of most significant note is a single account that was admitted December 3, 2008 and was discharged on March 14, 2009 which accumulated $876,000 in charges and has an estimated reimbursement of $175,550 or approximately 20.0%

Inpatient Acute Care Payor Mix



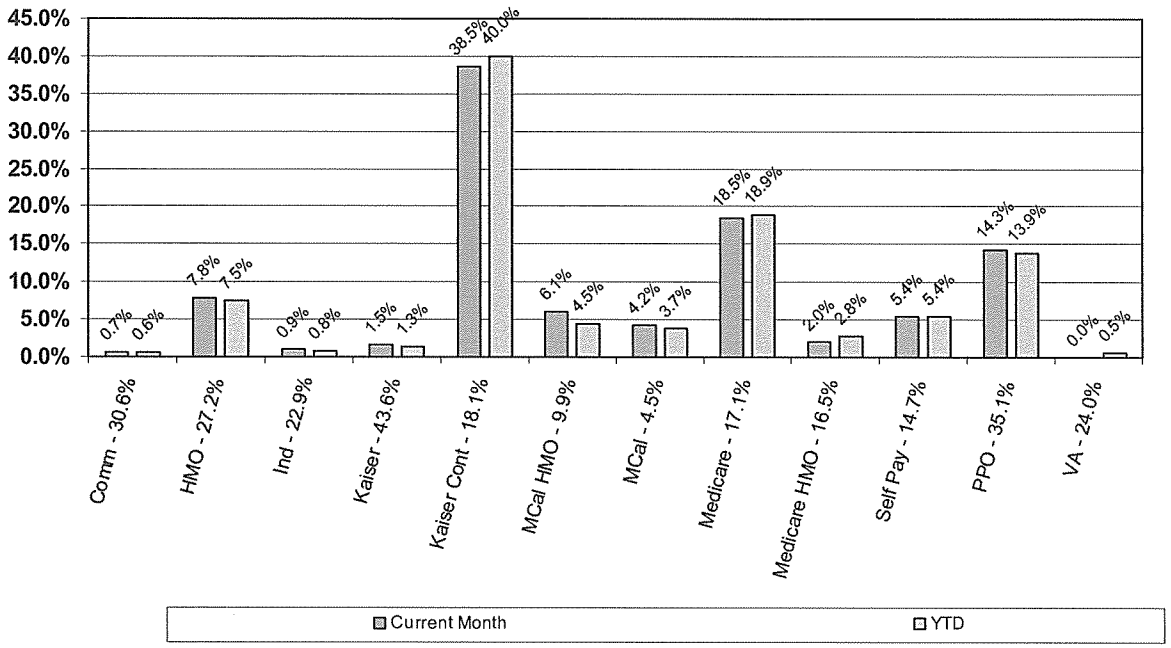
In March the Sub-Acute care program was again was dominated by Medi-Cal utilization of 57.9% based on gross revenue.

Inpatient Sub-Acute Care Payor Mix



Outpatient gross revenue payor mix for March was comprised of 40.0% Kaiser, 18.5% Medicare, 14.3% PPO and 7.8% HMO and is shown on the following graph.

Outpatient Services Payor Mix



Deductions from Revenue

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

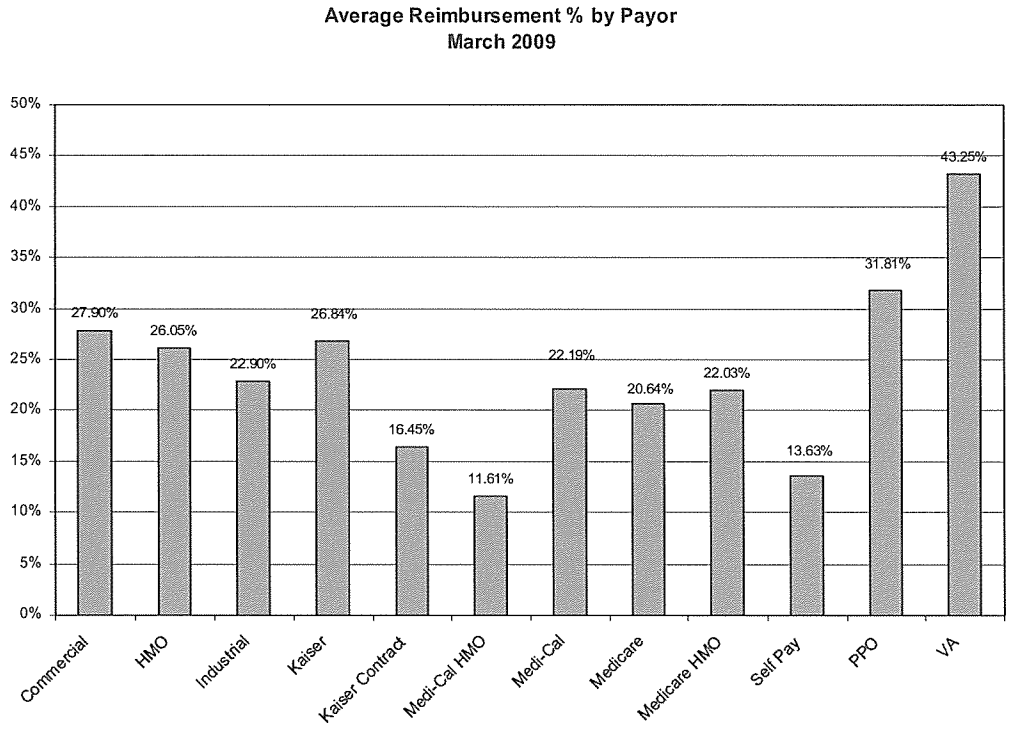
In the month of March contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 79.4% versus the budgeted 78.7%. Contractual reserves in the month of March include additional reserves attributable to recently enacted legislation, AB 1183, the Health Budget Trailer Bill, which requires a reduction to the interim payment for inpatient services provided by hospitals that do not participate in the Selective Provider Contracting Program (commonly known as non-contract hospitals), unless the hospital meets exemption criteria contained in the bill. Effective October 1, 2008, AB 1183 requires the Department of Health Care Services (DHCS) to limit the amount paid to non-contract hospitals for inpatient services to the lesser of the interim per diem rate (28% of gross Medi-Cal patient charges) reduced by 10%, or the applicable regional average per diem contract rate for tertiary and non-tertiary hospitals ($1,682 per Medi-Cal patient day) reduced by 5%. This resulted in additional contractual reserves of approximately $155,000.

In March there were again no DRG "take backs" associated with the Recovery Audit Contractor (RAC) project. The new National Recovery Audit program is to be phased in state-by-state starting in the fall of 2008. A new RAC contractor has been selected by CMS for California, HealthDataInsights, Inc., with California RAC audits slated to resume some time in the spring of 2009. It is anticipated that we will begin to see requests for information under this program in the upcoming months and are working on developing appropriate mechanisms to ensure compliance with our rights to ensure timely responses to these requests.

Net Patient Service Revenue

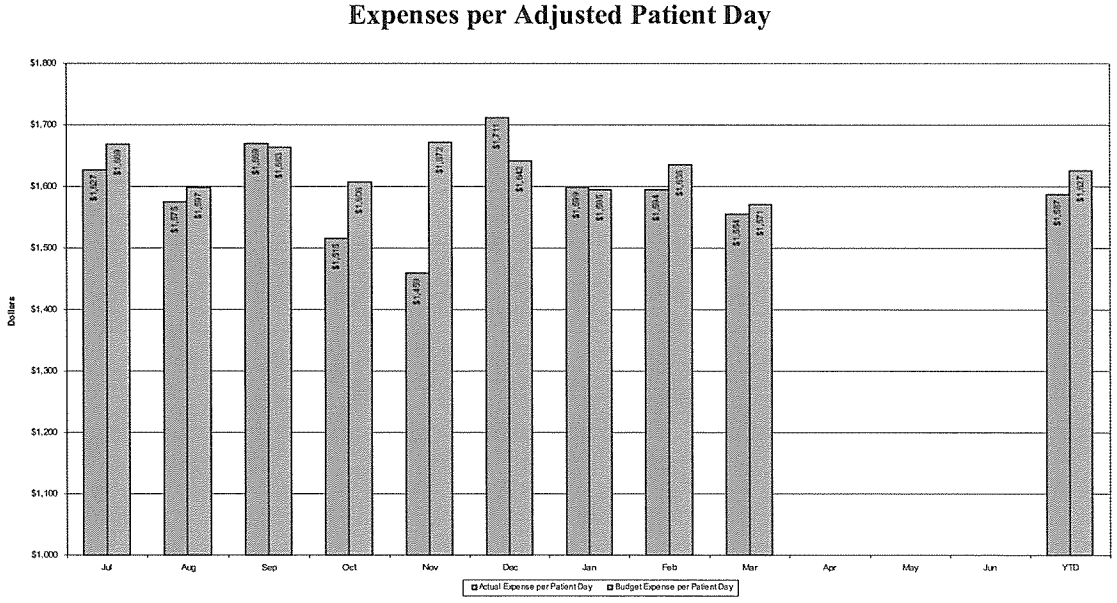
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is to receive for the services

provided. The graph below shows the level of estimated reimbursement that the Hospital has estimated for the current month of fiscal year 2009 by major payor category.



Total Operating Expenses

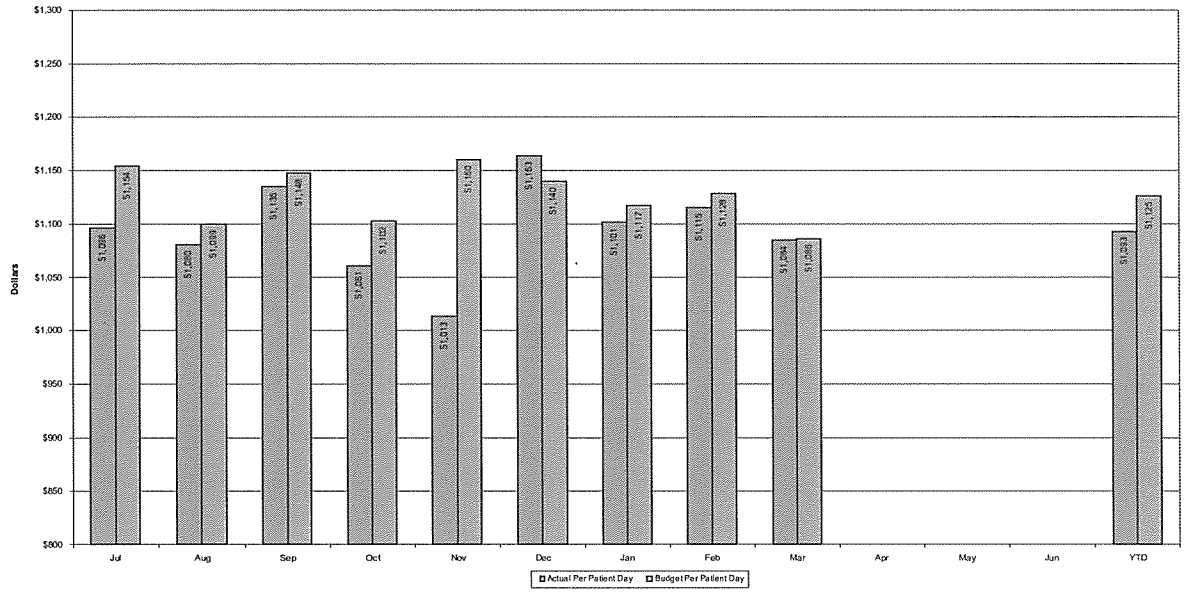
Total operating expenses were greater than the fixed budget by $7,000 or 0.1%. On an adjusted patient day basis, our cost per adjusted patient day decreased to $1,554 for the month which was only $14 per adjusted patient day higher than budgeted. On a year to date basis our cost per adjusted patient day is 2.4% better than budgeted. The graph below shows the hospital operating expenses on an adjusted patient day basis for the 2009 fiscal year by month and is followed by explanations of the significant areas of variance.



Salary and Registry Expenses

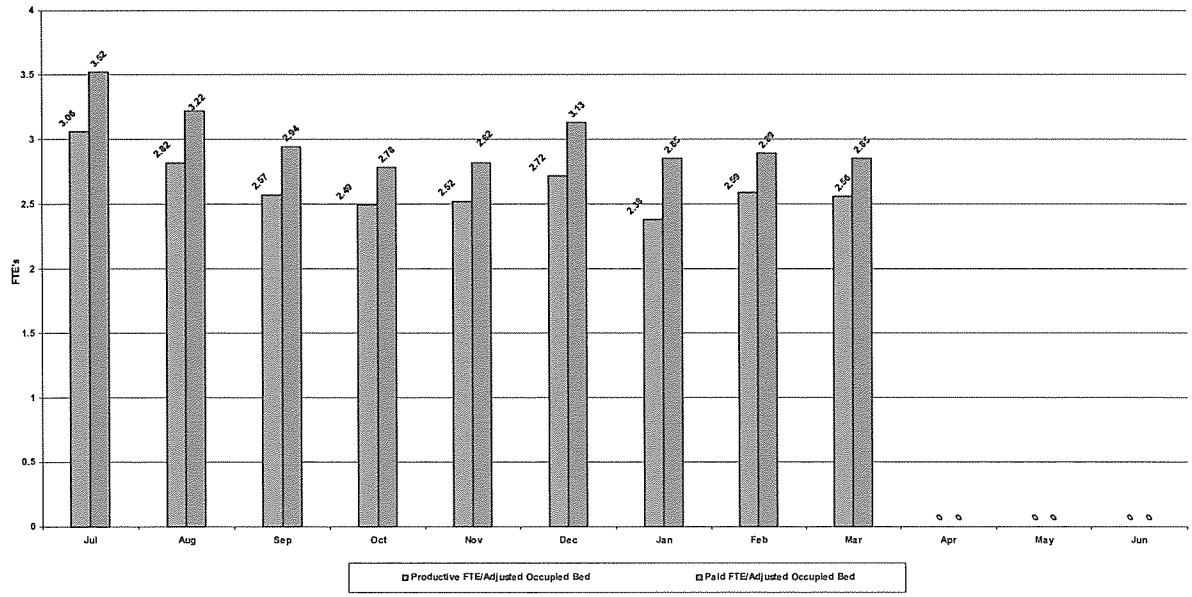
Salary and registry costs combined were unfavorable to the fixed budget by $76,000 and $12 per adjusted patient day unfavorable to budget in March. Included in March is $46,000 of February invoices that were not accrued in February. In addition to nursing units ($122,644), registry utilization in surgery ($10,548) and pharmacy ($30,382) cost centers had unfavorable variances from budget. Despite this unfavorable variance in March for the nine months ending March 31, 2009, the hospital is $55,000 favorable to the fixed budget and $15 per adjusted patient day favorable to budgeted expectations as seen on the graph of the next page.

Salary, Registry and Benefit Cost per APD



Combined productive FTE's per adjusted occupied bed was 2.56 in March versus the budgeted 2.41. The graph below shows the combined (Hospital including South Shore) productive and paid FTE's per adjusted occupied bed for FY 2009.

FTE's per Adjusted Occupied Bed



Benefits

For the month of March benefit costs were favorable to budget by $41,000 as a result of the following:

- Reduced the year-to-date accruals that were budget based, for health insurance as actual claims costs have consistently averaged $123,000 less than budgeted during FY 2009.
- In addition there was a favorable adjustment to our health insurance IBNR ($16,900) as a result of the latest lag analysis which decreased to $709,843.
- Offsetting the health insurance favorable adjustments was $64,930 of workers compensation expense related to the recent analysis of our closed self insured plans claim experience related to fiscal years 2007 and 2008.

Supplies

Supply costs were $21,000 favorable to budget as a result of lower than budgeted medical supply costs of $42,000 offset by the purchase of replacement computers for various departments in the hospital totaling $12,000.

Insurance

In March insurance costs exceeded budget by $10,000 as a result of the payment of an extension of a tail insurance policy for medical malpractice coverage for December 15, 1999 through December 15, 2001.

ALAMEDA HOSPITAL
Balance Sheet
March 31, 2009

	March 31, 2009	February 28, 2009	Audited June 30, 2008
Assets			
Current assets:			
Cash and cash equivalents	$ 885,033	$ 1,563,919	$ 4,520,156
Net Accounts Receivable	10,786,378	10,147,803	7,944,522
Net Accounts Receivable %	25.88%	23.55%	20.17%
Inventories	1,015,565	1,021,287	1,048,503
Est.Third-party payer settlement receivable	528,127	518,042	245,115
Other assets	3,793,838	3,867,436	7,270,116
Total Current Assets	17,008,941	17,118,487	21,028,412
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate	566,649	556,369	602,817
Total fixed assets, net of accumulated depreciation	6,916,361	7,014,105	7,450,244
Total Assets	$ 24,491,951	$ 24,688,961	$ 29,081,473
Liabilities and Net Assets			
Current Liabilities:			
Current portion of long term debt	$ 465,301	$ 477,046	$ 2,744,870
Accounts payable and accrued expenses	6,125,458	6,236,322	7,057,073
Payroll and benefit related accruals	4,724,751	4,343,076	3,133,574
Est.Third-party payer settlement payable	502,229	502,229	441,409
Other liabilities	3,010,557	3,503,697	8,190,530
Total Current Liabilities	14,828,297	15,062,370	21,567,456
Long-Term Liabilities:			
Debt borrowings net of current maturities	1,867,952	1,904,289	80,992
Total Long-Term Liabilities	1,867,952	1,904,289	80,992
Total Liabilities	16,696,249	16,966,659	21,648,448
Net Assets			
Unrestricted Funds	7,229,054	7,165,934	6,830,209
Restricted Funds	566,649	556,369	602,817
Net Assets	7,795,702	7,722,303	7,433,025
Total Liabilities and Net Assets	$ 24,491,951	$ 24,688,962	$ 29,081,473

City of Alameda Health Care District

Statements of Operations - Combined

March 31, 2009

S's in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 15,031	$ 14,975	$ 55	0.4%	$ 12,442	$ 117,915	$ 121,142	$ (3,227)	-2.7%	$ 120,173
Gross Outpatient Revenues	11,298	10,668	631	5.9%	9,122	88,831	85,326	3,505	4.1%	61,005
Total Gross Revenues	26,329	25,643	686	2.7%	21,564	206,746	206,468	278	0.1%	181,178
Contractual Deductions	20,102	19,433	(669)	-3.4%	15,435	153,690	153,608	(82)	-0.1%	136,248
Bad Debts	686	618	(69)	-11.1%	1,164	5,583	4,939	(644)	-13.0%	3,871
Charity and Other Adjustments	24	22	(2)	-11.1%	152	816	794	(22)	-2.8%	810
Net Patient Revenues	5,516	5,571	(54)	-1.0%	4,813	46,657	47,127	(471)	-1.0%	40,250
Net Patient Revenue %	21.0%	21.7%			22.3%	22.6%	22.8%			22.2%
Other Operating Revenue	12	10	2	22.2%	9	136	90	46	50.4%	90
Total Revenues	5,529	5,581	(52)	-0.9%	4,823	46,793	47,218	(425)	-0.9%	40,340
Expenses										
Salaries	2,999	3,111	112	3.6%	2,552	25,848	26,941	1,093	4.1%	24,226
Registry	296	121	(175)	-144.7%	178	1,978	1,046	(932)	-89.2%	1,142
Benefits	870	900	30	3.3%	807	7,369	7,932	564	7.1%	6,522
Professional Fees	296	282	(14)	-4.8%	281	2,707	2,540	(166)	-6.6%	2,883
Supplies	779	799	19	2.4%	770	6,747	6,738	(9)	-0.1%	6,387
Purchased Services	325	345	21	6.0%	278	3,017	3,105	89	2.9%	2,668
Rents and Leases	69	55	(14)	-25.5%	46	546	483	(63)	-13.1%	422
Utilities and Telephone	68	76	8	10.3%	69	641	666	25	3.8%	613
Insurance	75	65	(10)	-15.4%	64	413	555	142	25.6%	541
Depreciation and amortization	115	113	(2)	-1.5%	132	1,086	1,020	(67)	-6.6%	1,396
Other Opertaing Expenses	70	67	(2)	-3.7%	54	675	598	(77)	-12.9%	472
Total Expenses	5,961	5,934	(27)	-0.5%	5,231	51,026	51,623	598	1.2%	47,272
Operating gain (loss)	(432)	(353)	(79)	-22.4%	(408)	(4,233)	(4,405)	173	-3.9%	(6,932)
Net Non-Operating Income / (Expense)	495	498	(3)	-0.7%	492	4,425	4,483	(58)	-1.3%	4,592
Excess of Revenues Over Expenses	$ 62	$ 145	$ (83)	-57.0%	$ 84	$ 192	$ 77	$ 115	148.8%	$ (2,340)

City of Alameda Health Care District

Statements of Operations - Hospital Only

March 31, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 14,412	$ 14,548	$ (135)	-0.9%	$ 12,442	$ 114,519	$ 118,118	$ (3,600)	-3.0%	$ 120,173
Gross Outpatient Revenues	11,298	10,668	631	5.9%	9,122	88,831	85,326	3,505	4.1%	61,005
Total Gross Revenues	25,711	25,215	496	2.0%	21,564	203,350	203,444	(94)	0.0%	181,178
Contractual Deductions	19,702	19,215	(487)	-2.5%	15,435	151,669	152,074	405	0.3%	136,248
Bad Debts	686	618	(69)	-11.1%	1,164	5,583	4,939	(644)	-13.0%	3,871
Charity and Other Adjustments	24	22	(2)	-11.1%	152	816	794	(22)	-2.8%	810
Net Patient Revenues	5,298	5,360	(62)	-1.2%	4,813	45,281	45,637	(356)	-0.8%	40,250
Net Patient Revenue %	20.6%	21.3%			22.3%	22.3%	22.4%			22.2%
Other Operating Revenue	12	10	2	22.2%	9	136	90	46	50.4%	90
Total Revenues	**5,310**	**5,370**	**(60)**	-1.1%	**4,823**	**45,418**	**45,728**	**(310)**	-0.7%	**40,340**
Expenses										
Salaries and Benefits	2,894	2,993	99	3.3%	2,552	25,101	26,089	987	3.8%	24,226
Registry	296	121	(175)	-144.7%	178	1,978	1,046	(932)	-89.2%	1,142
Benefits	825	866	41	4.8%	807	7,253	7,684	430	5.6%	6,522
Professional Fees	276	269	(7)	-2.6%	281	2,544	2,421	(123)	-5.1%	2,883
Supplies	767	789	21	2.7%	770	6,658	6,664	5	0.1%	6,387
Purchased Services	314	344	29	8.6%	278	2,959	3,094	135	4.4%	2,668
Rents and Leases	60	47	(13)	-26.9%	46	484	425	(59)	-13.9%	422
Utilities and Telephone	64	73	9	12.5%	69	617	647	30	4.7%	613
Insurance	74	64	(10)	-15.6%	64	407	549	142	25.9%	541
Depreciation and Amortization	114	112	(2)	-1.6%	132	1,080	1,012	(68)	-6.7%	1,396
Other Operating Expenses	68	66	(2)	-2.5%	54	662	589	(73)	-12.3%	472
Total Expenses	**5,752**	**5,744**	**(7)**	-0.1%	**5,231**	**49,743**	**50,219**	**475**	0.9%	**47,272**
Operating Gain / (Loss)	(441)	(374)	(67)	-18.0%	(408)	(4,326)	(4,491)	165	-3.7%	(6,932)
Net Non-Operating Income / (Expense)	495	498	(3)	-0.7%	492	4,425	4,483	(58)	-1.3%	4,592
Excess of Revenues Over Expenses	$ 53	$ 124	$ (71)	-57.0%	$ 84	$ 99	$ (8)	$ 107	-1330.9%	$ (2,340)

City of Alameda Health Care District

Statements of Operations - South Shore

March 31, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 618	$ 428	$ 190	44.5%	$ -	$ 3,396	$ 3,024	$ 372	12.3%	$ -
Gross Outpatient Revenues	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Gross Revenues	618	428	190	44.5%	-	3,396	3,024	372	12.3%	-
Contractual Deductions	400	217	(183)	-84.2%	-	2,021	1,534	(487)	-31.8%	-
Bad Debts	-	-	-	0.0%	-	-	-	-	0.0%	-
Charity and Other Adjustments	-	-	-	0.0%	-	-	-	-	0.0%	-
Net Patient Revenues	218	211	8	3.7%	-	1,375	1,490	(115)	-7.7%	-
Net Patient Revenue %	35.3%	49.3%			0.0%	40.5%	49.3%			0.0%
Other Operating Revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Revenues	**219**	**211**	**8**	3.6%	-	**1,376**	**1,490**	**(115)**	-7.7%	-
Expenses										
Salaries	106	118	13	10.6%	-	746	852	106	12.4%	-
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	45	34	(11)	-33.2%	-	115	249	133	53.6%	-
Professional Fees	20	13	(7)	-49.2%	-	163	119	(43)	-36.5%	-
Supplies	12	10	(2)	-21.0%	-	89	75	(14)	-19.0%	-
Purchased Services	10	1	(9)	-596.4%	-	58	11	(46)	-419.8%	-
Rents and Leases	9	8	(1)	-17.1%	-	62	58	(4)	-7.0%	-
Utilities and Telephone	4	3	(1)	-54.2%	-	24	19	(5)	-25.5%	-
Insurance	1	1	(0)	-0.6%	-	6	6	0	1.2%	-
Depreciation and amortization	1	1	0	10.3%	-	7	7	1	12.2%	-
Other Operating Expenses	2	1	(1)	-72.4%	-	13	8	(5)	-54.5%	-
Total Expenses	**210**	**190**	**(20)**	-10.3%	-	**1,282**	**1,405**	**122**	8.7%	-
Opertaing Gain / (Loss)	9	21	(12)	56.5%	-	93	86	8	8.8%	-
Net Non-Operating Income / (Expense)	-	-	-	**0.0%**	-	-	-	-	**0.0%**	-
Excess of Revenues Over Expenses	$ 9	$ 21	$ (12)	-56.5%	$ -	$ 93	$ 86	$ 8	8.8%	$ -

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day - Combined

March 31, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,098	$ 3,094	$ 4	0.1%	$ 3,547	$ 3,015	$ 3,092	$ (77)	-2.5%	$ 4,745
Gross Outpatient Revenues	2,329	2,204	125	5.7%	2,600	2,272	2,178	93	4.3%	2,409
Total Gross Revenues	5,426	5,297	129	2.4%	6,147	5,287	5,270	16	0.3%	7,154
Contractual Deductions	4,143	4,014	(128)	-3.2%	4,400	3,930	3,921	(9)	-0.2%	5,380
Bad Debts	141	128	(14)	-10.8%	332	143	126	(17)	-13.2%	153
Charity and Other Adjustments	5	4	(0)	-10.8%	43	21	20	(1)	-2.9%	32
Net Patient Revenues	1,137	1,151	(14)	-1.2%	1,372	1,193	1,203	(10)	-0.8%	1,589
Net Patient Revenue %	21.0%	21.7%			22.3%	22.6%	22.8%			22.2%
Other Operating Revenue	3	2	0	21.9%	3	3	2	1	50.7%	4
Total Revenues	**1,140**	**1,153**	**(14)**	-1.2%	**1,375**	**1,197**	**1,206**	**(9)**	-0.7%	**1,593**
Expenses										
Salaries	618	641	23	3.6%	526	661	688	27	3.9%	957
Registry	61	25	(36)	-144.7%	37	51	27	(24)	-89.5%	45
Benefits	179	185	6	3.3%	166	188	202	14	6.9%	258
Professional Fees	61	58	(3)	-4.5%	80	69	65	(4)	-6.7%	114
Supplies	161	165	4	2.6%	219	173	172	(1)	-0.3%	252
Purchased Services	67	71	4	6.0%	57	77	79	2	2.7%	105
Rents and Leases	14	11	(3)	-25.2%	13	14	12	(2)	-13.3%	17
Utilities and Telephone	14	16	2	10.5%	20	16	17	1	3.6%	24
Insurance	15	13	(2)	-15.1%	18	11	14	4	25.5%	21
Depreciation and Amortization	24	23	(0)	-1.2%	38	28	26	(2)	-6.7%	55
Other Operating Expenses	14	14	(0)	-3.5%	15	17	15	(2)	-13.1%	19
Total Expenses	**1,229**	**1,224**	**(5)**	-0.4%	**1,190**	**1,305**	**1,318**	**13**	1.0%	**1,867**
Operating Gain / (Loss)	**(89)**	**(71)**	**(18)**	-26.0%	**185**	**(108)**	**(112)**	**4**	-3.8%	**(274)**
Net Non-Operating Income / (Expense)	**102**	**103**	**(1)**	-0.9%	**140**	**113**	**114**	**(1)**	-1.1%	**181**
Excess of Revenues Over Expenses	$ 13	$ 32	$ (19)	-59.7%	$ 325	$ 5	$ 2	$ 3	134.0%	$ (92)

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day - Hospital Only

March 31, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,893	$ 3,970	$ (77)	-1.9%	$ 3,547	$ 3,649	$ 3,818	$ (170)	-4.4%	$ 4,745
Gross Outpatient Revenues	3,052	2,911	141	4.8%	2,600	2,830	2,758	72	2.6%	2,409
Total Gross Revenues	6,946	6,882	64	0.9%	6,147	6,479	6,576	(98)	-1.5%	7,154
Contractual Deductions	5,322	5,244	(78)	-1.5%	4,400	4,832	4,916	84	1.7%	5,380
Bad Debts	185	169	(17)	-10.0%	332	178	160	(18)	-11.4%	153
Charity and Other Adjustments	7	6	(1)	-10.0%	43	26	26	(0)	-1.3%	32
Net Patient Revenues	1,431	1,463	(32)	-2.2%	1,372	1,443	1,475	(33)	-2.2%	1,589
Net Patient Revenue %	20.6%	21.3%			22.3%	22.3%	22.4%			22.2%
Other Operating Revenue	3	3	1	20.9%	3	4	3	1	48.3%	4
Total Revenues	1,435	1,466	(31)	-2.1%	1,375	1,447	1,478	(31)	-2.1%	1,593
Expenses										
Salaries	782	817	35	4.3%	728	800	843	44	5.2%	957
Registry	80	33	(47)	-142.2%	51	63	34	(29)	-86.5%	45
Benefits	223	236	14	5.7%	230	231	248	17	7.0%	258
Professional Fees	75	73	(1)	-1.5%	80	81	78	(3)	-3.6%	114
Supplies	207	215	8	3.7%	219	212	215	3	1.5%	252
Purchased Services	85	94	9	9.5%	79	94	100	6	5.7%	105
Rents and Leases	16	13	(3)	-25.6%	13	15	14	(2)	-12.3%	17
Utilities and Telephone	17	20	3	13.4%	20	20	21	1	6.0%	24
Insurance	20	17	(3)	-14.4%	18	13	18	5	26.9%	21
Depreciation and Amortization	31	31	(0)	-0.5%	38	34	33	(2)	-5.2%	55
Other Operating Expenses	18	18	(0)	-1.5%	15	21	19	(2)	-10.7%	19
Total Expenses	1,554	1,568	14	0.9%	1,491	1,585	1,623	38	2.4%	1,867
Operating Gain / (Loss)	(119)	(102)	(17)	-16.9%	(116)	(138)	(145)	7	-5.1%	(274)
Net Non-Operating Income / (Expense)	134	136	(2)	-1.7%	140	141	145	(4)	-2.7%	181
Excess of Revenues Over Expenses	$ 15	$ 34	$ (19)	-57.2%	$ 24	$ 3	$ (0)	$ 3	-7854.4%	$ (92)

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day - South Shore

March 31, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 890	$ 600	$ 290	48.2%	$ -	$ 734	$ 602	$ 132	21.9%	$ -
Gross Outpatient Revenues	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Gross Revenues	890	600	290	48.2%	-	734	602	132	21.9%	-
Contractual Deductions	575	304	(271)	-88.9%	-	437	305	(131)	-43.0%	-
Bad Debts	-	-	-	0.0%	-	-	-	-	0.0%	-
Charity and Other Adjustments	-	-	-	0.0%	-	-	-	-	0.0%	-
Net Patient Revenues	314	296	19	6.3%	-	297	297	1	0.2%	-
Net Patient Revenue %	35.3%	49.3%			0.0%	40.5%	49.3%			0.0%
Other Operating Revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Revenues	**315**	**296**	**19**	6.3%	-	**298**	**297**	**0**	0.2%	-
Expenses										
Salaries	152	170	18	10.6%	-	161	170	8	4.9%	-
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	64	48	(16)	-33.2%	-	25	49	25	49.7%	-
Professional Fees	29	19	(10)	-53.1%	-	35	24	(11)	-48.1%	-
Supplies	17	14	(3)	-24.1%	-	19	15	(4)	-29.2%	-
Purchased Services	15	2	(13)	-596.4%	-	12	2	(10)	-464.2%	-
Rents and Leases	13	11	(2)	-20.2%	-	13	12	(2)	-16.2%	-
Utilities and Telephone	6	4	(2)	-58.2%	-	5	4	(1)	-36.3%	-
Insurance	1	1	(0)	-3.2%	-	1	1	(0)	-7.3%	-
Depreciation and amortization	1	1	0	8.0%	-	1	1	0	4.7%	-
Other Operating Expenses	3	2	(1)	-76.9%	-	3	2	(1)	-67.7%	-
Total Expenses	**302**	**272**	**(29)**	-10.8%	-	**277**	**280**	**3**	0.9%	-
Operating Gain / (Loss)	**13**	**24**	**(11)**	45.3%	-	**20**	**17**	**3**	17.2%	-
Net Non-Operating Income / (Expense)	-	-	-	**0.0%**	-	-	-	-	**0.0%**	-
Excess of Revenues Over Expenses	$ 13	$ 24	$ (11)	-45.3%	$ -	$ 20	$ 17	$ 3	17.2%	$ -

ALAMEDA HOSPITAL
KEY STATISTICS
March, 2009

	ACTUAL MARCH 2009	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	MARCH 2008	YTD MARCH 2009	YTD FIXED BUDGET	VARIANCE	%	YTD MARCH 2008
Discharges:										
Total Acute	225	264	(39)	-14.8%	261	2,085	2,205	(120)	-5.4%	2,157
Total Sub-Acute	1	2	(1)	-50.0%	-	28	18	10	55.6%	11
Total Skilled Nursing	8	10	(2)	-20.0%	1	89	68	21	30.9%	60
	234	276	(42)	-15.2%	262	2,202	2,291	(89)	-3.9%	2,228
Patient Days:										
Total Acute	1,023	1,054	(31)	-2.9%	1,004	8,646	8,816	(170)	-1.9%	8,349
Total Sub-Acute	1,052	1,060	(8)	-0.8%	994	9,030	9,145	(115)	-1.3%	7,827
Total Skilled Nursing	695	713	(18)	-2.5%	26	4,628	5,024	(396)	-7.9%	622
	2,770	2,827	(57)	-2.0%	2,024	22,304	22,985	(681)	-3.0%	16,798
Average Length of Stay										
Total Acute	4.55	3.99	0.55	13.9%	3.85	4.15	4.00	0.15	3.7%	3.87
Average Daily Census										
Total Acute	33.00	34.00	(1.00)	-2.9%	32.39	31.55	32.18	(0.62)	-1.9%	30.36
Total Sub-Acute	33.94	34.19	(0.26)	-0.8%	32.06	32.96	33.38	(0.42)	-1.3%	28.46
Total Skilled Nursing	22.42	23.00	(0.58)	-2.5%	0.84	20.21	22.04	(1.83)	-8.3%	2.26
	89.35	91.19	(1.84)	-2.0%	65.29	84.72	87.59	(1.04)	-1.2%	61.08
Emergency Room Visits	1,507	1,523	(16)	-1.1%	1,576	12,728	13,450	(722)	-5.4%	13,361
Outpatient Registrations	2,609	2,999	(390)	-13.0%	2,466	22,349	23,441	(1,092)	-4.7%	23,504
Surgery Cases:										
Inpatient	55	66	(11)	-16.7%	65	502	520	(18)	-3.5%	513
Outpatient	462	400	62	15.5%	370	3,812	3,236	576	17.8%	3,363
	517	466	51	10.9%	435	4,314	3,756	558	14.9%	3,876
Kaiser Inpatient Cases	11	-	11	-	8	81	-	81	-	45
Kaiser Eye Cases	177	151	26	17.2%	136	1,435	1,124	311	27.7%	1,173
Kaiser Outpatient Cases	171	160	11	6.9%	123	1,419	1,171	248	21.2%	1,160
Total Kaiser Cases	359	311	48	15.4%	267	2,935	2,295	640	27.9%	2,378
% Kaiser Cases	69.4%	66.7%			61.4%	68.0%	61.1%			61.4%
Adjusted Occupied Bed	153.51	156.36	2.85	1.8%	113.16	142.36	143.02	(0.66)	-0.5%	106.59
Productive FTE	400.16	376.24	(23.92)	-6.4%	351.01	373.24	363.75	(9.49)	-2.6%	348.02
Total FTE	445.71	429.32	(16.39)	-3.8%	393.33	424.85	424.96	0.11	0.0%	403.01
Productive FTE/Adj. Occ. Bed	2.61	2.41	(0.20)	-8.3%	3.10	2.62	2.54	(0.08)	-3.1%	3.27
Total FTE/ Adj. Occ. Bed	2.90	2.75	(0.16)	-5.7%	3.48	2.98	2.97	(0.01)	-0.4%	3.78

ALAMEDA HOSPITAL

12 MONTH CASH PROJECTION

PERIOD COVERED: 4/1/09 THRU 3/31/10

	COLLECTIONS		PROPERTY	W/C REFUND	OTHER	FY 2008		EST.	
MONTH	NON-KAISER	KAISER -USE	TAX[1]	NET		AB 915	TRANSFERS	DISBURSEMENTS	BALANCE[2]
APR 09	4,187,024	1,600,000	367,000		50,000		0	5,425,492	394,924
MAY 09	4,710,000	800,000	477,000		50,000		800,000	6,936,972	294,952
JUNE 09	4,620,000	800,000	477,000		50,000	180,000	(660,000)	5,460,815	301,137
JULY 09	4,840,000	800,000	477,000		50,000		(150,000)	6,067,397	250,739
AUG 09	4,620,000	800,000	477,000		50,000		110,000	6,067,397	240,342
SEP 09	4,725,000	800,000	477,000		50,000			6,067,397	224,945
OCT 09	4,950,000	800,000	477,000		50,000		(150,000)	6,099,854	252,091
NOV 09	4,370,000	800,000	477,000		50,000		350,000	6,067,397	231,694
DEC 09	5,060,000	800,000	477,000		50,000		(250,000)	6,133,157	235,537
JAN 10	5,060,000	800,000	477,000		50,000		(300,000)	6,133,157	189,379
FEB 10	4,140,000	800,000	477,000	100,000	50,000		550,000	6,133,157	173,222
MAR 10	5,060,000	800,000	477,000		50,000		(300,000)	6,133,157	127,065
TOTALS	56,342,024	10,400,000	5,614,000	100,000	600,000	180,000	0	72,725,851	

Notes:

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

12 Month Cash Projection - Disbursement Detail

PERIOD COVERED: 3/1/09 THRU 2/28/10

	DISBURSEMENTS								TOTAL CASH
			10%						
MONTH	PAYROLL	PENSION	PAYROLL RELATED	Total Payroll	Health expense	Refund	A/P	Debt Service	OUTLAYS
APR 09	2,704,396	50,714	282,247	3,037,357	278,000	20,000	2,041,842	48,293	5,425,492
MAY 09	4,245,869 a	85,500	407,603	4,738,972	278,000	20,000	1,855,987	44,013	6,936,972
JUNE 09	2,830,579	60,500	271,736	3,162,815	278,000	20,000	1,955,933	44,067	5,460,815
JULY 09	3,384,030	60,500	324,867	3,769,397	278,000	20,000	1,955,891	44,109	6,067,397
AUG 09	3,384,030	60,500	324,867	3,769,397	278,000	20,000	1,955,842	44,158	6,067,397
SEP 09	3,384,030	60,500	324,867	3,769,397	278,000	20,000	1,955,788	44,212	6,067,397
OCT 09	5,076,045 a	85,500	487,300	3,801,854	278,000	20,000	1,955,744	44,256	6,099,854
NOV 09	3,384,030	60,500	324,867	3,769,397	278,000	20,000	1,955,690	44,310	6,067,397
DEC 09	3,444,030	60,500	330,627	3,835,157	278,000	20,000	1,957,912	42,088	6,133,157
JAN 10	3,444,030	60,500	330,627	3,835,157	278,000	20,000	1,957,870	42,130	6,133,157
FEB 10	3,444,030	60,500	330,627	3,835,157	278,000	20,000	1,957,817	42,183	6,133,157
MAR 10	3,444,030	60,500	330,627	3,835,157	278,000	20,000	1,963,968	36,032	6,133,157
TOTALS	42,169,132	766,214	4,070,862	45,159,216	3,336,000	240,000	23,470,284	519,851	72,725,351

a) 3 pay periods in the month

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: April 28, 2009

To: City of Alameda Health Care District Board of Directors

Through: Strategic Planning and Community Relations Committee

From: Deborah E. Stebbins, CEO

Subject: District Board Meeting Video & Broadcasting Options

With the assistance of Robert Lundy-Paine, Director of Information Systems and Kristen Thorson, management has researched four (4) different options for video taping and broadcasting the monthly District Board meetings. Below is the summary, in no particular order, for your review and discussion. These options have been discussed with the Strategic Planning and Community Relations Committee and along with Management are recommending that the Board approve Option 1 as indicated below. Management is also recommending that the videotaping commence in Fiscal Year 2009/2010 as it is not budgeted for in the current fiscal year.

Option 1 – Videographer + Web Posting of Video

1. Local videographer to provide time and equipment to video tape the Board meetings.
    a. $434 (4 hours of time, video upload to web, and tape / DVD production)
2. Video would then be uploaded to Google Video or related sight with a link added to the Hospital website to view the video.
3. Tape/DVD could be distributed to Comcast for playback on Channel 28 at no charge. Playback would occur at odd times (i.e. 1:00 a.m.). Comcast does not take live programming.
4. Tape/DVD could be distributed to City of Alameda for playback on Channel 15, but would require approval by the City.

Total Cost/Month:	$434.00
Total Cost/Year:	$5,208.00

Option 2 – Calypso Communications LLC [enclosure]

1. All video equipment provided by Calypso.

2. Video would be hosted on Calypso servers with a link on our website for the 1st 6 months, after which time the Hospital has the option of hosting the videos on internal servers or continue service with Calypso at an additional $50/month.

3. Convert recordings to DVD with a menu that includes links to each agenda topic for more convenient viewing by the community. Five copies of DVD will be provided to the Hospital.

4. El Camino Hospital uses Calypso Communications. [Web Demonstration]

5. Virtually no IT impact for Hospital.

Total Cost/Month (1st 6 months):	$1,600.00
Total Cost/Month (2nd 6 months):	$1,650.00
Total Cost 1st Year:	$19,500.00
Annual / Subsequent Years:	$19,800.00

Option 3 – Granicus + Videographer [enclosure]

1. What is Granicus? A comprehensive software solution to stream audio or video broadcasts to the internet and archive them for future viewing and reference. "Granicus MediaManager™ helps you easily set up an online repository of government webcasts and documents – all cross-linked, keyword-searchable, and conveniently accessible on-demand." Many government entities utilize Granicus, including the City of Alameda.

    a. Total up-Front Software, Professional Services & Hardware Cost = $12,816.61

    b. Monthly Managed Services = $1,061.95

2. Local videographer to provide time and equipment to video tape the Board meetings.

    a. $334 (4 hours of time and tape / DVD production)

3. Would require staff training on Granicus system and some operation of system by staff during the Board Meeting.

4. Only option to provide live broadcasting.

One Time Installation:	$12,816.61

Total Cost/Month:	$1,395.95
Total Cost for 1st Year:	$29,568.01
Annual / Subsequent Years:	$16,751.40

Option 4 – Use of City Council Chambers and Resources

1. Requires City Council approval to use facilities and resources
2. Potential hourly rate for use of facility and resources which are not known at this time
3. Possible date conflicts with other city meetings (i.e. Rent Review Advisory Committee)

Total Cost/Month:	Unknown
Total Cost/Year with Installation:	Unknown

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: April 21, 2009

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

FROM: Kerry J. Easthope, Associate Administrator

SUBJECT: Alameda Towne Center, Medical Office Building Bid

The following is an update on the Alameda Towne Center, Medical Office Building remodel project.

Closed bids were required to be submitted to the District no later than 4:00 pm, on March 30th. Although a total of five companies expressed an initial interest in the project, and in fact pre qualified, only three companies submitted complete and competent bid proposals. The three bids submitted are as follows:

Coast Side Associates	$179,585
Rossi Builders Inc	$146,857
Euro Style Management Inc	$139,000

Euro Style Management subsequently has walked the project with hospital management and understands the scope and detail of work required. References were checked and the company appears to be competent and capable of performing the required work outlined in this project.

The District has received the required Surety, Faithful Performance and Payment Bonds that are required as part of the bid package. In addition, we have certificates of insurance for Workers Compensation and General Liability Insurance, naming the District as an "additional insured".

Given that the bids came in significantly under the previously approved estimation of $200,000 to $250,000 for this project, Management has awarded the contract to Euro Style Management Inc., effective April 9, 2009.

Subsequent to awarding the contract, a Notice of Receipt has been issued to the contractor allowing them to begin work. The contractor has provided a work plan that begins on Wednesday, April 22nd and completion projected to be June 23rd, with one week thereafter for punch list items and final inspections of the project.