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Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT

BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Monday, June 6, 2011

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

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

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

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

II. Roll Call — Kristen Thorson

III. Closed Session Agenda

A. Call to Order

B. Approval of Closed Session Minutes
   1. May 9, 2011 Regular Meeting

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

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

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

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

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

H. Discussion of Report Involving Trade Secrets — H & S Code Sec. 32106
   1. Discussion of Hospital Trade Secrets applicable to development of new hospital services, programs and facilities. No action will be taken

I. Adjourn into Open Session

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

A. Announcements from Closed Session — Jordan Battani

V. Regular Agenda

ACTION ITEMS

A. Consent Agenda

1) Approval of May 9, 2011 Regular Meeting Minutes [enclosure] (PAGES 3-11)
2) Acceptance of April 2011 Financial Statements [enclosure] (PAGES 12-33)
3) Approval of Side Letter Agreement with SEIU UHW-West Regarding Accumulation of Seniority [enclosure] (PAGES 34-38)
4) Approval of Revised FY 2012 Goals and Objectives [enclosure] (PAGES 39-48)

B. Action Items

1) Approval of FY 2012 Operating and Capital Budget **[enclosure]** (PAGES 49-62) — Deborah E. Stebbins, David A. Neapolitan, Kerry J. Easthope
2) Approval to Enter into a Lease Agreement with Legacy Marina Village for Building Lease Located at 815 Atlantic Avenue, Alameda, California for Wound Care Program **[enclosure]** (PAGES 63-72) — Kerry J. Easthope

C. President's Report — Jordan Battani

1) Report on the Findings of the Executive Compensation Survey **INFORMATIONAL [to be distributed]**

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

1) Contract Analysis for Medical Directorships and Analysis of Medical Office Space Leases **INFORMATIONAL [enclosure] (PAGES 73-74)**
2) Request for Licensure Change **INFORMATIONAL [enclosure] (PAGES 75-79)**
3) Monthly Statistics **INFORMATIONAL**
4) Hospital Updates / Events **INFORMATIONAL**
5) Stroke Certification Update **INFORMATIONAL**

E. Operations and Facilities Report — Kerry Easthope

1) PACS / Imaging Upgrade Project Update **INFORMATIONAL [enclosure] (PAGES 80-82)**

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

G. Community Relations and Outreach Committee Report — J. Michael McCormick

1) May 24, 2011 Committee Meeting Report **INFORMATIONAL**

H. Finance and Management Committee Report — J. Michael McCormick

1) June 1, 2011 Committee Meeting Report **INFORMATIONAL**

VI. General Public Comments

VII. Board Comments

XIII. Adjournment

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

May 9, 2011

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

Submitted by: Kristen Thorson

Topic	Discussion	Action / Follow-Up
I. 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 6:12 p.m.	
II. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
III. Closed Session Agenda	The meeting was adjourned into Executive Closed Session at 6:13 p.m.	
IV. Reconvene to Public Session	The meeting was reconvened into public session at 7:41 p.m. Director Battani reported that the following actions were taken in Closed Session. A. Announcements from Closed Session 1. Closed Session Minutes – April 4, 2011 (Regular) Closed Session Minutes – April 27, 2011(Special) 2. Board Quality Committee (BQC) Report – January 2011 3. Medical Executive Committee Report and Approval of Credentialing Recommendations	The Closed Session Minutes were approved. The BQC report was accepted as presented. The Medical Executive Committee Report and Credentialing Recommendations were approved as presented below.

Initial Appointments – Medical Staff

Name	Specialty	Affiliation
○ Benjamin Hornik, MD	Plastic Surgery	Kaiser
○ Jane Kim, MD	Plastic Surgery	Kaiser
○ Naini Sharma, MD	Internal Medicine	AIM

Reappointments – Medical Staff

Name	Specialty	Staff Status	Appointment Period
○ Richard Nolan, MD	Orthopedics	Active	06/01/11 – 05/31/13
○ Mark Tidyman, MD	Anesthesiology	Courtesy	06/01/11 – 05/31/13

Resignations

Name	Specialty
○ James Branscom, MD	Teleradiology
○ Evan Custer, MD	Teleradiology
○ Robert Hoffman, MD	Orthopedics
○ Sundeep Nayak, MD	Teleradiology
○ Ashish Patel, MD	Thoracic Surgery
○ Jason Pollard, DPM	Podiatry
○ Veronica Shim, MD	General Surgery
○ Mitzi Williams, DPM	Podiatry

4. Director Battani reported that the Board discussed, under potential and pending litigation, a letter received by the Board from Jerrold Kram, MD alleging improprieties in a process between Alameda Care Center, now know as Alameda Healthcare and Wellness Center(AHWC), and East Bay Pulmonary Medical Group (EPMG) of which Director Deutsch is a member. AHWC has entered into a Subacute Medical Directorship agreement with EBPMG. Director Battani clarified that the hospital does not have any contractual relationships with AHWC, therefore there is not conflict of interest for Director Deutsch as a Board member of the District participating in the new agreement. She stated that the Board reviewed the chronology of events surrounding the allegations in the letter and the Board concluded that no further action or investigation was required. In addition, there were a number of other concerns in the letter related to rental agreements for medical office space and the way in which medical directorships are awarded for the hospital. Director

Director Gorelick joined the open Session meeting.

	Battani stated that Management and Staff will report to the Board at next meeting in open session regarding the cost to lease medical office space at the Hospital as well as information regarding Medical Directorship agreements.	
V. Regular Agenda	A. Consent Agenda 1. Approval of April 4, 2011 Regular Meeting Minutes 2. Approval of April 27, 2011 Special Meeting Minutes	Director Gorelick removed Consent Agenda Item 3 for further discussion. Director Chen removed Consent Agenda Item 7 for further discussion. Director Battani removed Consent Agenda Item 8 for further discussion. Director Deutsch made a motion to approve Consent Agenda Items 1, 2, 4, 5 and 6. Director Gorelick seconded the motion. The motion carried unanimously.
	3. Acceptance of March 2011 Financial Statements Director Gorelick inquired about days cash on hand being higher than expected at $1.7 million considering that there will be three pay periods in April. Mr. Neapolitan stated that the parcel tax installment was received in April and that cash balance for April would be at our average levels. He also inquired about the census for March considering the better than expected census report the Ms. Stebbins reported last month at the Board meeting. Ms. Stebbins responded that the March financials had a higher than usual write-off of bad debt that contributed to the performance for the month.. In addition, there was a variance in staffing due to a new manager over SubAcute that was operating the department according to incorrect staffing guidelines and is currently in process of making any necessary corrections. Ms. Stebbins noted that the Hospital is utilizing physician consultants (Executive Health Resources) to assist the hospital and physicians to determine accurate patient admissions (Inpatient vs. Observation Admissions) that will improve quality of care as well as have a significant financial impact for the Hospital. Director Gorelick asked when IGT funds are expected and the amount that will be needed to transfer. Mr. Neapolitan replied we are expecting to contribute $700,000 and the deadline for an initial of two installments is June 30, 2011.	Being no further discussions of the March Financials, Director Gorelick made a motion to accept the March Financial Statements as presented. Director McCormick seconded the motion. The motion carried unanimously.

4. Approval of Tentative Agreement with ILWU, Local #6

5. Approval of FY2011 Auditor Engagement

6. Approval of Revisions of Committee Relations and Outreach Committee Structure and Purpose

7. Approval of New Procedure: Minimally Invasive Lumbar Decompression (MILD®)

   Director Chen asked about the efficacy of the MILD procedure. Dr. Yeh replied that the procedure is typically used for a patient with Lumbarstenosis. The old procedure would use a large incision to remove debris, while the new procedure is conducted by placing a large needle into the epidural space and a special tool that is used to remove ligaments that compress the space. The procedure is performed in an outpatient setting, leaves little to no scarring, and is FDA Approved.

   Being no further discussions of the MILD procedure, Director Chen made a motion to approve the new procedure as presented. Director McCormick seconded the motion. The motion carried unanimously.

8. Approval of Bank of Alameda's Modifications to the Terms and Conditions of the Line of Credit and Construction Loan for the Wound Care Program

   Director Battani stated that there were concerns discussed at the Finance and Management Committee with using the parcel tax revenues as security for the loan. Legal Counsel, Mr. Driscoll stated Measure A, passed in 2001, covers operations, capital, property improvements and indebtedness of the district/hospital. It is clear that the intended purpose of the loan is consistent with Measure A. The Bank of Alameda requested that specific language be added to the terms to ensure repayment of the loan. Mr. Driscoll also added that the healthcare district law allows for the borrowing and pledging of parcel tax revenues. Director Battani stated that the fundamental concern is whether or not Board members think that the Board should authorize money to expand. Director Gorelick commented that Measure A in 2001 was implemented with the philosophy that the hospital would not use the tax revenues beyond the life of the business. Ms. Battani stated that the hospital will have to borrow money in order to grow.

   Director McCormick mentioned that the hospital has been in business for over 70 years and that requesting the use of the parcel tax as security for a loan until revenues from new programs begin is minimal. The City of Alameda Health Care District carries little debt in comparison to other hospitals.

   Director Chen stated that he might be against using the parcel tax as security to borrow money for seismic work; however he supports the use in order to increase a long-term

   Being of no further discussions regarding the Bank of Alameda Loan, Director McCormick made a motion to accept the Terms and Conditions of the Credit and Construction Loan for the Wound Care Program as presented. Director Deutsch seconded the motion. Director Gorelick opposed the motion. The motion carried.

	outcome with the new investment of the Wound Care Program. Director Gorelick asked what the level of indebtedness would be if the hospital closed its business today. Ms. Stebbins replied that there are many financial obligations that are associated with shutting down a business and that it would take many staffing hours to determine that specific number. Mr. Gorelick asked if the number could be reached and discussed in two months. Director Deutsch requested that Administration may be able to cite a quote given by prior administration and Director Gorelick agreed that would be a good starting point. Ms. Battani asked for a report of outstanding indebtedness and short term obligations. Management will work to prepare something in response to the Board questions.	
	B. Action Items	
	1. Approval of FY 2012 Goals and Objectives to Board of Directors Ms. Stebbins reviewed the Goals and Objectives for the Fiscal Year 2012 <u>Financial Strength</u>. The hospital will plan to work with Alameda County for funding for capital improvements as well as funding for uncompensated care delivered in the Emergency Room. She stated that more refined revenue cycle metrics will be forthcoming Director Battani suggested that management focus on monitors related to the revenue cycle that return value to the organization based on our current issues. . <u>Growth</u>. Ms. Stebbins emphasized that new growth in FY 12 will be contributed by additional licensure of beds at long-term care facilities in which we partner, Wound Care Program implementation, and new outpatient Orthopedic surgeries. Facilities and Technology. Director Battani suggested that the terminology be changed to "Patient Portal" for a patient accessible website focused on registration and appointment scheduling. Meditech is a possible tool for additional services in reference to patient information sharing. Ms. Battani requested that milestones or deadlines be displayed in the goals and objectives for EMR and Meaningful Use as well as an Information Systems Strategy Plan and updates on the Timekeeping System. Director Chen requested that the Patient Portal to be at least bilingual in addition to major signage within the Hospital. Physicians. Ms. Stebbins reviewed the possible outsourcing management of the 1206 (B) clinic, a more efficient method for marketing the clinic and its physicians and improvement in overall performance of the clinic. Quality/Service. Ms. Stebbins reviewed the goals for quality and service, noting areas	Approval of the Goals and Objectives was deferred to the June 2011 Board meeting for further refinement by Management based on input from the Board of Directors.

	such as improving website functionality, improvement of core measure scores above the 90th percentile and improvement in HCAHPS scores for cleanliness, noise and communication. People. Ms. Stebbins reviewed the goals for the strategic pillar "People, noting several areas to communicate effectively with employees and physicians as well as key employee morale building events. Director Battani asked if there were plans for an employee satisfaction survey. Ms. Stebbins stated that surveys for 2011 were mailed out several weeks ago.	
	2. Appointment of Members to Community Relations and Outreach Committee Director Chen announced the following community members for appointment to the Committee upon District Board approval: Hein Doan, Shubha Fanse, Monica Valerio, and Tracy Zollinger, LaC. Director Deutsch extended his appreciation of Director Chen's solicitation, screening, and recommendation of the new Community and Outreach Committee members. Director Chen reported on the Community Relations and Outreach Committee of April 26 as written below.	Director Deutsch made a motion to approve the Appointment of Members as presented. Director McCormick seconded the motion. The motion carried unanimously.
	C. President's Report 1. Director Battani stated the Executive Compensation Survey has been reviewed by the District Board of Directors and the findings will be presented at the June Board Meeting. D. Chief Executive Officer's Report 1. Monthly Statistics Ms. Stebbins reported on the monthly statistics, noting that the April acute census was 27.6 versus a budgeted 28.8 and 21.1% below March acute census. SubAcute census was close to budget at 32.4 versus 33.5. South Shore census was slightly below budget at 21.0 versus 23.0. Patient days were below budget by 5.2%. Emergency Room Visits were below budget by 6.0% at 1,382 and were lower than March volumes of 1,461 or 5.4%. Total surgeries were 202 which was11% better than March volumes. Outpatient surgeries were 15.8% better than March volumes. 2. Hospital Updates / Events	No action taken No action taken No action taken

	Ms. Stebbins announced the following upcoming Hospital Events: Nurses Week, Ice Cream Social and Awards, and Hospital Week. Ms. Stebbins and Ms. Bond announced that the Emergency Room went live with the EDM meditech module, which is for nursing documentation, on April 26th, Director Deutsch commented that the implementation of the new module has been very challenging, but he has been pleased to find many positive attitudes. 3. Stroke Certification Update No update was given.	No action taken
	E. Operations and Facilities Report 1. Seismic Update (Structural and Non-Structural) Mr. Easthope reviewed the four main items that need to be addressed by the Hospital to comply with the NPC-2 seismic retrofit requirement: • Bulk Oxygen Tank Anchorage – Relocation or to anchor and fortify the existing vessel. • Radiator / Emergency Generator – Replacement • Phone Switch Anchorage – Permit and verification • Decommission the 1925 Administrative Building – Relocation of Medical Records, CEO Office, Nursing Administration, and the Kitchen Mr. Easthope summarized the seismic implications contained in SB90. For SB 90's seismic relief component to become effective, SB335 must be enacted, which establishes the 2011-12 Medi-Cal hospital fee program, the federal government must approve the federal match for the hospital fee program, and OSHPD must develop emergency regulations to implement SB90. The SB90 extension is for up to seven years and cannot extend beyond 2020. When OSHPD grants the extension on a case-by-case basis they use the following criteria: Structural integrity of the building based on its HAZUS score, community access to health care if the hospital building is closed, and financial capacity to complete the construction project. The City of Alameda Health Care District faces challenges due to its unique nature.	
	2. Marina Village Lease Update Mr. Easthope commented that the Marina Village Lease is still under review. Lease	No action taken.

	negotiations are anticipated to be complete by the next Board meeting at which time a recommendation to enter into a lease agreement will be brought to the Board for final approval.	
	F. Medical Staff President Report Dr. Yeh informed the Board that the Continuing Medical Education (CME) program would be presented on May 24, 2011 regarding Bronchial Thermoplasty for Asthma. The Executive Health Resources education session held on April 28, 2011was informative and many physicians affiliated with Alameda Hospital attended.	No action taken.
	G. Community Relations and Outreach Committee Report	
	1. April 26, 2011 Committee Meeting Report Director Chen announced the continued interest in the Stroke Awareness Campaign by the community. A community lecture is scheduled for May 23, 2011 at 6:00 p.m. which features physicians affiliated with Alameda Hospital. Appointments for Stroke Risk Assessments are booked and another Assessment is scheduled for September 20, 2011. The Let's Move Alameda, city-wide childhood obesity campaign will begin on June 4, 2011 at the Sand Castle and Sand Sculpture Contest and will continue throughout the summer. More information regarding the events may be located on the Alameda Hospital website. Tom Clifford, of Tramutola, presented a Communications Enhancement Plan for Alameda Hospital which will work to increase communication to Alameda residents and build stronger relationships with Alameda County staff and elected officials. Future community events include the Park Street Spring Festival, the Chamber of Commerce Business Expo, the Mastick Senior Center's Senior Health Day, and the Alameda Asian Pacific Islander Cultural Festival.	
	H. Finance and Management Committee Report	
	1. April 27, 2011 Committee Meeting Report Director McCormick stated that at the Committee meeting, Mr. Neapolitan discussed the financial impact of AB5 and AB 1183 as it relates to the hospital. As the result of the governor signing these two bills, the hospital has received a repayment notice for $623,000 which relates to a retroactive rate freeze and injunction that was lifted as a result of this legislation. The Hospital is working with the state on a repayment plan. This liability has not been reported in the financials as of yet, but will be incorporated into the April Financial Statements. Director McCormick reported, Ms. Stebbins reported on recent budget changes will profoundly affect the hospital due to	

	SNF/Subacute cutes. Rates will be cut to 2008-2009 levels minus 10%. This will mean a $2 million hit to net revenue to the hospital.	
VI. General Public Comments	None.	
X. Board Comments		
XII. Adjournment	A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 9:43 p.m.	

Attest:

Jordan Battani
President

Elliott Gorelick
Secretary

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING APRIL 30, 2011

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
APRIL 30, 2011

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
APRIL, 2011

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 April 30, 2011 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of April, 2011

- For the month of April 2011, combined expense over revenues (loss) is $1,389,000. This loss was driven by a significant decline in April's inpatient case mix index, indication of lower acuity level patients, lower than expected outpatient volumes, an adjustment to the reduce the amount of accrued intergovernmental transfer receivable (discussed further on page 11) and the inclusion of $642,000 of additional contractual allowances related to the settlement of the Medi-Cal fiscal year 2009 cost report (discussed further on page 11).

- For the ten months ended April 30, 2011, combined expense over revenues (loss) is $2,087,000 before the inclusion of $1,451,000 of other non-operating income. This additional other non-operating income, which was recorded in March 2011, was the result of the elimination of a liability that was established in fiscal year 2006. The liability was the result of a dispute over contractual language related to the amounts due under the terms of an insurance contract. After inclusion of the elimination of this liability the year to date expense over revenue (loss) is $636,000 versus budgeted revenue over expenses (profit) of $567,000.

- Gross patient revenue for the month of April was less than budget by $2,155,000 or 10.2%. This unfavorable variance was the result of unfavorable variances of $1,021,000 and $1,134,000 in inpatient and outpatient programs, respectively. On adjusted patient day basis gross patient revenue was 2.4% less than budgeted at $5,180 compared to a budgeted amount of $5,310 for the month of April.

- Total patient days for the month were 2,425 compared to the prior month's total patient days of 2,747 and the prior year's 2,544 total patient days. The average daily acute care census was 27.5 compared to a budget of 28.8 and an actual average daily census of 35.0 in the prior month; the average daily Sub-Acute census was 32.4 versus a budget of 33.5 and 33.3 in the prior month and the Skilled Nursing program had an average daily census of 21.0 versus a budget of 23.0 and prior month census of 20.3, respectively.

- Emergency Care Center (ECC) visits were 1,382 or 6.0% less than the budgeted 1,470 visits and were only 30 visits or 1.4% less than the prior year's visits of 1,402.

- Total surgery cases were greater than budgeted expectations for the month at 202 cases versus the budgeted 182 cases. The current month's surgical volume was 5.2% greater than the same month prior year's 192 cases.

- Outpatient registrations were 12.8% below budgeted targets at 1,996 and at 66.5 visits per day were 6.2% less than the prior month's 70.9 visits per day.

- Combined excess expense over revenues (loss) for April was $1,398,000 versus a budgeted excess of expense over revenues (loss) of $79,000.

Total assets decreased by $1,860,000 from the prior month as a result of a decrease in current assets of $2,086,000, offset by increases in net fixed assets of $215,000 and restricted contributions of $11,000. The following items make up the decrease in current assets:

- Total unrestricted cash and cash equivalents for April increased by $667,000 and days cash on hand including restricted use funds increased to 17.7 days on hand in April from 14.1 days on hand in March.

- Net patient accounts receivable decreased in April by $436,000 compared to a decrease of $429,000 in March. Day's in outstanding receivables increased slightly to 58.6 at April 30, 2011 from 58.5 at March 31, 2011. Collections in April totaled $4.4 million compared to $5.5 million in March. This decrease in collections was the result of the State's processing of the normal weekly payment on Thursday, March 31, 2011 rather than the normal Monday processing that would have occurred on Monday, April, 1, 2011. This was done by the State to take advantage of the higher Federal Matching percentage that expired on March 31, 2011 and resulted in the inclusion of $332,000 in our March collections.

- Other receivables decreased by $2,242,000 as a result of the receipt of the April installment of parcel tax revenues that were collected by the county as of April 10, 2011 and remitted to the hospital on April 15th.

Total liabilities decreased by $473,000 compared to a decrease of $662,000 in the prior month. This decrease in the current month was the result of the following:

- Payroll related accruals decreased by $850,000 from the prior month primarily as a result of twelve fewer days of accrued payroll being required at the end of April.

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

- Estimated third party payables increased by $642,000 in April as a result of the fiscal year 2009 Medi-Cal cost report settlement. This increased liability was caused by the State of California's application of AB 5 and AB 1183 to non-contracted hospitals. These bills were passed as measures to help with the States budgetary shortfalls and arbitrarily reduced allowable hospital costs.

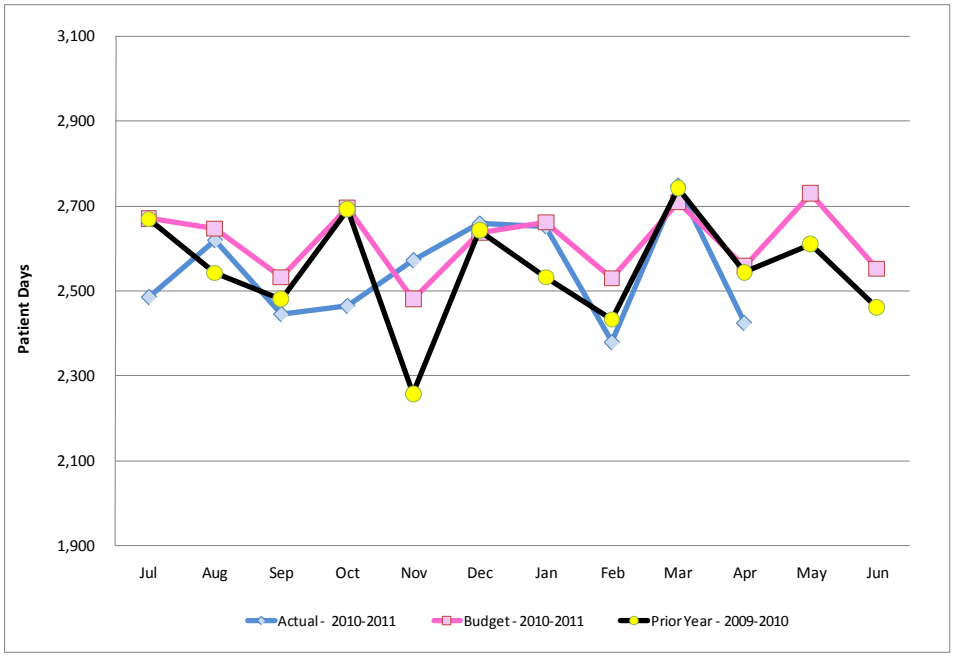
- Long term debt decreased by $37,000 as a result of the monthly payment of the principle portion of the note payable to the Bank of Alameda.

Volumes

The combined actual daily census was 80.8 versus a budget of 85.3 or an unfavorable variance of 5.2%. The current month's overall unfavorable variance from the budgeted census was the result of average daily census that were unfavorable to budget in the acute care areas by 1.3 patients per day or 4.4%. The Sub-Acute and Skilled Nursing programs were also unfavorable to budgeted expectations with average daily census of 32.4 versus the budgeted 33.5 and 21.0 versus the budgeted average daily census of 23.0, respectively.

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

Total Patient Days

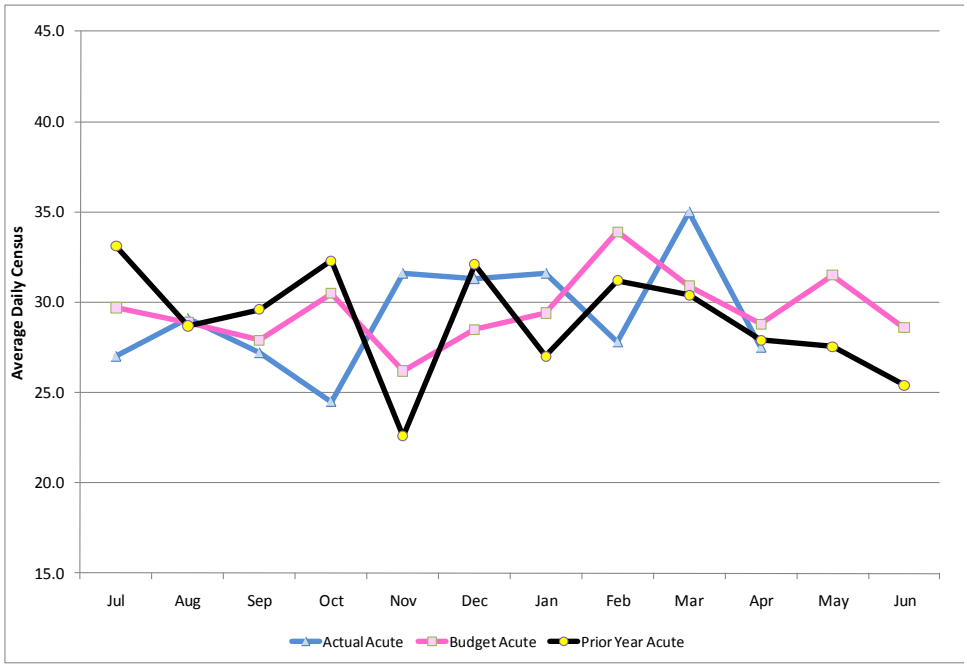


The various components of our inpatient volumes for the month of April are discussed in the following sections.

Acute Care

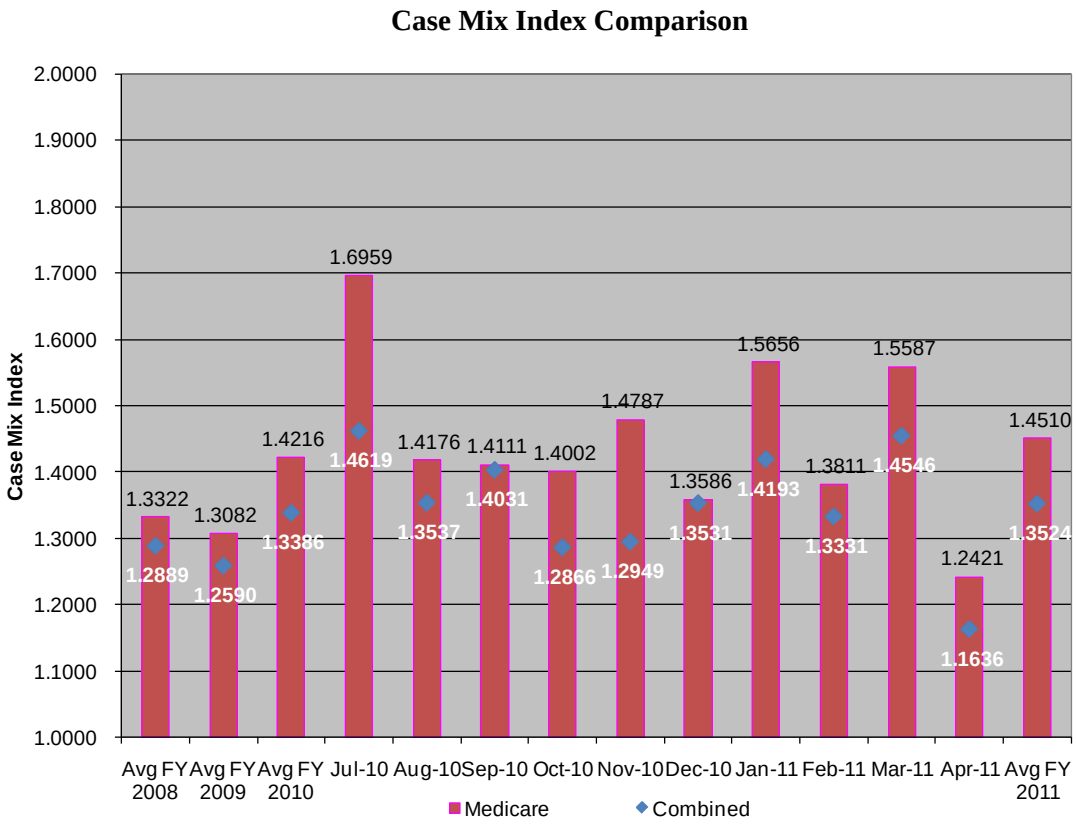
The acute care patient days were 4.4% (38 days) less than budgeted and were 1.3% less than the prior year's average daily census of 27.9 for March. The acute care program is comprised of the Critical Care Unit (3.9 ADC, 25.6% favorable to budget), Definitive Observation Unit (9.2 ADC, 22.0% unfavorable to budget) and Med/Surg Units (14.3 ADC, 3.8% favorable to budget). The graph below shows the inpatient acute care census by month for the current fiscal year, the operating budget and prior fiscal year actual.

Inpatient Acute Care Average Daily Census



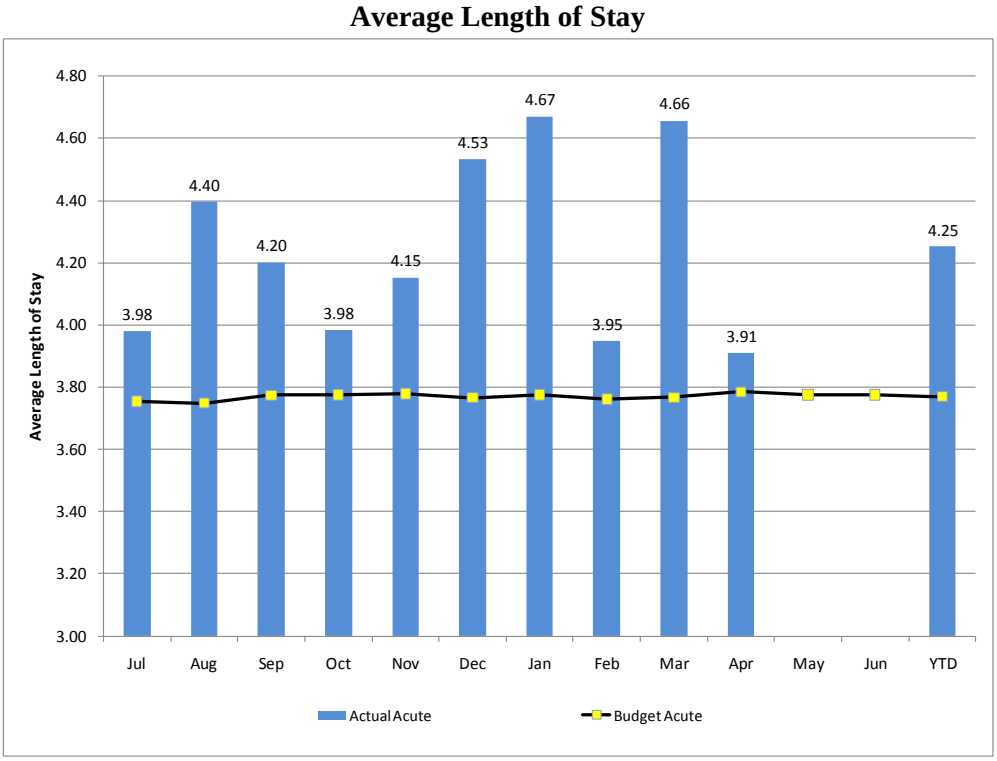
Case Mix Index

The hospitals overall Case Mix Index (CMI) decreased to 1.1636 from 1.4546 in the prior month and the Medicare CMI decreased over the prior month from 1.5587 in March to 1.2421 in April. In April there was one (1) outlier case. The graph below shows the CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.



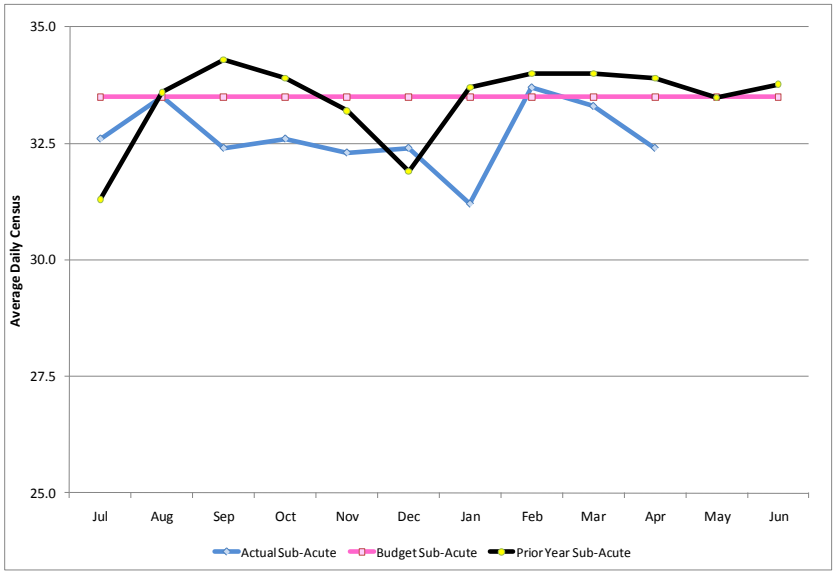
Average Length of Stay

The average length of stay (ALOS) decreased from that of the prior month to 3.91 days for the month of April bringing the year-to-date average to 4.25 versus the budgeted FY 2011 average of 3.77. The graph on the following page shows the ALOS by month and the budgeted ALOS for fiscal year 2011.



Sub-Acute Care

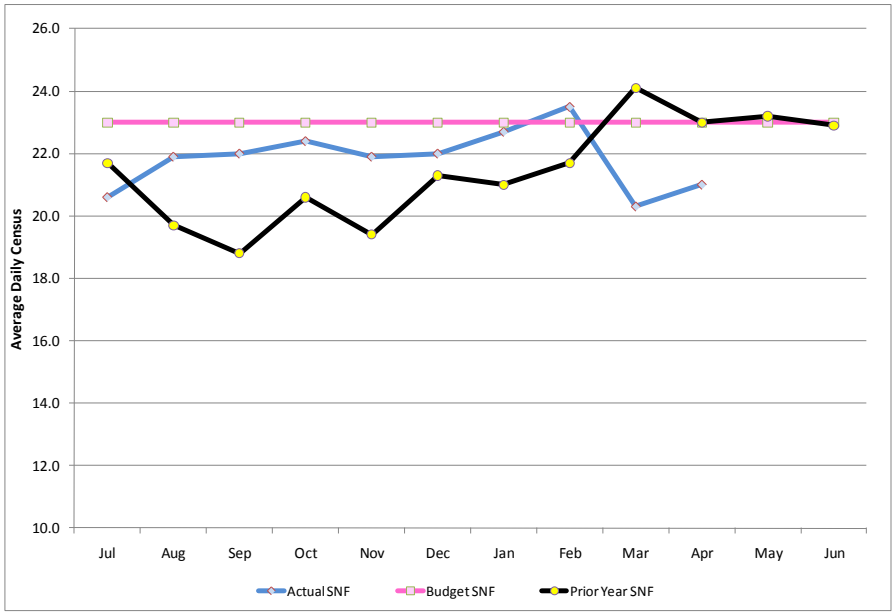
The Sub-Acute program patient days were less than budgeted projections with an average daily census of 32.4 for the month of April which was budgeted for an average daily census of 33.5. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget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



Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were 8.8% or 61 patient days less than budgeted for the month of April. Comparing performance to the prior year this programs volume remains slightly greater than the prior year's performance for the ten months of fiscal year 2011 that has had an average daily census of 21.8 versus 21.1 in fiscal year 2010. The following graph shows the Skilled Nursing Unit monthly average daily census as compared to budget and the prior year.

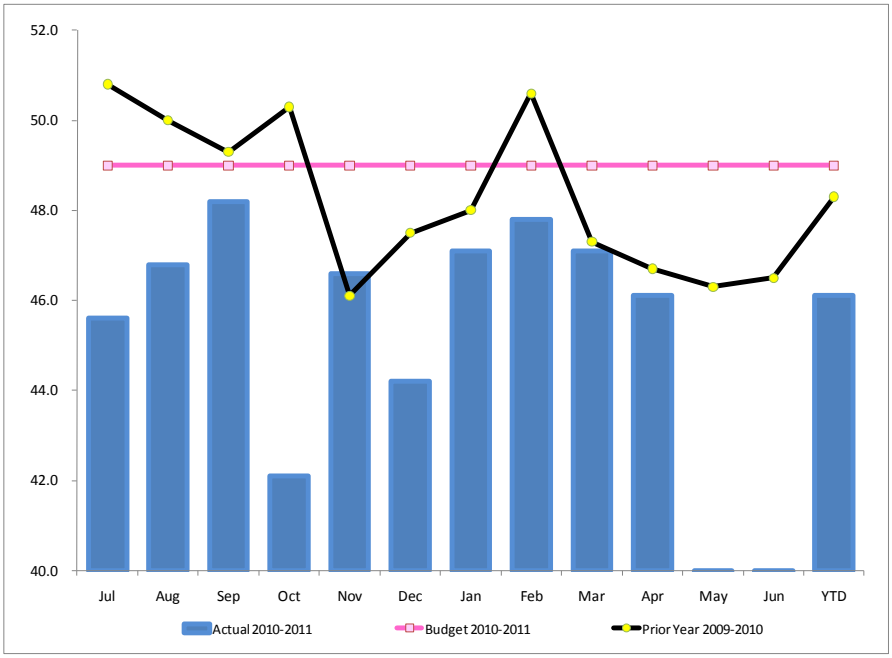
Skilled Nursing Unit Average Daily Census



Emergency Care Center (ECC)

Emergency Care Center visits in April totaled 1,382 and were 6.0% or only 88 visits less than budgeted for the month with 15.0% of these visits resulting in inpatient admissions versus 16.2% in March. In April there were 256 ambulance arrivals versus 318 in the prior month, on a per day basis this represents a decrease of 19.5% over the prior month daily average. Of the 256 ambulance arrivals in the current month 152 or 59.4% were from Alameda Fire Department (AFD) ambulances. The graph on the following page shows the Emergency Care Centers average visits per day for fiscal year 2011 as compared to budget and the prior year performance.

Emergency Care Center Visits per Day

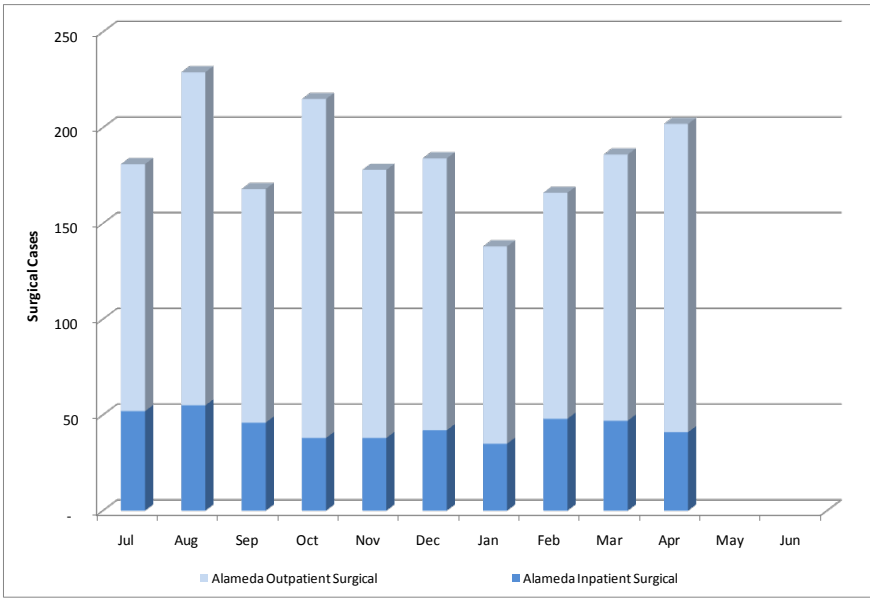


Surgery

Surgery cases were 202 versus the 182 budgeted cases and 192 cases in the prior year. In April, surgery cases increased over the prior month by 8.6%. The increase of 16 cases over the prior month was the result of an increase of 20 outpatient cases. Inpatient and outpatient cases totaled 41 and 161 versus 47 and 139 in April and March, respectively. The increase in cases from the prior month was driven by increases in Gastrointestinal (26), Ophthalmology (7) and Podiatry (6) cases offset by *decreases* in Orthopedic (9), General (7) Gynecology (6) and Cardiology (4) cases.

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

Surgical Cases

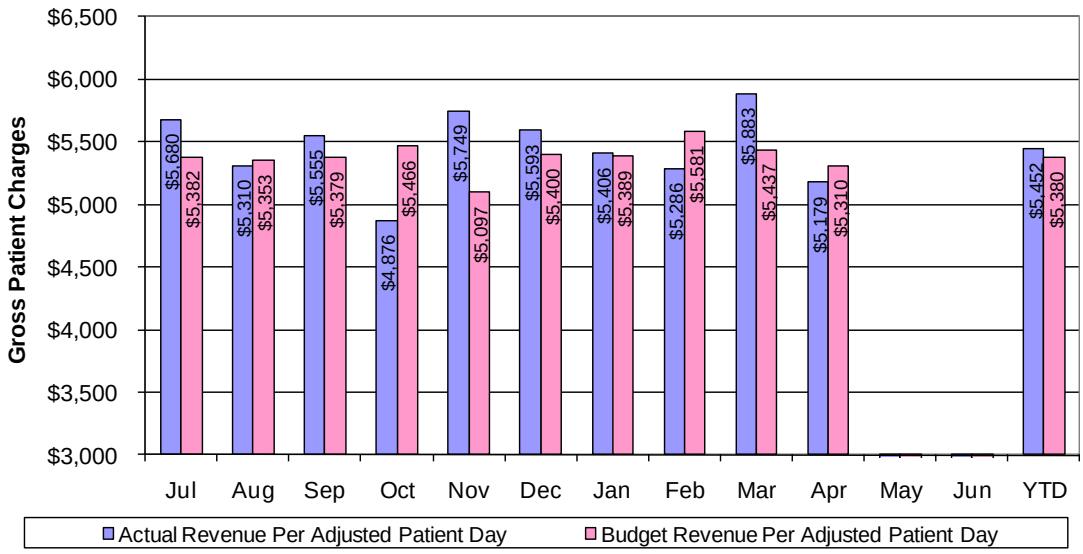


Income Statement

Gross Patient Charges

Gross patient charges in April were less than budgeted by $2,155,000. This unfavorable variance was comprised of unfavorable variances of $1,021,000 and $1,134,000 in inpatient and outpatient revenues, respectively. The decrease in inpatient gross revenues was primarily driven by lower patient census in all inpatient programs coupled with a significant decline in acute inpatient acuity levels. Outpatient revenues were lower than budgeted as a result of the delayed opening of the Wound Care program ($480,000), which now has a planned January 2012 opening, lower than expected emergency room visits ($216,000), surgical volumes that while greater than budget resulted in lower than budgeted revenues ($229,000) due to the mix of surgical cases and lower than budgeted laboratory activity ($137,000). On an adjusted patient day basis total patient revenue was $5,180 versus the budgeted $5,310 for the month of April. The following table shows the hospitals monthly gross revenue per adjusted patient day by month and year-to-date for fiscal year 2011 compared to budget.

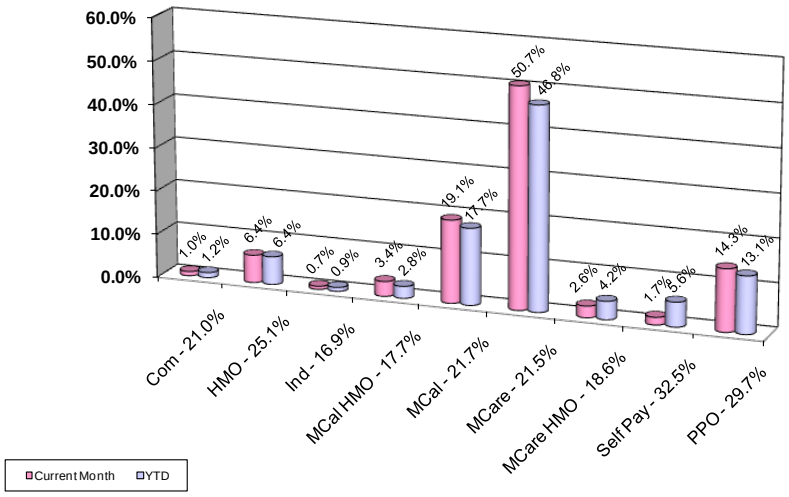
Gross Charges per Adjusted Patient Day



Payor Mix

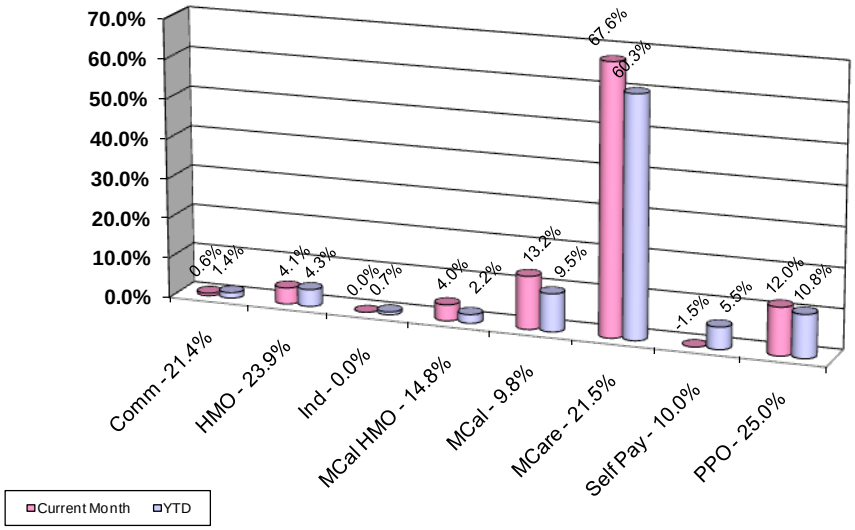
Combined acute care services, inpatient and outpatient, Medicare and Medicare Advantage total gross revenue in April made up 53.3% of the months total gross patient revenue. Combined Medicare revenue was followed by Medi-Cal Traditional and Medi-Cal HMO utilization at 22.5%, HMO/PPO utilization at 20.7 and self pay at 1.7%. The graph on the following page shows the percentage of gross revenues generated by each of the major payors for the current month and fiscal year to date as well as the current months estimated reimbursement for each payor for the combined inpatient and outpatient acute care services.

Combined Acute Care Services Payor Mix

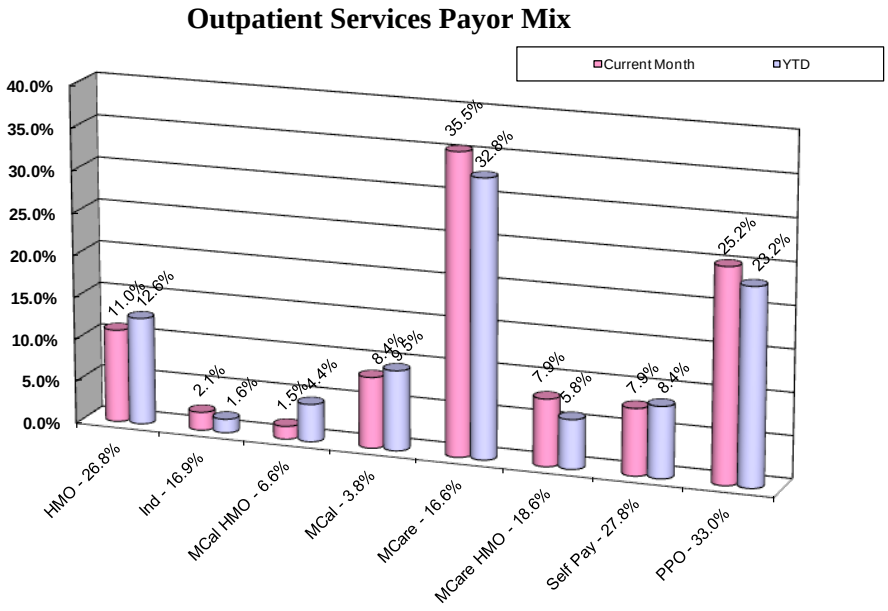


The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 67.6% of our total inpatient acute care gross revenues followed by Medi-Cal and Medi-Cal HMO at 17.2, HMO/PPO at 16.1%, and Self Pay at 1.5% of the inpatient acute care revenue. As a result of the decline in acuity levels and the current month's payor mix the overall net inpatient revenue percentage decreased from the prior month to 20.3% in April versus 21.7% in March. Similarly, as a result of the decline in Medicare case mix index, the estimated Medicare reimbursement decreased to 21.5% in April versus 23.6% in March. The graph on the following page shows inpatient acute care current month and year to date payor mix and current month estimated net revenue percentages for fiscal year 2011.

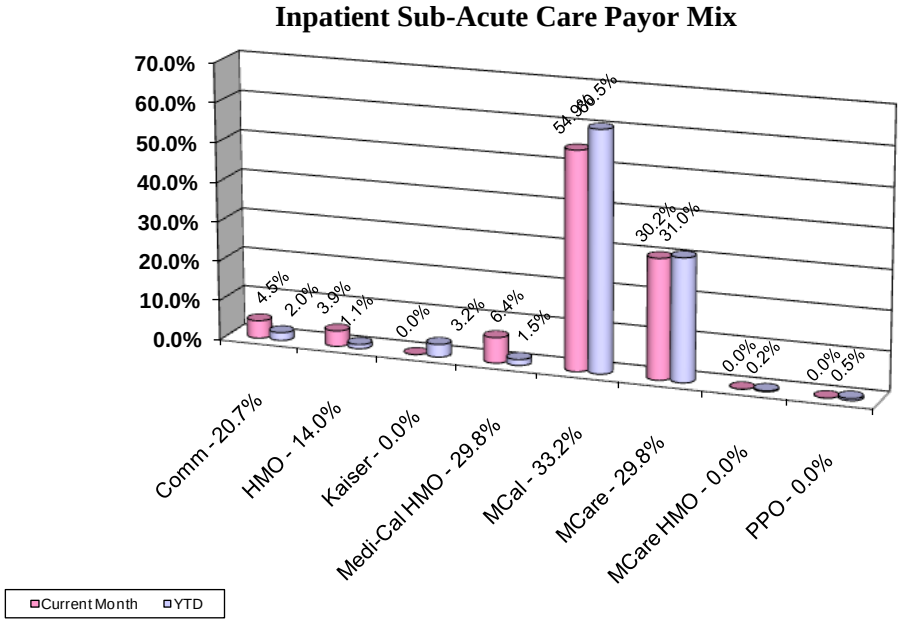
Inpatient Acute Care Payor Mix



The outpatient gross revenue payor mix for April was comprised of 43.2% Medicare and Medicare Advantage, 36.2% HMO/PPO, 9.9% Medi-Cal and Medi-Cal HMO, and 7.9% self pay. The graph on the following page shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

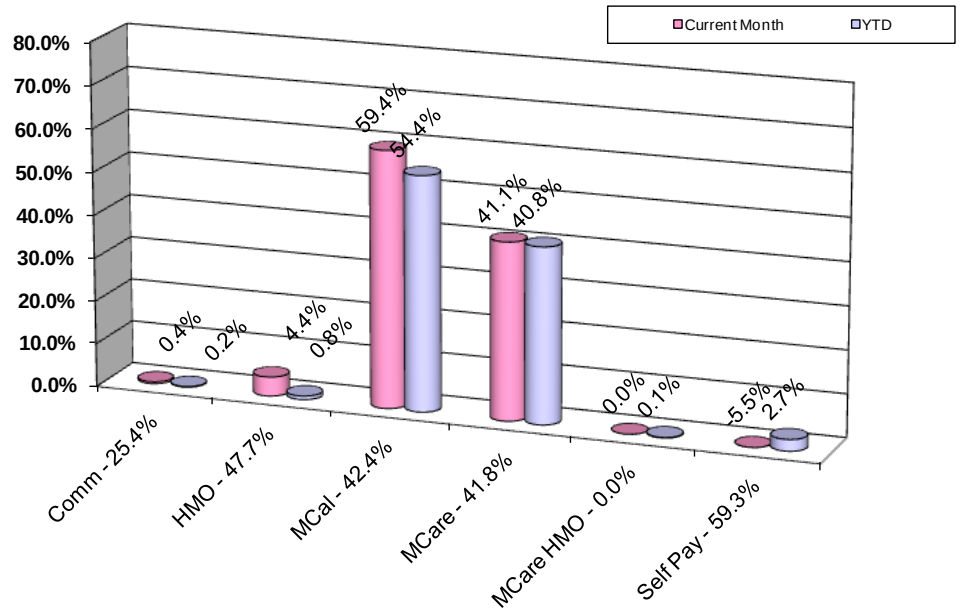


In April, the Sub-Acute care program again was dominated by Medi-Cal utilization of 54.9% versus 58.4% in March. The graph on the following page shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.



In April, the Skilled Nursing program was again comprised primarily of Medi-Cal at 59.4% and Medicare at 41.1%. The graph below shows the current month and fiscal year to date skilled nursing payor mix and the current months estimated level of reimbursement for each payor.

Inpatient Skilled Nursing Payor Mix



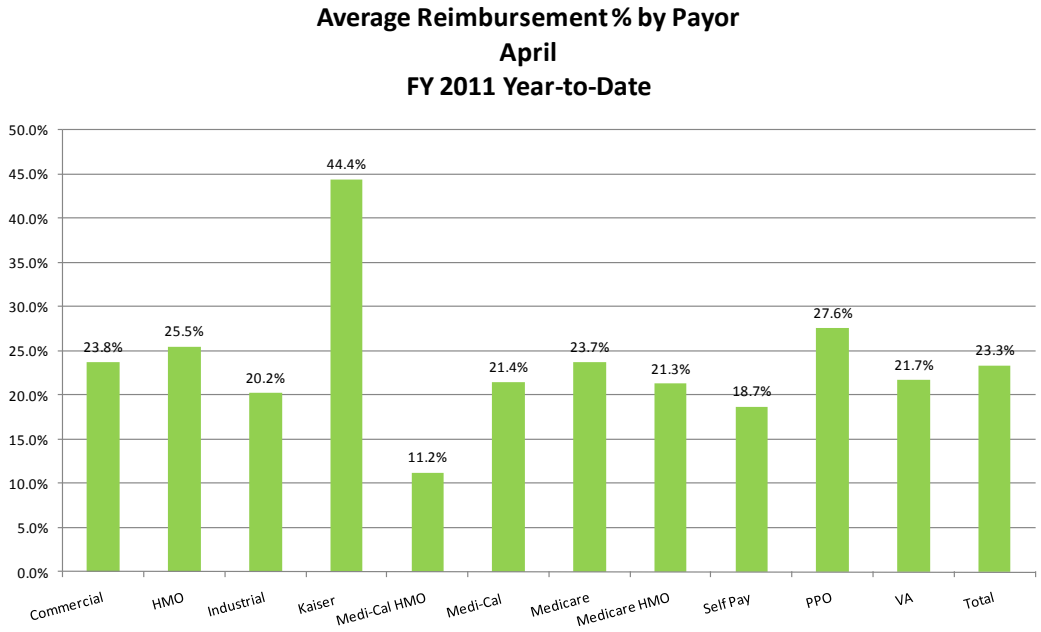
Deductions from Revenue

Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross. In the month of April contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 80.3% versus the budgeted 75.8%. A major factor causing the increase in this percentage was the inclusion of a cost report settlement for FY 2009 in the amount of $642,000. This settlement was the result of the State of California's inclusion of reductions to allowable costs resulting from the implementation of AB 5 and AB 1183.

Net Patient Service Revenue

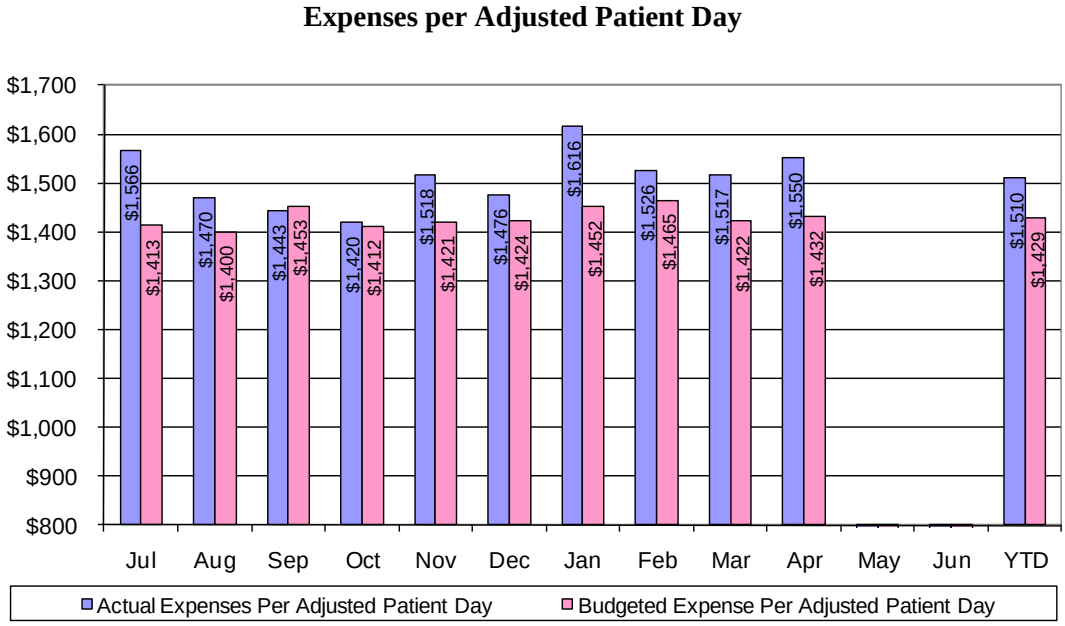
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. In addition, included in the year to date net patient service revenue are the estimated amounts to be received from participation in the State of California's FY 2011 Intergovernmental Transfer (IGT) Program, $180,000 per month and $1,083,000 for the six month ended December 31, 2010. As a result of the inclusion of all forty-six (46) California district hospitals in the fiscal year 2011 IGT program and finalization of amounts that will be received by each of these Hospitals an additional reduction of $102,000 will be included each month over the remainder of fiscal year 2011. This reduction will result in an adjusted amount to be received of $776,000 for fiscal year 2011. It is anticipated that this amount will be received before June 30, 2011.

The graph below on the following page shows the level of reimbursement that the Hospital has estimated for fiscal year 2011 by major payor category.



Total Operating Expenses

Total operating expenses were less than the fixed budget by $20,000 or 0.4%. On an adjusted patient day basis, our cost per adjusted patient day was $1,551 which was $118 per adjusted patient day unfavorable to budget. This variance in expenses per adjusted patient day was primarily the result of an unfavorable variance in salaries and temporary agency costs of $104 per adjusted patient day. The graph below shows the actual hospital operating expenses on an adjusted patient day basis for the 2011 fiscal year by month as compared to budget and is followed by explanations of the significant areas of variance that were experienced in the current month.

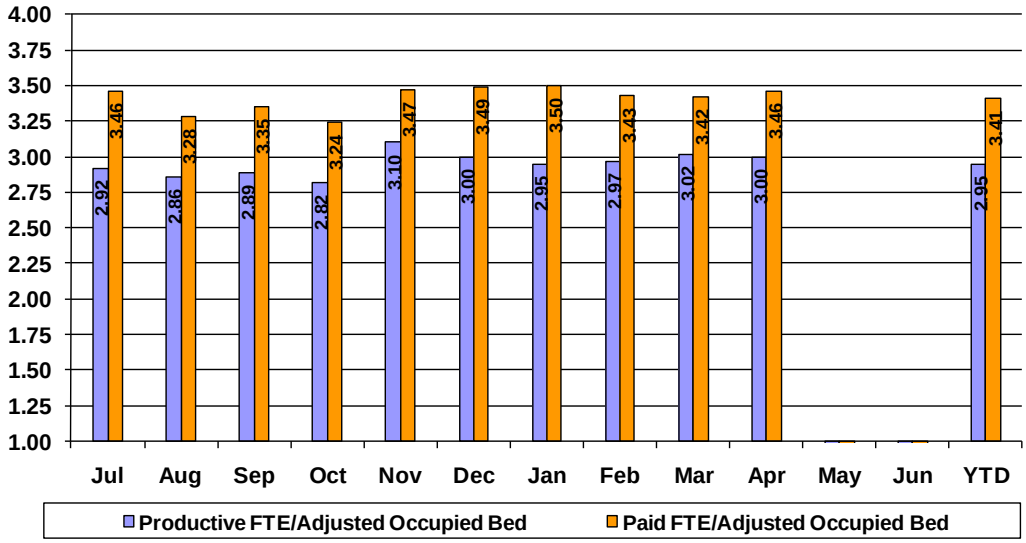


Salary and Temporary Agency Expenses

Salary and temporary agency costs combined were unfavorable to the fixed budget by $143,000 and were unfavorable to budgeted levels on a per adjusted patient day basis by $104 or 20.7%. This unfavorable variance

was the result of unfavorable variances in salary costs of $98,000 and greater than budgeted temporary agency utilization in several hospital departments of $45,000. On an adjusted occupied bed basis, productive FTE's were unfavorable to budget by 7.5% at 3.04 FTE's versus the budgeted 2.83 FTE's. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2011 by month.

FTE's per Adjusted Occupied Bed



Benefits

Benefits were favorable to the fixed budget by $24,000 or 2.6%. This favorable variance was primarily the result of lower than budget workers compensation insurance costs of $25,000.

Supplies

Supplies were favorable to budget by $64,000 or $3 per adjusted patient day in April. This favorable variance was the result of lower than budgeted medical supplies expense of $50,000 and non-medical supplies expense of $13,000. The favorable medical supplies expense was primarily the result of lower than budgeted expenses for infusion therapy medications.

Purchased Services

Purchased services were favorable to budget by $65,000 or $10 per adjusted patient day for the month. This favorable variance was primarily the result of lower than budgeted purchased medical services related to adjustments to our contract for MRI services which will lower our monthly expense by $3,000 per month and was retroactive back to February 2011 ($13,000) and other purchased services ($45,000) and was the result of the adjustment of accrued liabilities for unemployment insurance costs that had been over accrued during the course of the fiscal year.

Rents and Leases

Rents and leases were $25,000 favorable to the fixed budget and $4 per adjusted patient day favorable to budget for the month of April. This favorable variance was primarily the result of lower than budgeted rental expense related to the PACS and Digital Radiology upgrade project ($21,000). This project will not be completed until the end of the third quarter of calendar 2011 due to Office of Statewide Health Planning delays.

Other Operating Expenses

Other operating expenses were greater than budgeted by $35,000. This unfavorable variance was the result of several factors including the following:

- Recruitment expenses exceeded budget by $14,000 as a result of a recruitment of a staff member into the Information Technology department that will support various Meditech applications.
- The other expense category exceeded budget by $20,000 as a result of a correction to materials inventory that was incorrectly increased in March. The correction recorded in April, adjusted this inventory account to its proper value.

Action Items

The management team has implemented several initiatives to respond to the unfavorable financial performance. In addition, there are many initiatives that are in process and will be implemented over the next months. Most of these initiatives are also part of the Fiscal Year 2012 budget that will be presented separately.

Initiatives that have been implemented include:

- We have implemented mandatory closure of most support departments on eight major holidays as well as two "non-holiday" closure days during the next fiscal year (beginning Memorial Day 2011). Essential support departments will staff at core staffing levels on these days. Productive salary cost savings are estimated to be $59,000 per year for the two days.

- Mandatory furlough days for the months of June, July and August will be implemented. All non nursing employees will be required to take one PTO or non paid day off per pay period during this period when patient activity is typically slower. Savings are estimated to be $59,000 per month in productive salary expense during these three months.

- Elimination of outside consulting services from Robert Half and Jacobus who provided support for the EMR implementation and IT department ($68,000 - $80,000 per month). While this will not have an impact on the monthly Statement of Revenues and Expenses this will help with our cash flow.

- Reduction in the use of approximately 8.4 Certified Nursing Assistants (CNA's) on nursing units resulting in savings of $30,000 per month, while still complying with state staffing guidelines.

- Negotiation of a new service agreement with Alliance Imaging who provides mobile MRI service, resulting in a reduction in fees of $4,000 per month.

- Reduction in scope of service and coverage limits for GE Biomedical Service support, resulting in an expense reduction of about $4,100 per month.

- Reduced stacked parking service to 11:00 am to 4:00 pm. Monthly savings are $3,000 (60 day notice given).

- Reduced security guard coverage to night shift only, seven days a week resulting in savings of $6,250 per month.

- Memberships deemed to not be of a benefit to the ongoing operations of the organization will be cancelled or not renewed. These include memberships with: Aging Services of California, Association of California Hospital Districts, Advisory Board and the Governance Institute for monthly savings of $6,250. Some of the annual fees for these memberships have been prepaid and as such savings will be realized over the next fiscal year.

The annual impact of the above cost reduction initiatives that will affect the Statement of Revenues and Expenses is about $879,000 per year or an average of $73,266 per month, plus $445,000 cash flow savings associated with the discontinuation of the IT consulting firms.

Initiatives that are in process:

- Expansion of the number of sub acute beds by twelve beds. A letter has been sent to representatives at the California Department of Health Services expressing our interest and the need to expand sub acute capacity at Alameda Hospital. In addition, a meeting is scheduled for May 31st with medical staff and clinical staff leadership to discuss this potential opportunity.

- Management, together with representatives from the California Hospital Association, have spoken with regional representatives from CMS, and will be meeting with CMS in Baltimore MD on June 2nd, to provide information and data to support the rejection of the State's request under AB 97 (Medi-Cal D/P SNF & Sub Acute reimbursement reductions).

- Proposal to terminate our inpatient Medi-Cal contract.

- Progressive steps to expand our operational presence in skilled nursing within the District.

- Many other operational and staffing changes that are part of the FY 2012 Operating.

The following pages include the detailed financial statements for the ten (10) months ended April 30, 2011, of fiscal year 2011.

ALAMEDA HOSPITAL
KEY STATISTICS
APRIL 2011

	ACTUAL APRIL 2011	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	APRIL 2010	YTD APRIL 2011	YTD FIXED BUDGET	VARIANCE	%	YTD APRIL 2010
Discharges:										
Total Acute	211	228	(17)	-7.5%	217	2,093	2,374	(281)	-11.8%	2,386
Total Sub-Acute	1	1	-	0.0%	1	19	15	4	26.7%	12
Total Skilled Nursing	14	12	2	16.7%	6	93	122	(29)	-23.8%	102
	226	241	(15)	-6.2%	224	2,205	2,511	(306)	-12.2%	2,500
Patient Days:										
Total Acute	825	863	(38)	-4.4%	836	8,899	8,947	(48)	-0.5%	8,963
Total Sub-Acute	971	1,005	(34)	-3.4%	1,018	9,917	10,184	(267)	-2.6%	10,145
Total Skilled Nursing	629	690	(61)	-8.8%	690	6,634	6,992	(358)	-5.1%	6,428
	2,425	2,558	(133)	-5.2%	2,544	25,450	26,123	(673)	-2.6%	25,536
Average Length of Stay										
Total Acute	3.91	3.79	0.12	3.3%	3.85	4.25	3.77	0.48	12.8%	3.76
Average Daily Census										
Total Acute	27.50	28.77	(1.27)	-4.4%	27.87	29.27	29.43	(0.16)	-0.5%	29.48
Total Sub-Acute	32.37	33.50	(1.13)	-3.4%	33.93	32.62	33.50	(0.88)	-2.6%	33.37
Total Skilled Nursing	20.97	23.00	(2.03)	-8.8%	23.00	21.82	23.00	(1.18)	-5.1%	21.14
	80.83	85.27	(4.43)	-5.2%	84.80	83.72	85.93	(1.04)	-1.2%	84.00
Emergency Room Visits	1,382	1,470	(88)	-6.0%	1,402	14,022	14,899	(877)	-5.9%	14,792
Outpatient Registrations	1,996	2,289	(293)	-12.8%	1,954	19,877	22,271	(2,394)	-10.7%	25,032
Surgery Cases:										
Inpatient	41	43	(2)	-4.7%	44	442	493	(51)	-10.3%	585
Outpatient	161	139	22	15.8%	148	1,405	1,409	(4)	-0.3%	3,986
	202	182	20	11.0%	192	1,847	1,902	(55)	-2.9%	4,571
Kaiser Inpatient Cases	-	-	-	-	-	-	-	-	-	91
Kaiser Eye Cases	-	-	-	-	-	-	-	-	-	1,461
Kaiser Outpatient Cases	-	-	-	-	-	-	-	-	-	1,417
Total Kaiser Cases	-	-	-	-	-	-	-	-	-	2,969
% Kaiser Cases	0.0%	0.0%			0.0%	0.0%	0.0%			65.0%
Adjusted Occupied Bed	120.18	130.29	10.11	7.8%	124.98	124.24	120.64	3.60	3.0%	144.70
Productive FTE	365.20	368.40	3.20	0.9%	369.56	368.33	367.65	(0.68)	-0.2%	391.46
Total FTE	421.72	419.35	(2.37)	-0.6%	426.03	425.11	418.35	(6.76)	-1.6%	447.28
Productive FTE/Adj. Occ. Bed	3.04	2.83	(0.21)	-7.5%	2.96	2.96	3.05	0.08	2.7%	2.71
Total FTE/ Adj. Occ. Bed	3.51	3.22	(0.29)	-9.0%	3.41	3.42	3.47	0.05	1.3%	3.09

City of Alameda Health Care District
Statements of Financial Position
April 30, 2011

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 2,423,796	$ 1,756,993	$ 3,480,668
Patient Accounts Receivable, net	9,656,474	10,092,275	9,558,147
Other Receivables	2,164,043	4,406,065	6,654,035
Third-Party Payer Settlement Receivables	604,885	581,670	374,557
Inventories	1,157,875	1,158,531	1,149,706
Prepaids and Other	295,478	393,075	453,872
Total Current Assets	16,302,551	18,388,609	21,670,985
Assets Limited as to Use, net	579,225	567,899	476,630
Property, Plant and Equipment, net	8,027,889	7,813,368	6,993,735
Total Assets	**$ 24,909,665**	**$ 26,769,876**	**$ 29,141,350**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 416,000	$ 416,000	$ 450,831
Accounts Payable and Accrued Expenses	7,198,801	6,948,676	6,112,296
Payroll Related Accruals	4,259,003	5,109,484	4,351,133
Deferred Revenue	956,656	1,434,503	5,736,951
Employee Health Related Accruals	554,371	554,371	645,750
Third-Party Payer Settlement Payable	999,297	357,474	500,000
Total Current Liabilities	14,384,128	14,820,508	17,796,961
Long Term Debt, net	894,001	931,024	1,236,831
Total Liabilities	15,278,129	15,751,532	19,033,792
Net Assets:			
Unrestricted	8,924,735	10,322,869	9,560,928
Temporarily Restricted	706,801	695,475	546,630
Total Net Assets	9,631,536	11,018,344	10,107,558
Total Liabilities and Net Assets	**$ 24,909,665**	**$ 26,769,876**	**$ 29,141,350**

City of Alameda Health Care District

Statements of Operations

April 30, 2011

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,425	2,558	(133)	-5.2%	2,544	25,450	26,123	(673)	-2.6%	25,536
Discharges	226	242	(16)	-6.6%	224	2,205	2,510	(305)	-12.2%	2,499
ALOS (Average Length of Stay)	10.73	10.57	0.16	1.5%	11.36	11.54	10.41	1.13	10.9%	10.22
ADC (Average Daily Census)	80.8	85.3	(4.43)	-5.2%	84.8	84	85.9	(2.21)	-2.6%	84.0
CMI (Case Mix Index)	1.1636				1.3926	1.3524				1.3266
Revenues										
Gross Inpatient Revenues	$ 12,561	$ 13,582	$ (1,021)	-7.5%	$ 13,509	$ 138,884	$ 140,554	$ (1,671)	-1.2%	$ 139,323
Gross Outpatient Revenues	6,379	7,486	(1,106)	-14.8%	6,384	67,462	72,030	(4,567)	-6.3%	100,604
Total Gross Revenues	18,940	21,067	(2,127)	-10.1%	19,894	206,346	212,584	(6,238)	-2.9%	239,926
Contractual Deductions	14,463	15,220	757	5.0%	14,327	148,620	152,942	4,322	2.8%	178,277
Bad Debts	707	617	(90)	-14.6%	437	6,551	6,333	(218)	-3.4%	5,256
Charity and Other Adjustments	35	154	120	77.6%	112	1,481	1,584	103	6.5%	639
Net Patient Revenues	3,737	5,077	(1,340)	-26.4%	5,018	49,693	51,726	(2,032)	-3.9%	55,753
Net Patient Revenue %	19.7%	24.1%			25.2%	24.1%	24.3%			23.2%
Net Clinic Revenue	36	28	8	28.4%	17	339	279	60	21.4%	111
Other Operating Revenue	11	14	(3)	-19.5%	(3)	102	138	(36)	-26.1%	417
Net Assets Released	-	-	-	0.0%	-	-	-	-	0.0%	-
Total Revenues	**3,784**	**5,118**	**(1,335)**	-26.1%	**5,031**	**50,134**	**52,143**	**(2,009)**	-3.9%	**56,282**
Expenses										
Salaries	2,891	2,792	(98)	-3.5%	2,903	29,647	28,216	(1,431)	-5.1%	31,408
Temporary Agency	211	167	(45)	-26.7%	168	2,087	1,714	(373)	-21.8%	1,719
Benefits	897	921	24	2.6%	927	8,152	8,906	754	8.5%	9,453
Professional Fees	354	371	17	4.6%	248	3,069	3,317	248	7.5%	2,935
Supplies	616	679	64	9.4%	768	7,205	6,973	(232)	-3.3%	8,455
Purchased Services	326	391	65	16.7%	383	3,657	3,883	227	5.8%	3,866
Rents and Leases	85	110	25	22.6%	96	702	853	151	17.7%	714
Utilities and Telephone	64	71	7	9.2%	73	630	717	87	12.1%	709
Insurance	33	36	3	7.0%	45	318	358	40	11.1%	444
Depreciation and amortization	79	73	(6)	-8.2%	78	798	730	(67)	-9.2%	974
Other Opertaing Expenses	115	80	(35)	-43.1%	78	878	817	(61)	-7.5%	808
Total Expenses	**5,670**	**5,691**	**20**	0.4%	**5,767**	**57,142**	**56,484**	**(658)**	-1.2%	**61,486**
Operating gain (loss)	**(1,887)**	**(572)**	**(1,314)**	-229.6%	**(736)**	**(7,008)**	**(4,341)**	**(2,667)**	61.4%	**(5,204)**
Non-Operating Income / (Expense)										
Parcel Taxes	482	479	3	0.6%	478	4,789	4,795	(7)	-0.1%	4,792
Investment Income	1	-	1	0.0%	2	10	-	10	0.0%	22
Interest Expense	(16)	(8)	(8)	-99.3%	(8)	(96)	(109)	12	-11.3%	(84)
Other Income / (Expense)	22	22	(1)	-2.9%	23	1,670	222	1,448	652.7%	228
Net Non-Operating Income / (Expense)	**488**	**493**	**(5)**	**-1.0%**	**496**	**6,372**	**4,908**	**1,464**	**29.8%**	**4,959**
Excess of Revenues Over Expenses	**$ (1,398)**	**$ (79)**	**$ (1,319)**	**1666.8%**	**$ (240)**	**$ (636)**	**$ 567**	**$ (1,203)**	**-212.2%**	**$ (245)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

April 30, 2011

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,435	$ 3,423	$ 12	0.4%	$ 3,606	$ 3,673	$ 3,557	$ 116	3.2%	$ 3,168
Gross Outpatient Revenues	1,745	1,887	(142)	-7.5%	1,704	1,784	1,823	(39)	-2.1%	2,288
Total Gross Revenues	5,180	5,310	(130)	-2.4%	5,310	5,457	5,380	77	1.4%	5,456
Contractual Deductions	3,955	3,836	(119)	-3.1%	3,824	3,930	3,871	(60)	-1.5%	4,054
Bad Debts	193	155	(38)	-24.3%	117	173	160	(13)	-8.1%	120
Charity and Other Adjustments	9	39	29	75.7%	30	39	40	1	2.3%	15
Net Patient Revenues	1,022	1,279	(258)	-20.1%	1,339	1,314	1,309	5	0.4%	1,268
Net Patient Revenue %	19.7%	24.1%			25.2%	24.1%	24.3%			23.2%
Net Clinic Revenue	10	7	3	39.3%	4	9	7	2	26.8%	3
Other Operating Revenue	3	3	(0)	-12.7%	(1)	3	4	(1)	-22.8%	9
Total Revenues	**1,035**	**1,290**	**(255)**	-19.8%	**1,343**	**1,326**	**1,320**	**6**	0.5%	**1,280**
Expenses										
Salaries	791	704	(87)	-12.3%	775	784	714	(70)	-9.8%	714
Temporary Agency	58	42	(16)	-37.5%	45	55	43	(12)	-27.2%	39
Benefits	245	232	(13)	-5.7%	248	216	225	10	4.4%	215
Professional Fees	97	93	(3)	-3.6%	66	81	84	3	3.3%	67
Supplies	168	171	3	1.7%	205	191	176	(14)	-8.0%	192
Purchased Services	89	99	10	9.6%	102	97	98	2	1.6%	88
Rents and Leases	23	28	4	16.0%	26	19	22	3	14.0%	16
Utilities and Telephone	18	18	0	1.5%	19	17	18	1	8.2%	16
Insurance	9	9	(0)	-0.9%	12	8	9	1	7.1%	10
Depreciation and Amortization	22	18	(3)	-17.4%	21	21	18	(3)	-14.1%	22
Other Operating Expenses	31	20	(11)	-55.3%	21	23	21	(3)	-12.3%	18
Total Expenses	**1,551**	**1,434**	**(116)**	-8.1%	**1,540**	**1,511**	**1,430**	**(82)**	-5.7%	**1,398**
Operating Gain / (Loss)	**(516)**	**(144)**	**(372)**	-257.7%	**(197)**	**(185)**	**(110)**	**(75)**	68.8%	**(118)**
Non-Operating Income / (Expense)										
Parcel Taxes	132	121	11	9.2%	128	127	121	5	4.3%	109
Investment Income	0	-	0	0.0%	1	0	-	0	0.0%	1
Interest Expense	(4)	(2)	(2)	-116.3%	(2)	(3)	(3)	0	-7.3%	(2)
Other Income / (Expense)	6	6	0	5.4%	6	44	6	39	686.5%	5
Net Non-Operating Income / (Expense)	**134**	**124**	**9**	**7.5%**	**132**	**169**	**124**	**44**	**35.6%**	**113**
Excess of Revenues Over Expenses	**$ (382)**	**$ (20)**	**$ (362)**	1817.2%	**$ (64)**	**$ (17)**	**$ 15**	**$ (31)**	-213.6%	**$ (5)**

City of Alameda Health Care District
Statement of Cash Flows
For the Ten Months Ended April 30, 2011

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ (1,398,134)	$ (636,192)
Items not requiring the use of cash:		
Depreciation and amortization	78,661	$ 797,810
Write-off of Kaiser liability	-	$ (1,451,597)
Changes in certain assets and liabilities:		
Patient accounts receivable, net	435,801	(98,327)
Other Receivables	2,242,022	4,489,992
Third-Party Payer Settlements Receivable	618,608	268,969
Inventories	656	(8,169)
Prepaids and Other	97,597	158,394
Accounts payable and accrued liabilities	250,125	2,538,102
Payroll Related Accruals	(850,481)	(92,130)
Employee Health Plan Accruals	-	(91,379)
Deferred Revenues	(477,847)	(4,780,295)
Cash provided by (used in) operating activities	997,008	1,095,178
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(11,326)	(102,595)
Additions to Property, Plant and Equipment	(293,182)	(1,831,964)
Other	(0)	(1)
Cash provided by (used in) investing activities	(304,508)	(1,934,560)
Cash flows from financing activities		
Net Change in Long-Term Debt	(37,023)	(377,661)
Net Change in Restricted Funds	11,326	160,171
Cash provided by (used in) financing and fundraising activities	(25,697)	(217,490)
Net increase (decrease) in cash and cash equivalents	666,803	(1,056,872)
Cash and cash equivalents at beginning of period	1,756,993	3,480,668
Cash and cash equivalents at end of period	$ 2,423,796	$ 2,423,796

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: June 6, 2011

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

FROM: Kerry Easthope, Association Administrator
Phyllis J. Weiss, Director of Human Resources

SUBJECT: Approval of Side Letter Agreement with SEIU UHW-West Regarding Accumulation of Seniority

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Recommendation:

To adopt and approve the Side Letter Agreement streamlining the language regarding "seniority" in the SEIU UHW-West Memorandum of Understanding (MOU).

Background:

The SEIU UHW-West MOU contains language that carves out time spent in a "Per Diem" position from the time accumulated towards "seniority". Seniority application occurs in several instances, some of which are:

- The order in which vacations are granted
- The order in which positions are granted for internal bid
- The order in which daily cancellations occur (during low census days)
- The order in which employees are laid off from their positions

However, prior to now, the Hospital historically used an employees' date of hire" in the Nursing Department synonymously with their "seniority date".

The Hospital is now moving forward to right-size the number of Certified Nursing Assistants (C.N.A.s) on each unit which will result in a layoff of some, less senior, C.N.A.s.

When HR produced a seniority list reflecting accumulated seniority which was calculated in compliance with the language in the MOU (carving out Per Diem time), the members requested the Hospital to consider by-passing the language in the MOU and instead sign a Side Letter Agreement reflecting the members' wish to continue to have seniority and date of hire be used synonymously for all purposes in the MOU.

HR then conducted clarification meetings with the Union and a select group of their members in order to assure mutual understanding of the impact on all parts of the MOU referring to seniority.

The Union then held a ratification vote on **June 1, 2011** and it was voted affirmatively by the members.

Discussion:

Since this process reduced the amount of work required of the Hospital to produce a seniority list and since "seniority" is a product of the Union's desires (not the Hospital's), recognizing an employee's date of hire as their seniority date is less cumbersome and in keeping with past practice at Alameda Hospital.

SECTION 8. SENIORITY

A. Definitions:

1. Unless otherwise specified, seniority shall commence on the most recent date of continuous employment **in an SEIU-UHW bargaining unit position** with the Hospital ~~as~~ **for** a full-time employee or regular part-time employee or short-hour employee and shall mean total continuous service with the Hospital thereafter; provided that seniority shall have no application during the first thirty (30) days of continuous employment.

(a) A casual employee's seniority is determined by his/her most recent date of employment. A casual employee cannot exercise seniority against a full time or part time or short hour employee. Casual employees have seniority only among themselves.

~~(a)~~ **(b) Seniority will not change when an employee reclassifies.** If a full-time, part-time or short-hour employee is reclassified to casual, that employee ~~shall not continue to accrue seniority and the seniority that employee has previously accumulated shall have no application until such time the employee is reclassified to a fulltime, part-time or short-hour status~~ **will retain their seniority and will only have seniority among other casual employees. If a casual employee is reclassified to or successfully bids into a full-time, part-time or short-hour position, that employee will retain their seniority.**

(c) Employees will only lose their seniority according to provisions in Section 8. I.

2. An anniversary date will be established for employees whose seniority date is adjusted according to provisions in Section 16. G. The anniversary date will be used in place of the employee's seniority.

Side Letter of Agreement

The Union and Hospital tentatively agrees to and will enter into this side letter agreement upon a majority ratification of the SEIU-UHW bargaining unit. The agreement is to improve the existing seniority language to help facilitate better compliance and understanding of the MOU. The new language may be revisited and re-bargained in the 2012 MOU re-opener.

The new language agreed to is:

SECTION 8. SENIORITY

A. Definitions:

1. Unless otherwise specified, seniority shall commence on the most recent date of continuous employment in an SEIU-UHW bargaining unit position with the Hospital for a full-time employee or regular part-time employee or short-hour employee and shall mean total continuous service with the Hospital thereafter; provided that seniority shall have no application during the first thirty (30) days of continuous employment.

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_____ _____

SEIU-UHW West Date

_____ _____

Kerry Easthope, Associate Administrator Date

_____ _____

Phyllis J. Weiss, Director, Human Resources Dept. Date

Side Letter of Agreement

The Union and Hospital tentatively agrees to and will enter into this side letter agreement upon a majority ratification of the SEIU-UHW bargaining unit. The agreement is to improve the existing seniority language to help facilitate better compliance and understanding of the MOU. The new language may be revisited and re-bargained in the 2012 MOU re-opener.

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   (b) Seniority will not change when an employee reclassifies. If a full-time, part-time or short-hour employee is reclassified to casual, that employee will retain their seniority and will only have seniority among other casual employees. If a casual employee is reclassified to or successfully bids into a full-time, part-time or short-hour position, that employee will retain their seniority.

   (c) Employees will only lose their seniority according to provisions in Section 8. I.

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SEIU-UHW West	5/24/11 Date
Kerry Easthope, Associate Administrator	5/23/11 Date
Phyllis J. Weiss, Director, Human Resources Dept.	5/23/11 Date

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: June 6, 2011

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

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Approval of Revised FY 2012 Goals and Objectives

Based on feedback from the discussions at the May Board of Directors meeting, attached are revised FY 2012 Goals and Objectives. Changes are highlighted in red. The document is presented to the Board of Directors for approval.

May 9, 2011

City of Alameda Health Care District

2009-2013 Goals and Objectives

FY~~E~~ 2012 Update

Financial Strength	
Achieve long-term financial viability	
Measures of success:	
■ Achievement of positive operating margin = 3% of net revenues by 2013	
■ Generate operating profitability levels necessary to support capital needs/service debt	
■ Raise $500,000 per year through Foundation fundraising initiatives	
■ Shift reliance on parcel tax from support of operations to support for capital investments and strategic development projects	
■ Sustain Performance vis-à-vis operating benchmarks at 90th percentile levels (e.g., FTE/Adj. Occupied Bed, Length of Stay, Costs per UOS)	
Initiatives	**Status**
(A) STRATEGY: Seek $250,000 contribution from Alameda County to assist with capital improvements of clinic space at Marina Village designed to serve low income patients	
(B) STRATEGY: Seek $1 million from Alameda County to underwrite uncompensated care delivered in Alameda Hospital Emergency Department	
(C) STRATEGY: Improve Revenue Cycle Metrics *	
1. Reduce Gross Days in Accounts Receivable, excluding unbilled by 5% to 47.1 days from the current 49.6 days (4th Qtr HARA Report indicated the National Average at 49.4 days).	
2. Reduce volume of late charges as a percentage of gross charges (posted after bill drop) by 10%. (Current baseline: 0.9% for the last 4 months)	
3. Increase percentage of AR less 60 days to 65% from current 60%	
4. Achieve Reimbursement in compliance with contract terms to ~~____% (TBD)~~ 90%	
5. Reduce percentage of self pay ~~to ____% (TBD)~~ by 10%	
(D) STRATEGY: Improve aggregate HCAHPS scores (willingness to recommend) to 66%	
(E) STRATEGY: Reduce readmission rates from 29% to 26% by the end of FY 2012	
(F) STRATEGY: ~~Convert 30% of~~Establish appropriate target ratio of Inpatient Admission: Observation of patients ~~to inpatient status~~ with assistance of Executive Healthcare Resources by December 2011.	

*Revenue cycle metrics will be reassessed following completion of HFS Revenue Cycle Analysis.	
Growth	
Pursue fiscally responsible growth in services that target the most pressing acute and non-acute healthcare needs of the community.	
Measures of success:	
■ Market share growth. ■ From 31.25 percent to 35.0 percent – Alameda Island (ZIP Codes 94501 and 94502). ■ From 0.94 percent to 1.10 percent - Off-Island.	
■ Service line growth: volume targets defined by service line.	
■ Development of new access points and locations.	
■ Increase inpatient census by 5 ADC by 2013 to offset loss of Kaiser revenue and to support basic INP/ER infrastructure.	
Initiatives	**Status**
(A) STRATEGY: Secure partnership with one additional long-term care facility within the District	
(B) STRATEGY: Complete implementation of Wound Care Program, achieving volumes (IP and OP) services as projected in pro forma	
1. For 6 months of FY 2012: 125 patients, 1,250 patient visits, $26,000 Net Income	
(C) STRATEGY: Implement one new surgical program reflecting an integrated continuum of services from pre-surgical to post surgical care. Programs to be considered include orthopedics and plastic surgery. This should contribute to the 5 % increase in surgeries.	
(D) STRATEGY: Increase selective higher outpatient services by the following:	
1. Diagnostic Imaging – 2% Increase	
2. Therapy: 5% Increase	
3. Surgery: 5% Increase	
(E) STRATEGY: Increase admissions from nursing homes from 22% (baseline) to 24% through improved transfer systems and quarterly communication with nursing home leadership	

Facilities and Technology	
Enhance our facility and technological capabilities to foster the achievement of our goals.	
Measures of success:	
■ Percentage of physicians who sign up for electronic access.	
■ Volume of hits to hospital website.	
■ Fund depreciation to TBD% in order to create capital reserve fund .	
Initiatives	Status
(A) STRATEGY: Develop master facility plan for Marina Village Space	
(B) STRATEGY: Improve HCAHPS scores for cleanliness of facility to 67.5% (quarterly average)	
(C) STRATEGY: Improve signage and way-finding systems in the following areas to improve image and reduce traffic through inpatient areas. Incorporate Bilingual signage where appropriate.	
1. South Shore Skilled Nursing Unit	
2. Alameda Towne Centre Medical Office Building	
3. East Building (Clinton and Doctor's parking lot entrance)	
(D) STRATEGY: Implement ECHO System upgrade	
(E) STRATEGY: Finalize scope and budget for implementation of required NPC-2 work. Meet reporting milestones for seismic extension provided by SB90	
(F) STRATEGY: Evaluate all Meditech modules which are currently being underutilized (ESS, PCS, EDM), making appropriate recommendations, if any, that should be activated.	
(G) STRATEGY: Evaluate formation of a dedicated surgical inpatient unit as mechanism to enhance quality of patient care and to increase surgical volume	
(H) STRATEGY: Explore use of Hospital website for improved patient accessibility and access to information, including online registration and appointment scheduling.	

(I) STRATEGY: Complete 3 year schedule, key milestones, budget and impact on cash flow of progression to full meaningful use no later than October 2011.
(J) STRATEGY: Define alternative plan for reducing manual labor necessary to capture payroll information (in wake of discontinuing McKesson Project) by September 2011.

Physicians	
Ensure that the Hospital attracts qualified and capable physicians through collaboration and alignment.	
Measures of success:	
■ Increase number and reduce average age of active physicians through targeted recruitment.	
■ Achieve annual recruitment goals.	
■ Increase volume of work by Alameda surgeons.	
Initiatives	**Status**
(A) STRATEGY: Continue to strengthen partnerships with key physician groups (Affinity, ABMG, Hill, AFP) to secure referral patterns, improve patient management, and coordinate approach to health plans.	
1. Develop quarterly system to track volume originating from each major group affiliation.	
~~1.~~2. Enhanced use of long term care placement to reduce acute care utilization	
~~2.~~3. Coordinated management of patients with chronic disease (e.g. CHF, Diabetes)	
~~3.~~4. Quarterly meetings	
(B) STRATEGY: Complete an inventory of physician practice based information systems and establish plan for gradual implementation of connectivity with MediTech system	
(C) STRATEGY: Establish data collection system for tracking admission and referral patterns by physician and/or institution (e.g. SNF's) or point of entry (e.g. Emergency Department	
(D) STRATEGY: Track utilization under new contracts (e.g. Alameda Alliance, Medi-Cal, Blue and Gold Plan, etc)	
(E) STRATEGY: Complete first physician satisfaction survey by 4th quarter of FY 2012	
(F) STRATEGY: Maintain regular contact with East Bay physicians who are seeking practice setting alternatives other than those offered by existing large multispecialty groups.	

(G) STRATEGY:	~~Complete evaluation of outsourcing management of 1206 (B) clinic to practice management company~~Develop metrics to evaluate practive efficiency, including target utilization, revenue collection, and patient satisfaction for 1206 (b) clinic; Based on baseline results evaluate outsourcing clinic management to practice management company.

Quality/Service	
Achieve superior clinical and service results on a consistent basis.	
Measures of success:	
■ Patient satisfaction (patient experience) as measured by 95% or more willing to recommend hospital to a friend	
■ Joint Commission Core Measure compliance	
■ Joint Commission/CMS/CDPH Accreditation	
■ QI/Risk Reports that demonstrate improvement in problem areas	
■ Improve accuracy of information collection at time of registration	
Initiatives	**Status**
(A) STRATEGY: Improve aggregate HCAHPS scores (willingness to recommend) to 66%. Current baseline:	
(B) STRATEGY: Redesign hospital website functionality as portal for patient service	
1. Evaluate on-line registration and appointment scheduling	
2. Add testimonials from patients and physicians	
3. Report key quality data on website	
4. Add key educational and instructional material for patients discharged or treated as outpatients	
(C) STRATEGY: Improve HCAHPS scores for cleanliness and noise and communication by 10%.	
(D) STRATEGY: All Core Measure scores above the 90th percentile	
(E) STRATEGY: Provide additional resources to patients upon discharge to raise awareness of hospital as broad health resource (e.g. Vial of Life, battery operated or crank radio or flash light, etc.)	
(F) STRATEGY: Complete The Joint Commission (TJC) certification process for Primary Stroke Program	
(G) STRATEGY: Implement childhood obesity prevention program in conjunction with schools (Let's Move Alameda)	

People	
Foster a culture of exemplary performance through recruitment and retention practices that are founded on adherence to core performance standards and the continual development and celebration of our employees.	
Measures of Success:	
■ Increase number of Staff Nurse III among nursing staff by 2 in FY 2010-11 and by 1 each year thereafter (4 SN III in FY 2010).	
■ Maintain employee vacancy rates below regional benchmarks.	
■ Develop and monitor employee satisfaction surveys.	
■ Turnover rates of ***15%*** or less (Q42009 = 3.58%).	
■ Less comments about non-English in the workplace.	
■ Annual performance evaluations include aggregate measurement of service excellence.	
Initiatives	**Status**
(A) STRATEGY: Establish annual master calendar of quarterly Town Hall Meetings with employees to communicate effectively and maintain employee confidence and inclusiveness	
(B) STRATEGY: Conduct quarterly update forums for medical staff at one of medical staff educational conferences	
(C) STRATEGY: In addition to maintaining ongoing annual events, consider increasing key employee morale building events that may include:	
1. Annual picnic for employees, medical staff, auxiliary and their families	
2. Administrative Hospital Rounding for all shifts / departments	
3. Weekend Pet parade	
4. Fall Pumpkin Carving contest	
(D) STRATEGY: Hold quarterly lunches with new employees (approximately 90 days after employment) and executive staff to communicate further and obtain input from new hires	

ALAMEDA HOSPITAL
FISCAL YEAR 2012
PROPOSED OPERATING BUDGET NARRATIVE

Prelude:

Attached is the Fiscal Year 2012 Alameda Hospital Operating Budget as prepared by hospital management. Upon approval by the City of Alameda Health Care District Board of Directors, this budget will constitute the spending authority for management for fiscal year 2012. Even though the City of Alameda Health Care District is a governmental agency, this budget should be considered a business plan and projection of what is anticipated for fiscal year 2012 rather than a fixed authority to spend.

The FY 2012 budget was particularly challenging to develop this year because, in addition to recent census and case mix aberrations, we have had to absorb a worst case projected Medi-Cal reimbursement reduction of approximately $2.1 million in long term care reimbursement as a result of AB 97. In addition, following the finalization of acute budget cuts between CHA and Governor Brown's staff, certain injunctions on rate reductions were lifted creating a liability of over $600,000 in State overpayments. While we have been able to negotiate a 24 month re-payment plan for that liability with the State the hospitals cash flow will be significantly impacted during FY 2012.

There are several strategic impact issues and initiatives that have not been built into the base FY 2012 operating budget. These issues and initiatives include:

- **Potential CMS rejection of the reimbursement reductions for distinct part skilled nursing (SNF) and Subacute services that were part of AB 97.** AB 97 was one of the enabling pieces of legislation passed to help balance the State of California budget in exchange for the extension of seismic deadlines and the decision to limit other reductions in acute reimbursement levels. Presently the proposed budget assumes that the reimbursement reductions outlined in AB 97 will be implemented. This amounts to a baseline reduction in net revenue for Alameda Hospital of approximately **$2.1 million**.

  Prior to implementation of the reduced rates, they must be approved by CMS based on a demonstration that they will not impact access to care for SNF and Subacute patients. In collaboration with CHA staff and four other hospitals CEO's, Deborah Stebbins has presented the impact of the reduction on our facility to the Regional CMS Administrator and his staff in early May. In addition, she will participate as a part of a delegation meeting with the federal CMS staff on June 2 in Baltimore. A strong case has been made that such a decision will be devastating to the availability of an adequate supply of Subacute and SNF beds. As a result of the former shortage we anticipate patients will

back up into longer stays in critical units resulting in higher health care costs to an already strained system. A serious crisis in finding placement for patients where units will close will occur. In the case of two of the hospitals meeting with CMS, including ourselves, we anticipate the longer term impact will threaten the continued operation of the entire hospital. In the case of a third hospital in the northeast region of the State, it will result in a closure of the only OB unit within a 1200 square mile area.

While we believe we are making a compelling case for serious negative consequences for access to care for a vulnerable population, the decision by CMS may not take place for several months. In the meantime, management feels the only prudent course of action is to anticipate that reimbursement for these programs will be at the reduced levels.

- **Acquisition of one or more large community based skilled nursing facilities within the District.**

We have had two recent promising meetings with local nursing home operators outlining our proposal to sublease their operation and assume their licenses as additions to our distinct part skilled nursing bed complement. We have submitted a term sheet to one of the facilities, outlining a proposal which is subject to Board approval. This acquisition could have as much as a $2.0-2.5 million impact on our bottom line as a result of allowing us to recoup more of our overall infrastructure expenses. Worst case, this impact would mitigate the reimbursement cuts outlined above. In the best case, if the rate reduction is not approved, this impact could mark the most significant improvement in our operating performance that we have on the strategic horizon.

We are awaiting an indication, expected within a couple of weeks, of whether the second facility with whom we are talking has a serious interest in similar discussions. Again, the positive financial impact on the Hospital is estimated to be in the $2-2.5 million range.

We are heartened for the first time in a couple of years about the level of receptivity we are experiencing and attribute it to the fact that our proposal would relieve these operators of assuming their own risk of declining operating margins under AB 97. While not built into our base budget for FY 2012, this strategic initiative would have a major favorable impact on our operating margin.

- **Application to expand our Subacute bed licensure by 12 beds**.
We have made an application to the California department of Public Health to increase our Subacute licensure by 12 beds and reduce our medical-surgical licensure by a like number. This would be accomplished by relocating the medical-surgical beds from 3 West to 3 South and relocating Telemetry to the old 12 bed telemetry unit which currently houses the 12 bed Subacute unit. This has the added advantage of having all three acute units (CCU, Telemetry, and Medical-Surgical) in contiguous spaces in the South building, which is already compliant with 2030 seismic standards.

We propose to move the 12 Subacute beds currently on 3 South to 3 West, creating a total unit of 24 beds on 3 West. Coupled with the existing 23 bed Subacute unit on 2 West, we would have a total of 47 Subacute beds. We also would be seeking a waiver from the requirement to bring all rooms into compliance with current Title 24 building standards due to the crisis level shortage of Subacute bed capacity in the State. We not only currently maintain a waiting list for Subacute but have had very promising discussions with Sutter, Kaiser and West Bay hospitals that could generate a potential flow of 60-70 more Subacute patients annually.

We have not yet completed an estimate of the financial impact of this action since it would be influenced by the impact on our cost report. Nevertheless, we believe it will be favorable. We are scheduled to discuss this plan with State representatives, as well as members of our medical and clinical staffs' early next week.

Fiscal Year 2012 Narrative:

The following sections discuss the key budget assumptions that have been incorporated into the FY 2012 Operating Budget

Utilization

Inpatient Acute Care Services

The hospitals acute average daily census (ADC) is projected to increase by 4% over the census levels experienced in FY 2011 (29.5) as a result of two key factors:

1. The implementation of the physician advisory program. This new program through consultation with a firm specializing in assisting clinicians appropriately identify patients that should be admitted to inpatient status rather than being classified as an observation status is anticipated to convert approximately 35% of our current observation level patients to inpatient status increasing our average daily census by 1.6.
2. The addition of the Wound Care Center, expected opening January 2012, will also provide some marginal increase in inpatient admissions and have been projected to increase our average daily census by 0.1 patients per day.

Inpatient Long Term Care Services

The South Shore Skilled Nursing Unit is projected to have an ADC of 22.0 which approximates the levels experienced in fiscal year 2011. The 35 bed Sub-Acute unit is projected to have an ADC of 33.0 which is also consistent with the current fiscal year's performance. Both programs are limited by the number of available beds in each of these units.

Outpatient Services

Total outpatient registrations are expected to increase by 2.1% over fiscal year 2011 levels. These change in outpatient registrations are driven by the following:

1. Volume in radiology and rehabilitation services is projected to increase by 2% as a result of the new digital radiology equipment coming on line in the second quarter of the fiscal

year and enhanced services in outpatient therapies. Outpatient therapy patient visits are down about 10% from prior years; with more focused management of the staff's time and scheduling, combined with increased promotion of these services, volumes will increase in the 2012 fiscal year.

2. Beginning in January 2012, an additional 125 registrations from the Wound Care Center will be added to the outpatient volume for the last six months of the fiscal year. In addition to the registrations at the Wound Care Clinic, an additional 223 registrations have been added for patients that will require other diagnostic services such as laboratory, radiology and rehab services.
3. Outpatient surgeries generated by Alameda surgeons have been projected to remain consistent with fiscal year 2011 levels, which already reflected a 20% increase over the fiscal year 2010 non-Kaiser volume. Of course our efforts to recruit additional surgeons will continue.
4. Observation visits is projected to decrease by 29% as a result of the physician advisory program as described above in the Inpatient Acute Care Services section.

Emergency Care Services

Emergency visits have been projected to remain consistent with the same levels as experienced during fiscal year 2011 which have averaged 46.0 visits per day.

Alameda Medical Offices

The Alameda Medical Offices volume is budgeted to decrease its visit activity in fiscal year 2012 by over 659 visits or 30% from fiscal year 2011. Visits will increase as a result of the addition of a new neurologist and continued efforts to market and promote referrals to the physicians providing services at this location. However, further analysis of the OB/GYN practice at the clinic shows this aspect of the clinic does not cover its direct expense. As a result, this contract will be terminated effective July 1, 2011. The physician has expressed an interest to remain at the clinic and in the community as an independent practitioner on a part-time basis.

Gross Charges

A charge specific price increase will be implemented effective July 1, 2011 which will result in an approximate overall increase of 6%. This increase is expected to generate an additional $15.3 million in annual gross charges which has been factored into the fiscal year 2012 operating budget. Also increasing gross revenues is the addition of the new Wound Care program that is budgeted to generate $2.3 million in gross charges during the first six months of operations based on current projections of service needs in the immediate service area.

Net Revenue

Our overall estimated net patient revenue percentage is projected to decline to 22.4% in FY 2012 versus the current year's 23.9%. Some of the factors contributing to the decrease in our projected net revenue percentage:

- Sub-Acute and Skilled Nursing rates for Medi-Cal beneficiaries have been estimated to be decline from current levels by 23%. This reduction is based upon a 10% reduction from fiscal year 2008-09 rates as indicated by AB 97.
- Included in the net revenue assumptions is the cancellation of the Medi-Cal inpatient contract. As part of the recent legislative changes, non-designated public hospitals no longer need to have a California Medical Assistance Commission (CMAC) contract in order to participate in the Intergovernmental Transfer (IGT) program. In addition, the inpatient rate freeze previously imposed by the State has been removed. We plan to cancel our inpatient Medi-Cal contract and return to cost based reimbursement and, based upon existing Medi-Cal days and our associated costs, the budget includes an increase of approximately $1 million in additional Medi-Cal net revenues.
- While we have implemented an annual price increase to all charges, the projected increased reimbursement is estimated at only $1,250,000 since the majority of hospital payments are based upon fixed per diem rates or rates established by federal and state governments for Medicare and Medi-Cal programs. However, this price increase allows the hospital to maximize reimbursements allowed under contractual arrangements with the various managed care payors.
- Based upon changes to the Medicare Inpatient Prospective Payment System Hospital reimbursement for Medicare beneficiaries is projected to decrease by 0.5% or $110,000 in FY 2012.
- Net patient revenue from the Wound Care program is projected to be $624,000.
- Additional net patient revenue from the Alameda Medical Offices is expected to be approximately $317,000 from physician clinic services.

In summary the increase in net revenue from fiscal year 2011 projected to fiscal year 2012 budget is approximately $2.1.

Labor and Benefits Expense

Overall labor costs are projected to decrease by approximately $2.4 million over the projected fiscal year 2011. The FY 2012 budget proposal includes negotiated salary increases for the one bargaining unit, SEIU, whose contract was negotiated prior to receiving notice from Kaiser that they would not be extending the Outpatient Surgery Services Contract. All other bargaining units have been budgeted at current levels with no estimated increases in salary either as agreed to in newly negotiated contracts, CNA, Local 29 and Local 6, or management's projections as to the final outcome of negotiations still to be had with Local 39. The unrepresented Exempt and Non-Exempt labor pool have been budgeted at the current wage rates which include the 5% reduction that was implemented effective January 31, 2010.

Total full time equivalents for fiscal 2012 are budgeted at 408.1, a decrease of 22.7 FTE's from the fiscal year 2011 forecasted total of 430.8 FTE's. This decrease in FTE's will be accomplished by decreased utilization of certified nursing assistants, consolidation and better utilization of operating room scheduling, mandatory closure of specified support departments on eight holidays and two non-holiday closures, furlough days during June through August, the closure of the lab draw station at Alameda Town Center and lay-offs and reductions in hours of

selective personnel and departments. We anticipate that approximately 16 FTE's will be laid off and the remaining FTE reduction will be achieved through changes in scheduled hours.

Staffing for nursing departments has been based upon the budgeted average daily census of the units and the California mandated nurse staffing hour ratios for inpatient acute services. In addition, adjustments to ensure appropriate levels of coverage for break and lunch relief have been factored into the determination of the calculated required hours of nursing care. The fiscal year 2012 budget builds in more realistic estimates for break / lunch relief staffing and inefficiency caused by census not always being at natural staffing guideline break points. These were causes of unfavorable staffing variances in fiscal year 2011.

Non-Labor Expenses

The following are the assumptions for the various categories of the operating budget non-labor expense categories:

Benefits

While salary costs are budgeted to decrease by $2.4 million, benefit costs have only been projected to decrease by $119,000 as a result of budgeting increased employee health benefit costs. The primary reason for this assumption was that fiscal year 2011 costs have been significantly lower than previous years' experience. Therefore, we estimate that health benefits in fiscal year 2012 will increase by approximately $319,000 to better reflect historical performance.

Professional Fees

Professional fees increased by approximately $89,000 overall as a result of the following;

- The new wound care program resulted in additional management fees to Accelcare for the management of the program in the amount of $292,000,
- a reduction in the amount of legal fees of $64,000, and
- a reduction of consulting fees in the information technology services of $148,000.

Supplies

Medical supply costs are projected to increase over current year projections as a result of the budgeted 4% increase in inpatient volumes. Also, blood utilization in fiscal year 2011 was inordinately low compared to prior years utilization, as such an additional $95,000 has been included in the fiscal year 2012 operating budget to better reflect anticipated utilization. In addition, supply costs for pharmaceuticals have been increased by 5% as costs in this area are anticipated to increase due to inflation. The Wound Care program will add approximately $31,000 of additional supply costs.

Purchased Services

Purchased services expenses increased by approximately slightly overall but were comprised of the following changes:

- the addition of NightHawk Pharmacy after hours coverage ($160,000), providing the legally-required 24/7 review of drug orders by a pharmacist,
- the addition of MD Office Solutions ($60,000) who provide cardiac imaging services in nuclear medicine,
- a reduction in security coverage ($70,000),
- savings from changes to service levels for the GE BioMedical contract ($50,000)
- a reduction in assisted parking services ($36,000), and
- a reduction in off-site medical records storage ($35,000).

Rents and Leases

This category will increase by approximately $343,000 over current year projected rent expenses. This increase is primarily the result of rental expenses for the Diagnostic Radiology and PACS System, ultrasound equipment, telemetry equipment and equipment related to the Electronic Health Record (EHR) implementation as well as the rental of facilities at the Marina Village complex that will be the site of the new Wound Care Program.

Insurance

As a result of our continued favorable performance and the overall performance of BETA, a one-time reduction in premiums to all members of BETA will be received in August 2011. This will lower our annual premium by $158,000 and has been incorporated into the operating budget.

Utilities

There were no noteworthy changes in this expense category between fiscal year 2011 and 2012.

Depreciation and Amortization

This classification will decrease by $80,000 or 8.4% from FY 2011, as a result of additional assets reaching their fully depreciated cost basis during the fiscal year.

Other Expenses

Other expenses were reduced by approximately $157,000 as a result of the elimination of various hospital memberships ($75,000), the reduction of recruitment and relocation costs ($60,000) and the reduction to estimated risk management litigation reserves ($40,000).

ALAMEDA HOSPITAL
STATEMENT OF INCOME AND EXPENSE
FY 2012 OPERATING BUDGET

	FY 2009	FY 2010	FY 2011 YTD April 30th	FY 2011 Forecast	FY 2012 Budget
Net Patient Revenue	63,041,903	67,513,961	50,031,819	58,988,144	61,047,530
	22.3%	24.2%	24.2%	23.9%	22.4%
Other Operating Income	197,258	422,951	102,278	122,081	121,100
Total Revenue	63,239,161	67,936,912	50,134,097	59,110,225	61,168,631
Expenses					
Salaries and Agency	37,711,335	39,524,441	31,734,181	38,101,577	35,697,602
Benefits	9,846,834	10,115,283	8,142,092	9,677,721	9,558,480
Professional Fees	3,536,554	3,447,118	3,068,695	3,673,827	3,762,958
Supplies	9,106,290	9,984,917	7,204,658	8,584,325	9,088,119
Purchased Services	4,126,176	4,651,602	3,656,613	4,404,126	4,435,339
Rent	722,041	843,137	702,471	838,483	1,181,095
Insurance	533,368	496,419	318,464	381,340	202,960
Utilities	840,806	836,617	630,020	753,370	778,878
Depreciation	1,406,626	1,155,022	797,809	955,254	875,256
Other	875,962	984,817	887,384	1,062,514	905,403
Total Expenses	68,705,992	72,039,371	57,142,388	68,432,537	66,486,089
Operating Ince / (Expense)	(5,466,831)	(4,102,459)	(7,008,292)	(9,322,312)	(5,317,459)
Non-Operating					
Parcel Tax Revenues	6,029,594	6,031,534	4,798,498	5,747,851	5,741,539
Interest Income	-	-	-	11,135	2,500
Interest Expense	(142,448)	(96,183)	(96,425)	(118,429)	(148,955)
Other Non-Operating Revenue	-	-	1,670,035	1,713,604	262,526
Total Non-Operating	5,887,146	5,935,351	6,372,107	7,354,161	5,857,610
Net Income / (Loss)	420,315	1,832,892	(636,185)	(1,968,151)	540,151

ALAMEDA HOSPITAL
FISCAL YEAR 2012 ASSUMPTIONS
OPERATING STATISTICS

			FY 2011	FY 2012	
	FY 2009 Actual	FY 2010 Actual	YTD Projected	Proposed Budget	Var from Proj. FY 2011
PATIENT DAYS					
CCU	1,320	1,406	1,622	1,682	3.70%
DOU	4,379	4,445	4,172	4,238	1.58%
Medical/Surgical	6,087	4,728	4,991	5,293	6.05%
Total Acute	11,786	10,579	10,785	11,213	3.97%
Sub-Acute	12,010	12,196	11,898	12,078	1.51%
SNF	6,666	7,832	8,001	8,052	0.64%
Total Long Term Care	18,676	20,028	19,899	20,130	1.16%
Grand Total	30,462	30,607	30,684	31,343	2.15%
DISCHARGES					
CCU	166	168	160	178	11.25%
DOU	1,047	1,191	988	1,102	11.54%
Medical/Surgical	1,598	1,443	1,366	1,523	11.49%
Total Acute	2,811	2,802	2,514	2,803	11.50%
Sub-Acute	34	14	21	17	-19.05%
SNF	112	127	115	106	-7.83%
Total Long Term Care	146	141	136	123	-9.56%
Grand Total	2,957	2,943	2,650	2,926	10.42%

ALAMEDA HOSPITAL
FISCAL YEAR 2012 ASSUMPTIONS
OPERATING STATISTICS

			FY 2011	FY 2012	
	FY 2009 Actual	FY 2010 Actual	YTD Projected	Proposed Budget	Var from Proj. FY 2011
AVG. LENGTH OF STAY					
Acute	4.2	3.8	4.3	4.0	-6.75%
AVG. DAILY CENSUS					
CCU	3.6	3.9	4.4	4.6	4.55%
DOU	12.0	12.2	11.4	11.6	1.75%
Medical/Surgical	16.7	13.0	13.7	14.5	5.84%
Total Acute	32.3	29.1	29.5	30.7	4.07%
Sub-Acute	32.9	33.4	32.6	33.0	1.23%
SNF	18.3	21.5	21.9	22.0	0.46%
Total Long Term Care	51.2	54.9	54.5	55.0	0.92%
Grand Total	83.5	84.0	84.0	85.7	2.02%
OUTPATIENT VISITS					
Outpatient Registrations	26,044	26,204	24,093	24,594	2.08%
Observation Days	602	795	746	532	-28.69%
Emergency	17,338	17,624	16,805	16,836	0.18%
IP Surgeries-Non Kaiser	588	592	550	526	-4.36%
IP Surgeries - Kaiser	102	91	-	-	0.00%
Total IP Surgeries	690	683	550	526	-4.36%

ALAMEDA HOSPITAL
FISCAL YEAR 2012 ASSUMPTIONS
OPERATING STATISTICS

			FY 2011	FY 2012	
	FY 2009 Actual	FY 2010 Actual	YTD Projected	Proposed Budget	Var from Proj. FY 2011
OP Surgeries - Non Kaiser	1,206	1,224	1,545	1,555	0.65%
OP Surgeries - Kaiser Eye	1,976	1,461	-	-	0.00%
OP Surgeries - Kaiser Amb.	1,931	1,417	-	-	0.00%
Total OP Surgeries	5,113	4,102	1,545	1,555	0.65%
Minor Procedures	82	127	133	130	-2.26%
Total Surgeries	5,885	4,912	2,228	2,211	-0.76%
Total Surgeries without Kaiser	1,876	1,943	2,228	2,211	-0.76%
ALAMEDA MEDICAL OFFICES					
Physician Clinic - Total Vistis		1,112	2,188	1,529	-30.12%
Physician Clinic - New Patients		376	585	878	50.00%

Alameda Hospital
Fiscal Year 2012
Capital Budget

As part of the District's annual budgeting process, it is required to submit and approve a capital budget in addition to the operating budget. As part of the capital budget process, input is solicited from all departments of the organization as well as from members of the medical staff.

For FY 2012, the total of capital budget requests submitted was $2.4 million. Provided with the request, is an explanation of why the request is being made and the degree of importance/urgency. Management then has the task of evaluating the submitted requests against the organizations ability to fund them.

Given the challenge of developing a positive FY 2012 operating budget and given the capital projects that have already been approved or are in process, the amount of additional capital acquisitions being recommended is very limited. However, if some of the initiatives discussed in the operating budget narrative, but not included in the operating budget itself, come to realization, we will reevaluate our ability to recommend for approval additional capital budget expenditures.

Attached is a list of the recommended capital budget items for fiscal year 2012 that total $1,875,949. This is broken down as follows:

• Equipment	$89,986
• Information Technology	$85,963
• Plant Maintenance	$150,000
• Contingency	$100,000
Sub Total	$425,949

Already in process or previously approved items are as follows:

• Continue to develop Seismic Plans	$100,000
• Electronic Health Record Implementation	$450,000
• Wound Care Program	$900,000

<u>Funding:</u>

The Wound Care program will be funded with a $100,000 contribution from the Foundation, a $125,000 loan from the Foundation and the remaining $675,000 through an approved loan with the Bank of Alameda.

The Electronic Health Record implementation is primarily an internal employee who is dedicated to the implementation of PCS and PCM, as well as an allowance for outside consulting assistance as these implementations progress through the next fiscal year. These items are currently being funded with operating dollars.

Before acquisition of the other new capital items, we will need to find a funding source and obtain Board approval. Two such source could be the annual Jaber Fund contribution which has been averaging about $120,000 per year and the hospital auxiliary which has been contributing around $35,000 - $40,000 per year.

In addition, we will work through the Foundation to pursue external grants for select equipment items as we did during FY 2011.

FY2012 Capital Expenditure Budget

Cardiology			
	Mortara Stress Exercise System	Current Equipment in use for 10 years; parts and maintenance no longer supported. Wireless to prevent patient falls; will be interfaced with Meditech	$25,539
Engineering			
	Heating Boiler Retro Fit	Required to upgrade boilers by end of CY 2012 to decrease BTU emissions. This is retrofit rather than replacement for cost effectiveness.	$150,000
Neurology Clinic			
	Electromyograph - 2 channel Sierra Wave	Allows us to conduct EMG studies in addition to EEG studies ordered by two new active Neurologists. Will generate sufficient marginal revenue to return investment in well under 1 year.	$17,655
Surgery			
	Stryker Drill & Saw	Current system which is essential to support orthopedic and podiatric surgery is quite old and needs updating.	$46,792
Information Technology			
	CISCO Network Switch Expansion	Replaces existing switches or augments services allowing additional devices to connect	$24,436
	CISCO Wireless Controller	Expands wireless connectivity for the EMR project, supporting WOW deployment throughout facility	$18,796
	Servers - Meditech PCM/PCS Upgrades	5 addl. Servers to support Meditech modules and improve overall system and network performance	$42,731
		SUBTOTAL - HIGH PRIORITY	$325,949
		CONTINGENCY	$100,000
OTHER CAPITAL ITEMS			
	Seismic Plan Development (SPC & NPC)	Continue to advance SPC and NPC 2 planning and oshpd submittals.	$100,000
	Electronic Health Record - Installation	Mostly capitalized labor costs expended for 'EHR installation	$450,000
	Wound Care Tenant Improvements/FFE	Previously approved	$900,000
		TOTAL CAPITAL EQUIPMENT	**$1,875,949**

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: June 6, 2011

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

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approval to Enter into a Lease Agreement with Legacy Marina Village for Building Lease Located at 815 Atlantic Avenue, Alameda, California for Wound Care Program

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Recommendation:

It is being recommended that the Finance Committee and Board of Directors approve the Terms and Conditions of a building lease at Marina Village and authorize management to execute this lease at the appropriate time following approval. The key Terms and Conditions of the lease agreement are enclosed, and the complete lease document is available to review upon request.

Background:

An important aspect of the hospital's strategic plan is growth and the development of new programs and services that will allow us to better serve the medical needs of those in our community while providing a positive contribution to the hospitals financial strength. A second aspect of our strategic plan is to develop a more comprehensive medical staff base that will support the primary care physician needs in the community but also support the growth and medical strength of the acute care hospital.

As we look at new programs and services, especially outpatient programs, adequate medical office / clinical space have been an ongoing challenge. In addition, the future need for better and additional physician office space has been identified. The hospital currently leases approximately 8,400 sq. ft. of space at Alameda Towne Center. In that space, we have 12 physicians practicing, many of which are part of the hospitals 1206 (b) clinic. We also operate a lab draw station at that location to make it more accessible to patients who require this diagnostic testing.

The lease at Alameda Towne Center has a term date of April 30, 2012, with two 1-year renewal options at the hospital's discretion. The landlord has not been willing to provide extension options beyond that date and there have been discussion of possible alternative uses for this building space in the long term.

Space within the hospital available for outpatient services is very limited and very costly to renovate and bring up to current OSHPD building code if we were to convert space for alternative uses. Utilizing our current licensed inpatient space for inpatient services is a better and more cost effective use of these spaces once suitable services are identified.

Given the aforementioned, management has been directed to pursue other potential space within the district boundaries that can be utilized to serve the needs of our local physicians as well as enhance and/or expand our outpatient service capabilities.

For the past several months, management together with our attorney and commercial real estate agent, have been in negotiation with the Landlord (Legacy Partners), to finalize the terms, conditions and contract language. There have been compromises made by both parties and the final agreed to terms and conditions are enclosed.

Discussion:

There is very limited functional space available within Alameda for physician office and clinical services use. However, we have identified a building located at 815 Atlantic Avenue, part of the Marina Village business park, that would be suitable to help us accomplish our strategic plans.

The entire building is just less than 25,000 sq. ft. It is the first building you come to when accessing the business park off of Constitution Way or Webster Street and is therefore very accessible, not only to those residents living on the West end of Alameda, but to patients who would utilize the services provided at this location who live in Oakland.

Initial Leased Space (Suite 100):
The initial recommendation, presented last board meeting, was to enter into a lease for 10,612 sq. ft. We would have expansion rights for the remaining available suite (Suite 105) which is 11,640 sq. ft., as well as, two other smaller suites of 1,122 and 1,492 sq. ft. respectively once they come available.

The plan for the initial leased space (suite 100) is to open a Wound Care Center as previously discussed. This program would be operated in conjunction with Accelecare Wound Centers Inc., who is experienced in managing this type of service. Our preliminary schematic plan indicates that the Wound Care program would take about 4,000 sq. ft. of direct clinical space and waiting room area. We are prepared to move forward with implementation of this program once our lease agreement is finalized and we secure financing for the required tenant improvements.

The remaining space in suite 100 (approx 6,600 sq. ft.) would be used for Rehabilitation Services (outpatient physical therapy, speech therapy, occupational therapy, sports medicine, and potentially cardio fit services). Our current rehab services space here at the hospital is only about 1,400 sq. ft. and has limited treatment space. In addition, because of the lack of space, we do not have the desired equipment, machines and apparatuses that would provide for improved therapy and recovery for a broader spectrum of patients. There is currently a consistent back-log to schedule an initial assessment for outpatient therapy, due in part, to our limited clinical space.

Expansion Space:
Within the first year after executing the initial lease, it would be our goal to exercise our expansion right in to Suite 105. This space would be designed and built out for physician office

space and would allow us to vacate the space at Alameda Towne Center and even relocate some of the physicians currently located in the 1925 building. In addition to physician office space, the plan would be to have a Lab draw station, basic radiology and ultrasound. This would provide a comprehensive one-stop for primary care and diagnostic services.

Once we are able to exercise expansion rights into the smaller two suites that are currently occupied, we are contemplating adding an urgent care or possibly expanding and/or relocating other hospital based outpatient services to this building.

Summary:

In order to achieve our strategic plans of growth, physician recruitment and enhancing the types and quality of services that we provide to the community, securing the physical space where these activities can occur is an important first step. Given the terms and conditions that we have negotiated and that will become part of our long term lease, we will have space not only to implement a new service and expand existing services in the immediate future, but we will have the necessary space to meet our longer term expansion / relocation needs.

Furthermore, the location at Marina Village is very attractive because of its location on the west end of Alameda. Our ability to have a primary care and medical presence on the west end of Alameda will be of benefit to the residents who live or work in that area, but will also service the Oakland / Chinatown population. We feel that this is a good opportunity and will accomplish many of our short and long term objectives.

COBLENTZ, PATCH, DUFFY & BASS LLP ATTORNEYS AT LAW

MEMORANDUM

CONFIDENTIAL COMMUNICATION

TO: Kerry Easthope, Alameda Hospital

CC: Tom Driscoll, Esq.
Ryan Hattersley, Cushman & Wakefield

FROM: Eileen K. Chauvet

RE: Marina Village Business Park Alameda Hospital Wound Care Center Lease

DATE: May 17, 2011

As we have discussed, certain terms of the lease agreement have varied from the original terms let out in the Letter of Intent dated December 3, 2010 previously approved by the Hospital. The essential terms of the lease agreement, the final draft form of which is attached to this memorandum, are below. Note that this is a general overview, and you and the Board should refer to the lease agreement for detailed requirements. In addition, the form purchase and sale agreement referenced in the purchase options sections has been revised and comments sent to Landlord's counsel. We expect to have that exhibit finalized and attached to the lease this week.

Premises	815 Atlantic Avenue, Alameda, California, Suite 100, comprised of approximately 10,612 rentable square feet
Condition of the Premises	Landlord will deliver the Premises with building-wide systems in good working order and repair. Landlord will provide a warranty period of 90 days after the Lease Commencement Date during which time it will repair those systems at no cost to Tenant if the systems are not in good working order and repair.
Lease Commencement Date	The earliest to occur of (i) the date Tenant commences business operations in the Premises, or (ii) 180 days after both of the following have occurred (A) mutual execution and delivery of the Lease and (B) receipt of the signed SNDA (or the hospital's waiver of the requirement).
Term	10 years, 3 months (123 months) after the Lease Commencement Date. Term expires on the last calendar day of the 123rd month of the term.

Contingency/Right to Terminate	During the 175 days after (A) mutual execution and delivery of the Lease and (B) receipt of the signed SNDA (or the hospital's waiver of the requirement) Tenant will diligently pursue obtaining the OSHPD 3 permit and all other permits needed to build and operate the facility. If Tenant cannot obtain needed permits during that time, it may terminate the lease not later than 179 days after the above date. If Tenant terminates the lease, it must pay $12,500 to Landlord to compensate Landlord for its legal fees in preparing the lease.
Early Occupancy	After (A) mutual execution and delivery of the Lease and (B) receipt of the signed SNDA (or the hospital's waiver of the requirement), Tenant may enter the Premises install its furniture, fixtures, equipment, and leasehold improvements. Tenant may not install any improvements without Landlord's express written consent until after the 175-day permit contingency period has expired or it has waived its right to terminate.
Use	Operation of a medical office providing wound care, rehabilitation/physical therapy, medical laboratory services, radiology services, general physician services, urgent care services, and administrative offices. Tenant may install equipment as needed so long as it complies with all applicable laws and Tenant's permits. The Premises may not be used to perform abortion services, or for overnight or in-patient uses.
Base Rent	The 4th month of Base Rent is payable on (A) mutual execution and delivery of the Lease and (B) receipt of the signed SNDA (or the hospital's waiver of the requirement).

Months of Lease Term	Annual Base Rent	Monthly Installment of Base Rent	Monthly Rental Rate per Rentable Square Foot the Premises
1-3	$0	$0	$0
4-12	$89,140.80	$7,428.40	$0.70
13-24	$95,508.00	$7,959.00	$0.75
25-36	$101,875.20	$8,489.60	$0.80
37-48	$108,242.40	$9,020.20	$0.85
49-60	$114,609.60	$9,550.80	$0.90
61-72	$120,976.80	$10,081.40	$0.95
73-84	$127,344.00	$10,612.00	$1.00
85-96	$133,711.20	$11,142.60	$1.05
97-108	$140,078.40	$11,673.20	$1.10
109-120	$146,445.60	$12,203.80	$1.15
120-123	$152,812.80	$12,734.40	$1.20

Operating Expenses, Tax Expenses, and Utilities Costs	42.59% of Operating Expenses, Tax Expenses, and Utilities Costs. Operating Expenses include all costs of management, maintenance, repair, renovating, and managing the Building. Certain capital expenditures may be passed through, including (i) improvements intended as a labor saving device or to effect economies in operation or maintenance of the Project, (ii) improvements made after the Lease Commencement Date that required to comply with laws, (iii) replacements of wall and floor coverings, ceiling tiles and fixtures in common areas, and (iv) improvements reasonably required to maintain the functional character of the Project as a first class office park. Capital improvements with be amortized over the life of the improvement with interest at 10% per annum. But, items under (iii) and (iv) are limited—they may not exceed $30,000 in any year, will not include any work to the foundation of the building, and will be amortized over the life of the improvement without interest. Tax Expenses expressly exclude any assessments under the Marina Village Assessment District 84-3.
Option to Renew	Tenant has an option to extend the term for two 5-year periods. Tenant must provide an "interest notice" to Landlord not more than 13 months or less than 11 months before the end of the then-current term. The Landlord will then provide its estimate of the fair market rent not later than 10 months before the end of the term. Tenant must exercise its option to extend at least 9 months before the end of the term. In its exercise notice, Tenant will either accept the Landlord's proposed fair market rent or object, in which case the fair market rent will be negotiated in good faith, and if no agreement is reached, decided by a panel of experienced real estate brokers. Tenant has no right to extend the term if it is in default (after notice and expiration of any cure period) or if it and its Business Affiliates are in less than 30% occupancy of the Premises.

Option to Expand	For the first 18 months after the Lease Commencement Date, Tenant may expand into available space in the building. Space is considered available if it is unleased, no existing tenant has rights to lease that space and if the Landlord has not executed a letter of intent or is not in lease negotiations for that space. If Tenant wishes to expand, it may deliver an inquiry to the Landlord asking what space is available. Tenant may send the inquiry to the Landlord once every 2 months. If space is available, then the Landlord will respond identifying the space and the terms (other than rent) on which it is willing to lease. During the first 12 months after the Lease Commencement Date the expansion space would be at the same base rent as the Premises. From months 13-18, the expansion space will be at fair market rent. Tenant will have 15 days to respond to the Landlord either electing to lease the expansion space or pass. Tenant has no rights under the expansion option if it is in default (after notice and expiration of any cure period) or if it and its Business Affiliates are in less than 30% occupancy of the Premises.
Right of First Refusal to Lease	Until the last 24 months of the term (including any extension), Tenant will have the right to lease any remaining space in the building on the same economic terms as those offered to a 3rd party, or those that Landlord intends to accept from a 3rd party. Landlord will give Tenant 7 business days notice, during which time Tenant may elect to rent the space or pass. If the Landlord changes the economic terms by 10% or more or does not enter into a lease for space that is rejected by the Tenant, then the Landlord must re-offer the space to the Tenant. If the Tenant rejects the space but the 3rd party's lease expires while Tenant's right is active, then the Landlord must offer the space to the Tenant before entering into another 3rd party lease. Tenant has no right of first refusal if it is in default (after notice and expiration of any cure period) or if it and its Business Affiliates are in less than 30% occupancy of the Premises.
Landlord's Maintenance Obligations	Landlord will maintain the structural portion of the building, exterior glass, interior and exterior common areas, building-wide mechanical, electrical, plumbing, and life-safety systems. If Landlord fails to perform its maintenance obligations within 30 days after notice,, Tenant may provide an additional 3 business days notice to Landlord to perform. If Landlord does not perform, the Tenant may perform at Landlord's expense.

Assignment and Subletting	Tenant may sublet space to a Business Affiliate without Landlord's consent. A Business Affiliate is a health care provider offering health care services on behalf of or in cooperation with Tenant. In addition, Tenant may assign or sublease to an Affiliate without Landlord's consent. An Affiliate is (i) any entity that purchases all or substantially all of the assets of Tenant, or (ii) a successor to Tenant by purchase, merger, consolidation or reorganization. Landlord must consent to any other assignment of the lease of subletting of the Premises. Tenant will pay $1,500 per request for consent plus Landlord's reasonable legal fees, but if Tenant executes Landlord's standard consent documents, the forms of which are attached to the Lease, the legal fees will be capped at $1,000. In an assignment or subletting to anyone other than a Business Affiliate or an Affiliate, Landlord and Tenant will split any sublease or assignment profits 50-50. In an assignment or subletting to anyone other than a Business Affiliate or an Affiliate, if Tenant seeks consent to an assignment of all of Tenant's interest in the Lease or a sublease for more than 50% of the Premises for substantially all of the remaining term, the Landlord has the right to re-take the Premises (or portion proposed for subleasing).
Parking	Tenant has 36 unreserved parking spaces (i.e., 34 unreserved parking spaces/1,000 rentable square feet)
Alterations/Tenant Improvements	Landlord must consent to all improvements or alterations (including plans and Tenant's contractors) to the Premises, except minor alterations. Notice, but not consent is required for minor alterations. Minor alterations are non-structural, interior alterations that do not exceed $50,000 in any 12-month period, do not require a building permit, and are performed by qualified contractors that normally perform work in comparable buildings. Tenant will pay Landlord for its actual costs of supervising Tenant's alterations up to a maximum of the lesser of 2% of the cost of the alterations or $15,000 per project.
Signage	Tenant may install an exterior sign displaying Tenant's trade name, "Alameda Hospital," accompanying logo and any other markings (including the names and/or logos of Tenant's Business Affiliates) approved by Landlord. Tenant has the right to install the same on a monument sign, at its expense.
Access	Tenant has access to the Premises 24/7/365.
Security Deposit	$12,734.40, payable on execution of the Lease.

Subordination, Non-disturbance, and Attornment Agreement	Landlord will deliver a Subordination, Non-disturbance, and Attornment Agreement in the form approved by Tenant from its lender within 60 days after execution of the Lease. If the lender does not deliver the signed SNDA, then Tenant may terminate the lease or waive the requirement. The Lease is not effective until the SNDA is received.
Memorandum	Upon Tenant's request, Landlord will record a Memorandum in the County Recorder's office, providing notice of Tenant's rights to lease additional space and to purchase the Property.
Offset Right for Unpaid Broker's Commission	If Landlord does not pay Tenant's broker's commission, Tenant has the right to pay the commission and deduct the amount paid from the rent.
Oxygen Tank and Equipment Pad	Tenant has the right to pour a concrete pad or pads in the adjacent parking area for an approximately 17x21 foot enclosure and a 12x12 foot enclosure, each not to exceed 17 feet high, for bulk oxygen, emergency generator, and special medical equipment serving the Premises.
Right to Purchase at a Fixed Price	Until August 13, 2013, Tenant has the right to purchase the building for $4,983,400.00. Within 30 days after the Lease Commencement Date, Landlord will deliver to the Tenant due diligence materials on the building for Tenant's review before exercise of the option. If Tenant elects to purchase the building, it will execute the form of purchase agreement attached to the lease and deposit $150,000 deposit into escrow, which is nonrefundable unless Landlord defaults under the purchase and sale agreement. Closing will occur on the 60th day after exercise. Tenant has no rights under the Fixed Price Purchase Option if (i) it is in default after notice and expiration of any cure period, (ii) the Lease has been assigned, or (iii) the property has been sold to a buyer unrelated to Landlord, (iv) the property has been foreclosed upon or conveyed by a deed in lieu of foreclosure, unless the lender has expressly agreed to honor the option in its SNDA (which the current lender has agreed to do), or (v) Landlord previously delivered a First Refusal Notice and Tenant declined to purchase the building.

Right of First Refusal to Purchase	During the term of the Lease, if the Landlord is going to list the Building for sale, then it will first notify Tenant of the terms on which the Building will be offered for sale, and the Tenant will have the right to purchase the building on those terms. If the Landlord's notice is given during the term of the Fixed Price Option, then the price will be the lesser of the Fixed Price, or the list price. Tenant must respond within the later of 10 days after receipt of the Landlord's notice or 2 business days after receipt of an updated title report, and accept, decline, or indicate it would be interested in purchasing at a price that is 5% less than the listed purchase price. If Tenant indicated it would be interested in purchasing at a price that is 5% lower than the listed price, then, if Landlord agrees with a third party to sell the building at a price that is 5% lower than the listed price (or less than the Fixed Price, if during the time when the Fixed Price Option is in effect), then Landlord will reoffer the building to Tenant at the lower price. Tenant will have 5 business days to respond to the reoffer. The Right of First Refusal is not applicable if the building is a part of a sale of 10 or more other properties owned by Landlord. If the Tenant exercises its Right of First Refusal, it must deposit $150,000 in escrow, which is nonrefundable unless Landlord defaults under the purchase and sale agreement. Closing will occur on the 60th day after exercise. Tenant has no rights under the Right of First Refusal to Purchase if (i) it is in default after notice and expiration of any cure period, (ii) the Lease has been assigned, or (iii) Tenant previously exercised its Fixed Price Option to Purchase. In addition, the Right of First Refusal will terminate if the property has been foreclosed upon or conveyed by a deed in lieu of foreclosure, unless the lender has expressly agreed to honor the option in its SNDA (which the current lender has agreed to do) or if the building is sold as part of a portfolio sale (10 or more buildings).

Date: June 6, 2011

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

From: Deborah E. Stebbins
Chief Executive Officer

Subject: Background Information on Medical Directorship Compensation and Medical Office Rental

---

The following information is provided in response to a request by the Board of Directors at their May meeting that management provide background material regarding the compensation levels and selection process for medical directorships at the hospital as well as rental rates for medical office space. This information was requested in partial response to the April 25, 2011 letter to the Board from Dr. Jerrold Kram regarding Dr. Robert Deutsch. Based on the analysis, management concludes that the compensation for medical directorships and the rental rates for medical office space are within acceptable market values.

MEDICAL DIRECTOR ROLES AND APPOINTMENT PROCESS:

Medical Directorships are appointed by hospital management with appropriate input from the medical staff. Since Alameda Hospital has always been a small hospital, in most cases certain directorships were probably dictated by the fact that there were a limited number of qualified specialists in an appropriate sub-specialty. According to hospital files, Dr. Deutsch, originally with his former associate, Dr. Herb Schub, and currently with his associate, Dr. William S. Lowery, has been under contract for the provision of medical directorship services for the Pulmonary and Respiratory Therapy Departments, since at least 1980. Currently the East Bay Pulmonary Medical Group (Drs. Deutsch and Lowery) receive $ 6,650 per month for this medical directorship, which calls for them to devote a minimum of 50 hours per month to administrative oversight of the critical care, pulmonary and respiratory services. The hourly rate for East Bay Pulmonary Medical Group based on the minimum number of hours is $133.00.

Drs. Deutsch and Lowery also have served as medical director of the 35 bed Subacute unit. It is customary for most Subacute departments to be under the direction of Pulmonologists due to the respiratory complications and ventilator dependency of most of the patients. The East Bay Pulmonary Medical Group receives a total of $1,000 per month for this role, which calls for them to devote an average of 8 hours of administrative oversight per month.

According to a 2009 Physician Call Coverage and Medical Director Compensation Survey conducted by Horne LLP, the median hourly rate for medicine specialties directorships, such as critical care, pulmonology and respiratory, was $145.00. The 75th percentile hourly payment rate was $155.50. The survey was the result of a non-random sampling of hospitals primarily in the Southeast United States, including Alabama, Florida, Texas and Georgia. In addition, according

to 2007 data from Sullivan Cotter and Associates, the median hourly rate for medical directorships was reported as $134.00 for all specialties.

Most of Alameda Hospital medical directorships have been in place for several years. In the case of our newest anticipated Medical Director role for the Wound Care Center, which frankly does not lend itself to any particular medical specialty, my plan is to announce the availability of the position, solicit applications from any interested member of the medical staff, and appoint an advisory committee of medical staff and executives to interview candidates and make recommendations regarding acceptable candidates for my review and final selection. The advisory committee would of course exclude applicants for the position.

MEDICAL OFFICE RENTAL RATES:

Hospitals are required to charge physician tenants who occupy hospital space for purposes of conducting their private medical practices rental rates that reflect fair market value for comparable space in the community. Hospitals cannot subsidize the practice costs of independent practitioners. Establishing the fair market value of space is dependent on prevailing community rental values but also can take into consideration and age and physical attributes of the office space in question.

The East Bay Pulmonary Medical Group occupies 1,340 square feet on the third floor of the East Building (1925), paying a rate of $ $1.50 per square foot or a total of $2,000 per month. This is identical to the rental rate paid by every other physician in the East Building. CPI adjustments are made annually.

While there is limited medical office space available, other than a few buildings owned outright by physicians, comparative rental rates include the following:

- **501 South Shore Centre West (Rental rates paid by Alameda Hospital to building owners:**

  $1.50 per square foot + .25 per square foot common area maintenance (thru 4/30/12)

  $1.65 per square foot + .25 per square foot common area maintenance (thru 4/30/13)

  $1.80 per square foot + .25 per square foot common area maintenance (thru 4/30/14)

  We charge $3.00 per square to tenants in the building in spaces renovated at our expense in 2010.

- **711 Santa Clara (off Webster Street)**

  $1.65 per square foot

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: June 6, 2011

To: City of Alameda Health Care District
Board of Directors

From: Deborah E. Stebbins
Chief Executive Officer

Subject: Application to Increase SubAcute License by 12 Beds

Attached for the Board of Directors information is a letter and accompanying documentation to the California Department of Public Health requesting a change in the Hospital's licensure that would shift 12 beds from our acute bed inventory to our skilled nursing (Subacute) inventory. The rationale for the reclassification is the significant waiting list for our Subacute unit as well as the impending closure of a number of Subacute units in the Bay Area. In addition, the plan would have an advantage of locating all of our three acute units, CCU, Telemetry and Med-Surg in the South building, providing improvements in patient flow and staffing efficiencies. The impact of this request has not been folded into our FY 2012 budget.

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

May 24, 2011

Sent Via Certified Mail

Mr. Scott Vivona
Chief, Field Operations
Licensing & Certification Program
California Department of Public Health
1615 Capitol Avenue, MS 3001
P.O. Box 997377
Sacramento, CA 95899-7377

Dear Mr. Vivona:

The purpose of this letter is to initiate a request by the City of Alameda Health Care District (dba Alameda Hospital) to convert 12 of our acute licensed beds to skilled nursing facility status, and to certify them as Subacute care beds. Alameda Hospital currently is licensed for 100 acute beds (30 of which are in suspense) and 61 skilled nursing facility beds. Of our 61 skilled nursing facility beds, 35 are certified as Subacute beds.

As you may be aware, over the last couple of years, several hospitals have closed or intend to close their Subacute units. In part this is driven by financial performance of these units and the higher capital costs incurred by those hospitals that have undergone retrofit or replacement projects to address seismic compliance under SB 1953.

Alameda Hospital, as a small acute hospital serving primarily the population on the island of Alameda, has a strategic goal of expanding our services in the long term care arena, including Subacute care, in order to support the hospital's general acute care infrastructure. Our Subacute unit, which serves neurologically impaired patients most of whom are ventilator dependent, is virtually always full. In addition, we maintain a waiting list for patient admissions. Over and above the normal waiting list, we have been approached by many facilities that are attempting to close their Subacute units, to discuss placement of their patients.

We believe that there is an impending crisis regarding the placement of Subacute patients throughout the State. At this time, we are hoping to reconfigure our inpatient units to relocate our medical surgical unit from our West Building to the newest portion of the hospital (South Building). In turn, we hope to move 12 skilled nursing (Subacute) beds from the South building to the West building and add an additional 12 beds, creating a new 24 bed Subacute unit.

Diagrams of the existing and proposed moves and bed status changes is enclosed. Since this is a fairly complex topic, we plan to contact you by phone later this week to discuss the appropriate

process for obtaining necessary state approvals to accomplish this change. We felt it would be helpful if you received this material in advance of our call.

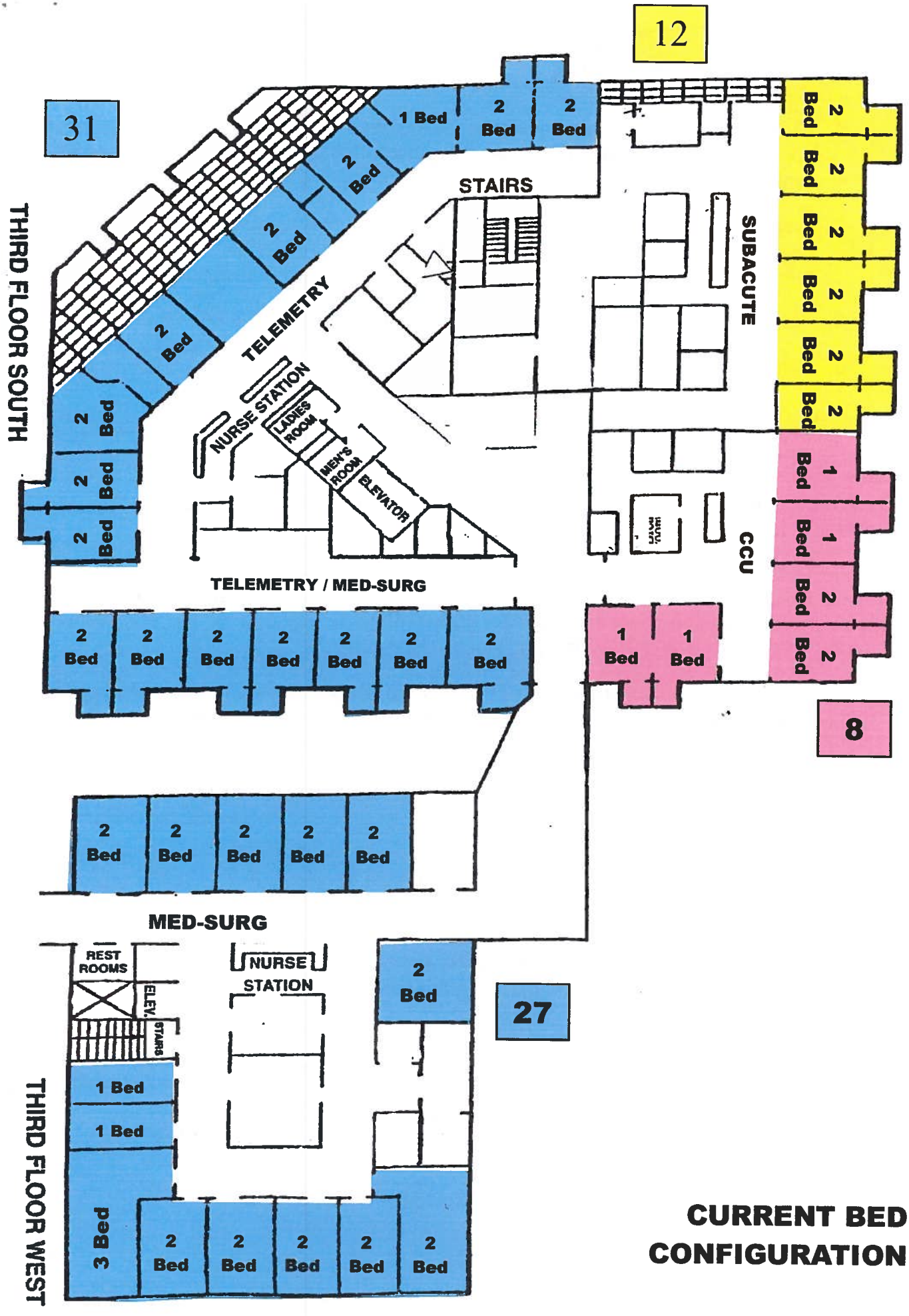
Thank you for your review of this matter.

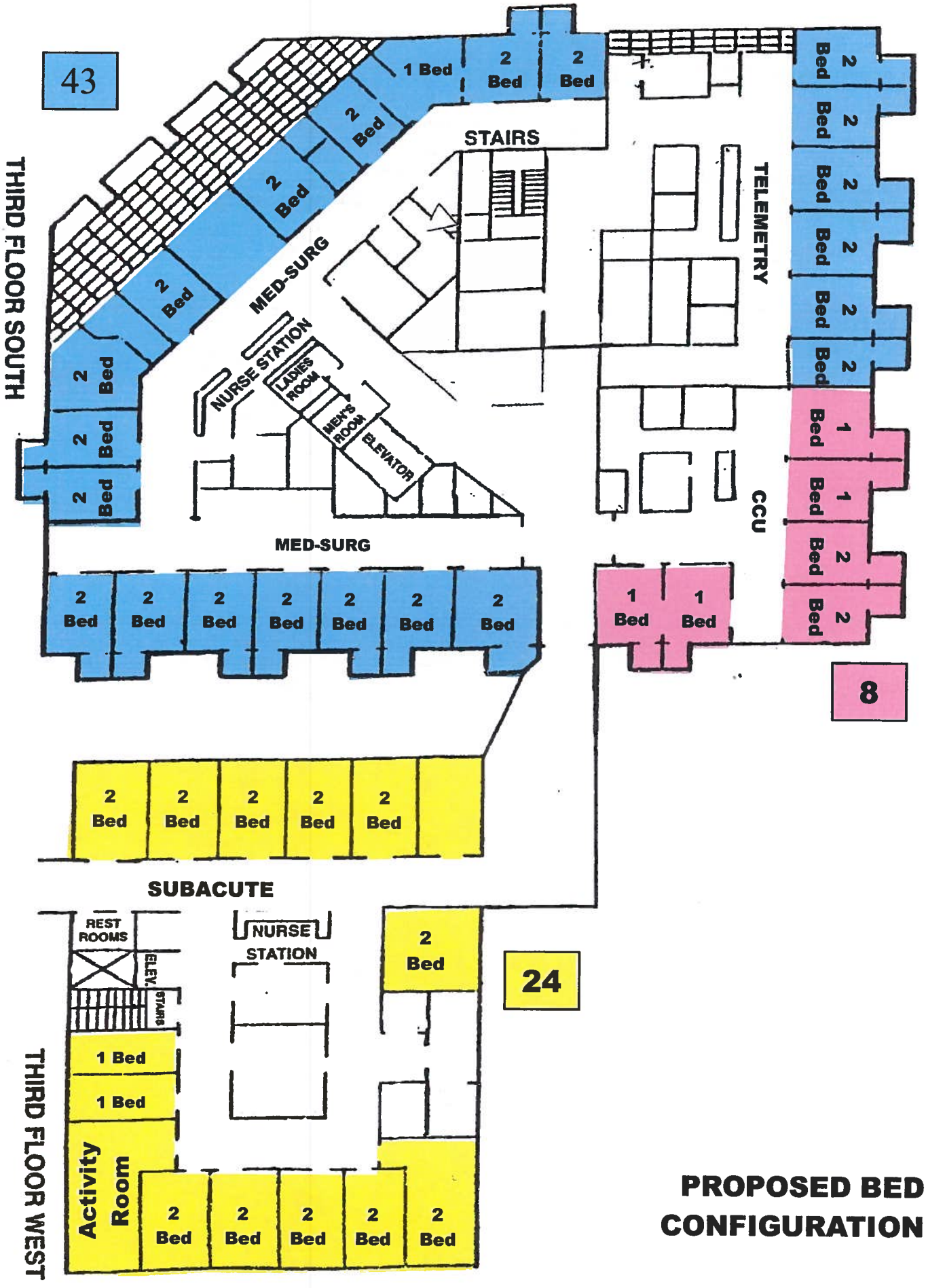
Sincerely,

Deborah E. Stebbins
Chief Executive Officer

CC: Ms. Eileen Carabine, District Administrator, Long Term Care
East Bay District Office
850 Marina Bay Parkway
Building P, 1st Floor
Richmond, CA 94804-6403

Mr. John Carlson, District Administrator, Non-Long Term Care
East Bay District Office
850 Marina Bay Parkway
Building P, 1st Floor
Richmond, CA 94804-6403


12
31
THIRD FLOOR SOUTH
1 Bed
2 Bed
STAIRS
SUBACUTE
TELEMETRY
NURSE STATION
LADIES ROOM
MEN'S ROOM
ELEVATOR
CCU
TELEMETRY / MED-SURG
8
MED-SURG
REST ROOMS
ELEV.
STAIRS
NURSE STATION
27
THIRD FLOOR WEST
3 Bed
CURRENT BED CONFIGURATION



PROPOSED BED CONFIGURATION

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: June 6, 2011

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

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Information Update on PACS and Imaging Equipment Upgrade

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The purpose of this memorandum is to provide an information update to the Board on the status of the hospital's Picture Achieving and Communication System (PACS) and Imaging equipment upgrade project. The hospital began this project over 1 1/2 years ago, in part, because of the need to have a PACS system in operation as part of achieving "meaningful use" with the Electronic Health Record.

It has been about one year since this project was approved and we were able to obtain external financing to start this project. The initial project budget was for $1.6 million, not including tax and shipping charges. To date we have spent $837,000, primarily for the PACS system and for OSHPD plan preparation costs. The budget did not allow for unforeseen contingencies and change orders which we now estimate will be about 12% - 13% ($192K - $210K) of the original budget amount. The need for these contingencies is described below under "Imaging Equipment Upgrades".

Status:

The PACS system has been installed and has been in use since April 2011. As expected there have been a number of issues to work out with the system to make it customized for our operation. Remote physician connectivity to the PACS system has been completed for most physicians. We are also scanning previous patient studies as they are scheduled in order to develop a more comprehensive digital database of their imaging history. Overall it is working very well. Mr. John Ellis, the Director of Diagnostic Imaging and the Hospital IT team have done a good job coordinating this project and working through issues as they came up.

We are in the process of installing the voice recognition system that is integrated into the PACS system. Once complete in the next couple of months, this will eliminate the need for transcription service and the Radiologist will be able to complete their report at the time they are reading the study. Turnaround time will be practically real-time.

Also still in process is the installation of wireless devices in the OR. This will allow the digital images to be viewed in the surgical suites at the time of surgery and eliminate the need for film. Cases requiring the use of C-ARM imaging will also be viewed real-time on the OR monitors. This will also be complete in the next couple of months. It has been somewhat challenging to

have the required digitizing device installed on the C-ARM but we believe we have this worked out and should have this complete in the next couple of weeks.

Imaging Equipment Upgrades:

This is the area of the project that has seen the most delays and required some changes of scope, primarily as required as a result of the OSHPD plan review process. First, the contract for the installation / construction portion of the project came in $42,000 higher than we had estimated in the budget. We had estimated (budgeted) this to be lower given that replacement of the Nuclear Medicine equipment was taken removed from the original proposed scope of work.

Plans were submitted to OSHPD nine months ago. Last week we finally received an approved OSHPD permit. OSHPD delayed all plan review for two months towards the end of calendar year 2010 as they were focusing on the hospital SB 499 seismic status reports that were required at that time. Since then, they have taken the maximum amount of time allowed to respond to our plan submittals and they were not complete in their review with each response, thus requiring more follow up submittals than were anticipated.

In addition, the cost proposal for this project assumed that the equipment would be able to be replaced with all of the existing conditions within the department (that OSHPD would not require any additional scope of work or modifications to non-related existing conditions). This is always difficult to predict until plans are submitted and approved. There have been a few items that have been added to the scope of work as required by OSHPD and some modifications requested by us to enhance the final outcome of this project. The significant items include:

1. Adding a long length imaging board in one of the x-ray rooms (quote pending).

2. The need to replace the uni-strut system (a ceiling mounted hanger for the x-ray camera) in one x-ray room, which was not properly installed when the existing equipment was installed with the original addition of this building in 1986 ($48,000).

3. Fire Life Safety identified that one section of the wall above the Mamo room does not go all the way to the roof and therefore provide proper fire protection to the suite. Additional construction and installation of new duct work and fire dampers and fire sprinklers above the ceiling are required (quote pending).

4. Additional fees for architect and engineers associated with these changes in scope and OSHPD plan review findings ($8,300).

5. Several other smaller change orders for customer requested scope of work changes (flooring replacement, painting of additional areas in the department for continuity, and additional ceiling work, relocation of bone densitometry, and misc IT related devices) all to enhance the optimal use of the equipment and desired outcome of the project(27,000).

The known additional costs associated with item #2 and some of #4 and #5 is approximately $83,300. Now that we have an OSHPD approved project and final scope defined, we are waiting for a final quote for the Fire Life Safety work, as well as, installation of the long length imaging board.

This project is financed as part of the $2.5 Million Master Lease with Banc of America. Projects committed under this Master Lease are this project ($1.6Million), the new Telemetry system (about $300,000) and the computers and carts for the electronic health record once PCS is implemented (about $280,000). There remains about $300,000 available under this line that should be more than sufficient to cover the unanticipated costs associated with the PACS / Imaging upgrade project.

Demolition of the first x-ray room is scheduled to begin June 13th. The contractor is working closely with Mr. Ellis, Mr. Tom Jones, Chief Engineer and the team from General Electric to ensure as smooth an installation process as possible. The entire construction project is scheduled to take four months and therefore is scheduled to be completed by mid October 2011. We have had, and will continue to have, weekly meetings with the contractors to keep this project progressing through completion.

Fiscal Year 2012
Proposed Operating Budget

Presented by:
Deborah E. Stebbins, CEO
David A. Neapolitan, CFO
Kerry Easthope, Associate Administrator

June 6, 2011
District Board Meeting

Alameda Hospital

Challenges of Bringing in Balance Operating Budget for FY 2012

- Received notice in May to repay $642 K in enjoined State rate reduction
- IGT revenue reduced from >$2 M (2010) to < $1 M
- Delayed start of Wound Care program
- AB 97 (passed by CA legislature) awaiting CMS approval ($2.1 M reduction in revenue)
- Budget as presented includes no wage increases with exception of scheduled SEIU increase.
- Budget includes a 22.7 FTE reduction (5.3%)

Alameda Hospital

Positive Factors

- Mid-year implementation of Wound Care ($624K increase in net revenue)
- 20% increase in FY 2011 of non-Kaiser OP surgeries
- Blue & Gold Plan contract is attracting interest from new physicians
- 25% increase in 1206(B) clinic volume in FY 2011
- Ability to cancel CMAC contract and return to cost-based reimbursement for MediCal (increases net revenue by $1M)

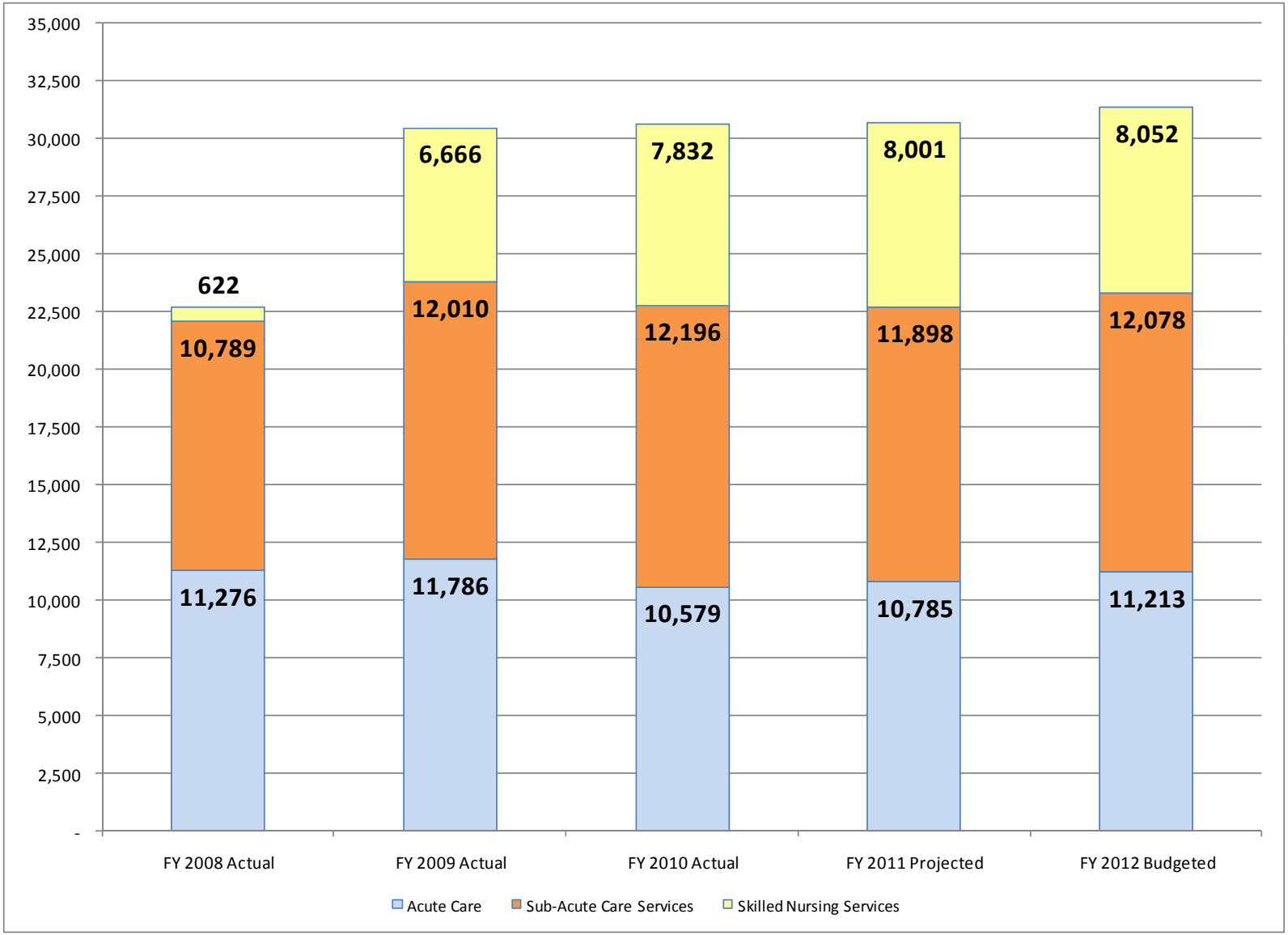
Alameda Hospital

Scenarios Not Included in FY 2012 Budget

- CMS decision to deny proposed AB 97 reduction in long term care rates
- Affiliation with one or more community-based SNF's
- Potential on-site expansion of Subacute program by 12 beds

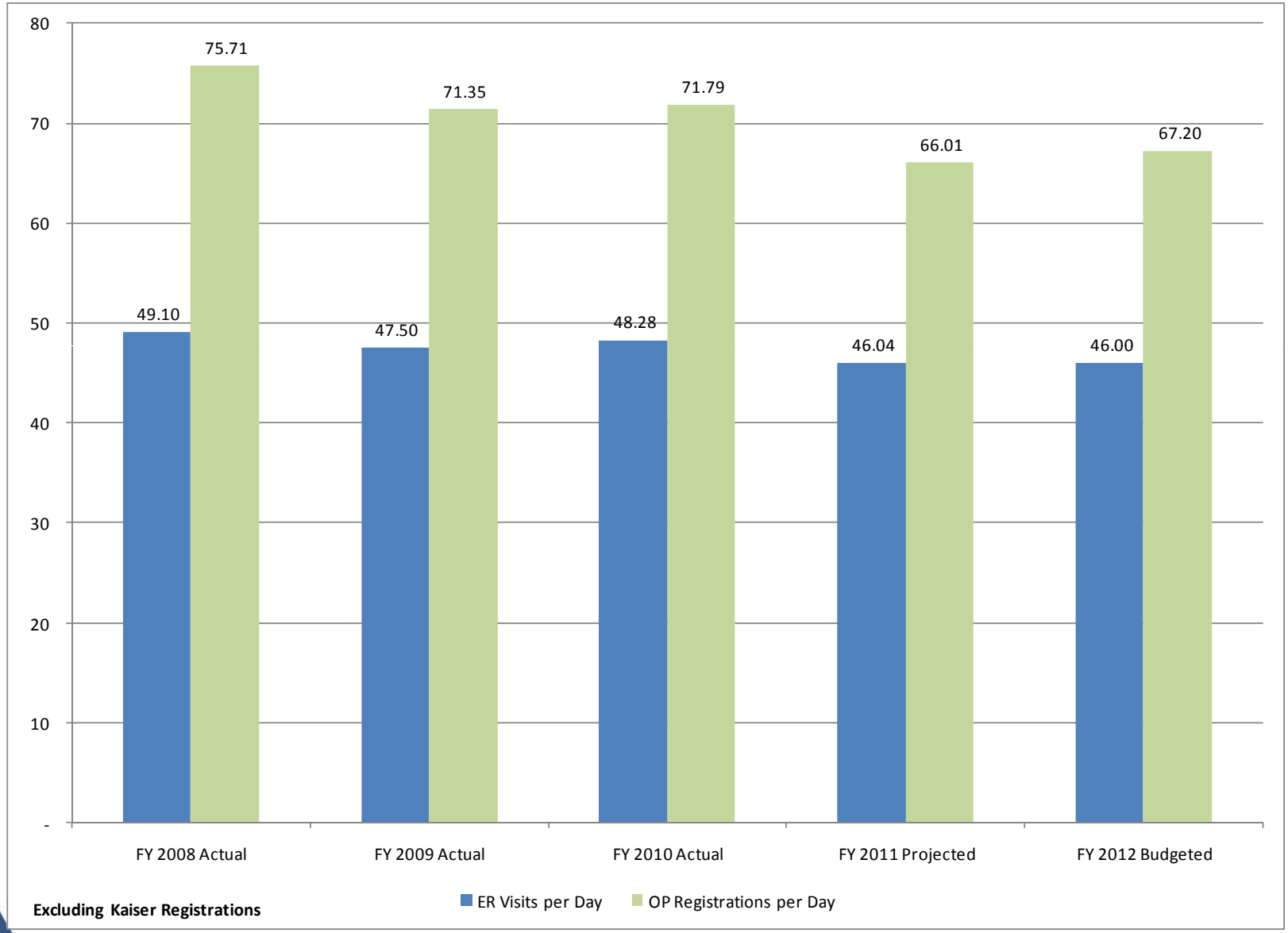
Alameda Hospital

Total Patient Days



Alameda Hospital

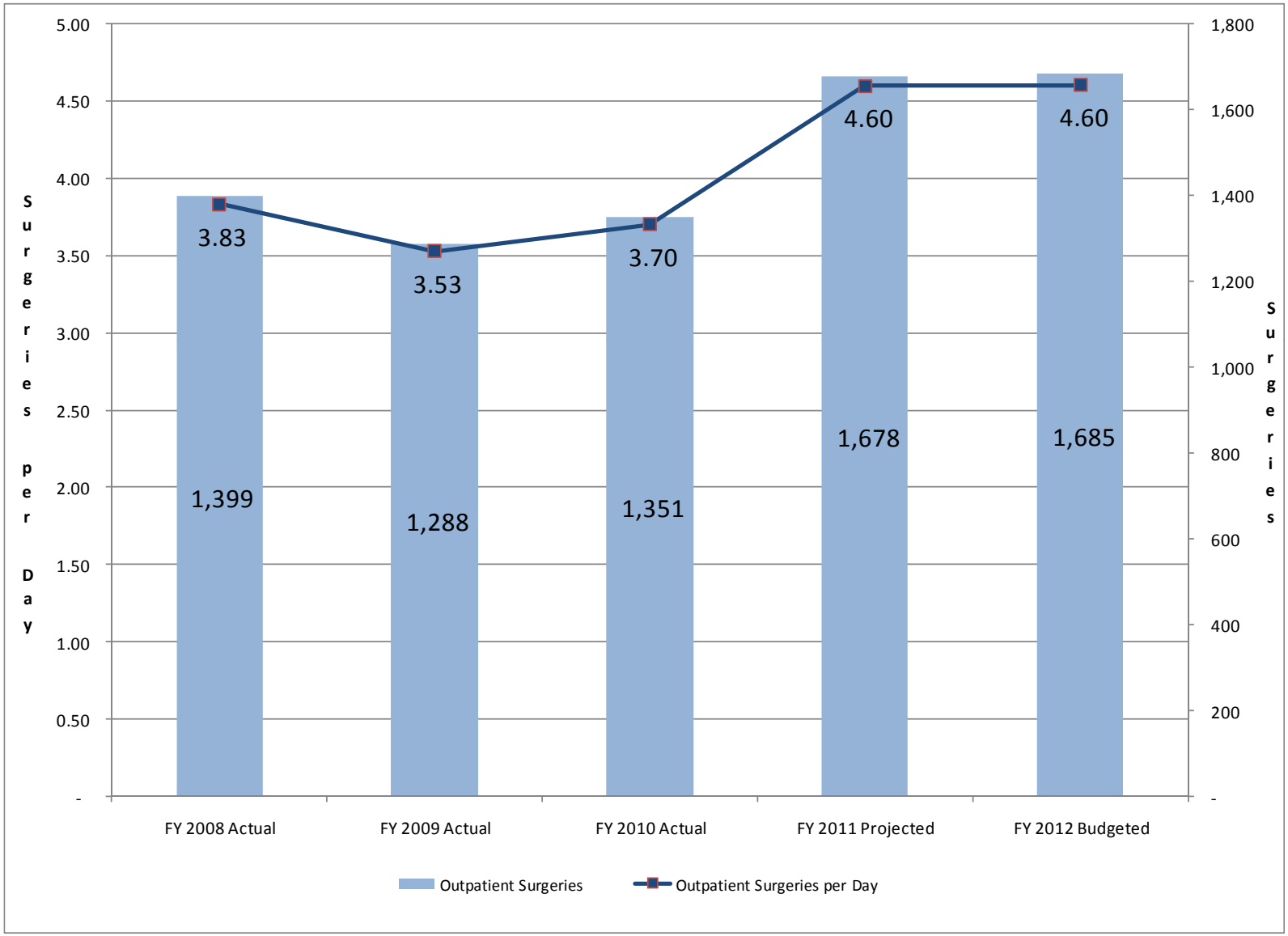
Outpatient Registrations per Day



Excluding Kaiser Registrations

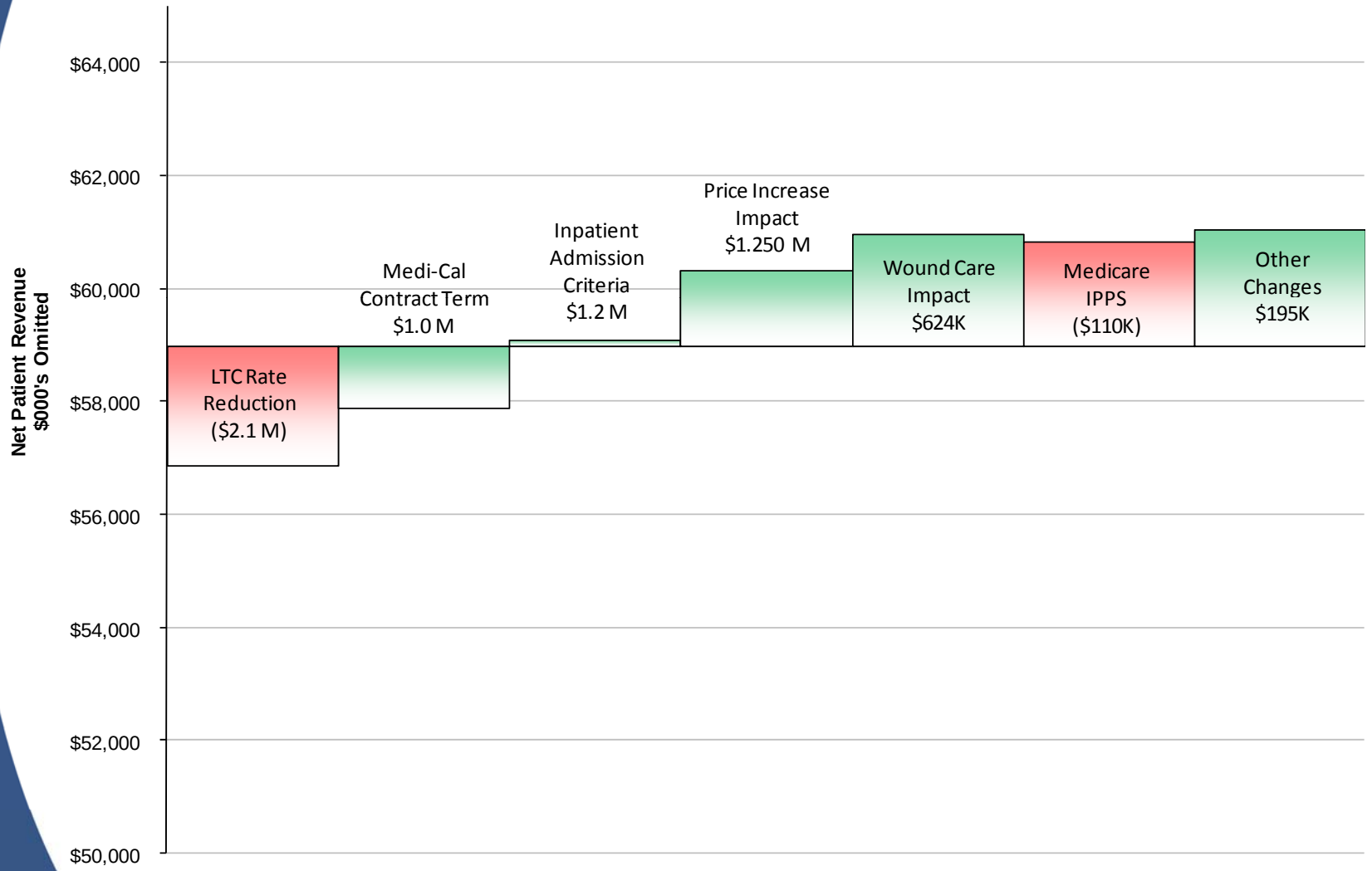
Alameda Hospital

Outpatient Surgeries



Alameda Hospital

Net Revenue Changes



Alameda Hospital

Labor & Benefits

- FY 2012 salary & agency expense is budgeted at $2.4 million below FY 2011 forecast.
  - No budgeted wage increase for unrepresented and all represented employees except SEIU (2.5%).
  - FTE's are budgeted at 408.1, a decrease of 22.7 FTE's from FY 2011 forecast of 430.8
    - About 16 layoffs with the remainder of the FTE reductions coming from reduced hours and departmental reorganizations.
    - Consolidate OR schedule to 4 days per week, with stand-by team on 5th day and weekends (not part of FTE reduction).
    - Nursing budget is based upon State mandated nurse to patient ratios (or nursing per patient day). Although there is some allowance for census fluctuation on the nursing units, tight control and efficiency will be required.

Alameda Hospital

Labor & Benefits continued

- Consolidate dietary service
- Mandatory department closure on specified holidays & three non-holiday closures.
- Mandatory furlough hours during June, July & August.
- Close lab draw station at Alameda Towne Center.
- Reduction in the number of nursing assistants on nursing units.
- Benefits expense is budgeted $119,000 lower than FY 2011 forecast.
  - However, health benefits expense is budgeted at $319,000 higher than FY 2011, to more accurately estimate anticipated cost *(FY 2011 was exceptionally low).*

Alameda Hospital

Non-Labor Expenses

- Professional Fees: Budget to increase $89,000
  - Wound Care Program management fees $292,000
  - Reduction in legal fees: $64,000
  - Reduction in consulting fees for IT: $148,000
- Supplies: Medical supplies budgeted to increase by $500,000 in FY 2012.
  - Budgeted 4% increase in inpatient volumes
  - Increase in blood bank for anticipated cost based upon prior year experience ($95,000).
  - Increase of 5% for Pharmaceutical expense due to anticipated inflation for these items.
  - Supplies associated with the new Wound Care program ($41,000).

Alameda Hospital

Non-Labor continued

- Purchased Services: Budgeted to increase by $30,000 in FY2012.
  - Addition for nighthawk pharmacy service $160,000
  - Full year of MD Office solution for cardiac imaging $60,000
  - Reduction in security coverage $70,000
  - Reduction in biomedical service contract $50,000
  - Reduction in assisted parking $36,000
  - Reduction in off-site storage $35,000

Alameda Hospital

Non-Labor continued

- Rents & Leases: Increase of $343,000
  - Rental expense for PACS, radiology equipment, telemetry equipment, E.H.R equipment (PC's etc)
  - Lease at Marina Village $160,000
- Insurance: budgeted at $158,000 less than FY 2011.
  - Reduction in premiums from program BETA, based on the programs positive claims experience.
- Depreciation & Amortization: Budgeted decrease of $80,000.
- Other Expenses: Budgeted decrease of $157,000
  - Elimination of hospital memberships, reduction in recruitment and relocation expenses, reduction in risk management reserves.

Alameda Hospital

Capital Budget

The following is a list of the recommended capital budget items for fiscal year 2012 that total $1,875,949:

•Equipment	$89,986
•Information Technology	$85,963
•Plant Maintenance	$150,000
•Contingency	$100,000
Sub Total	$425,949

Already in process or previously approved items are as follows:

•Continue to develop Seismic Plans	$100,000
•Electronic Health Record Implementation	$450,000
•Wound Care Program	$900,000

Alameda Hospital

Questions and Comments

Alameda Hospital

Alameda Hospital
2011 Executive Compensation Review

Selected findings from
Integrated Health Strategies Report (April 2011)
June 6, 2011 District Board Meeting

Alameda Hospital

Objectives

- Evaluate executive compensation for top executive positions at Alameda Hospital
  - CEO, CFO, Associate Administrator, Executive Director of Nursing and Director of HR
- Identify relevant national and state comparison peer groups
- Compare components of executive compensation at Alameda Hospital with those in peer group facilities
  - Confirm that current compensation practices are within the boundaries of competitive industry practice
  - Identify course corrections and next steps
- Formalize executive compensation philosophy

Peer Comparisons

- National hospitals comparable in size and complexity
  - For CEO and CFO positions, only independent facilities
  - A total of 55 independent facilities and 70 subsidiary facilities
- California hospitals comparable in size
  - For CEO and CFO positions, only independent facilities
  - To obtain a sufficient sample size, regression analysis was conducted to predict compensation levels in comparably sized hospital
  - A total of 47 facilities
- California data is, on average, 8% higher than national data at median
- No comparable position for AH “Associate Administrator” role

Summary of Findings

- **Total Compensation at Alameda Hospital is reasonable and well within the bounds of competitive practice**
  - 12% above median total compensation in the national peer group
  - 4% above median total compensation in the California peer group
- **Salaries**
  - Positioned at roughly the 70th percentile in the national peer group
  - Positioned slightly above median in the California peer group
- **Total cash compensation**
  - Positioned 1% above the 75th percentile in the national peer group
  - Positioned competitive to the 60th percentile in the California peer group
- **Incentive opportunity levels**
  - Above the average peer group levels for the CEO, CFO, and Associate Administrator
  - Below average peer group levels for the other executives
- **Benefits**
  - Benefit expenditures are positioned at roughly the 25th percentile
  - Retirement is below typical competitive standards
  - Perquisites are conservative and Severance is competitive for the CEO and CFO

Salary Comparisons by position

AH Position	AH Salary	National Median	National 75th %	California Median	California 75th %
CEO	293,550	277,000	322,000	308,000	364,000
CFO	194,293	170,000	203,000	185,000	218,000
Associate Admin.	194,293	157,000	177,000	165,000	188,000
Exec. Dir. Nursing	154,211	137,000	155,000	156,000	168,000
Director HR	128,502	124,000	137,000	129,000	149,000

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Total Cash (Salary plus Incentive) Comparisons by position

AH Position	AH Salary	National Median	National 75th %	California Median	California 75th %
CEO	377,269	326,860	379,960	363,440	429,520
CFO	228,537	187,000	223,300	203,550	239,800
Associate Admin.	228,537	172,700	194,700	181,500	206,800
Exec. Dir. Nursing	159,211	150,700	170,500	171,600	184,800
Director HR	133,502	131,440	145,220	136,740	157,940

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Next Steps

- Formalize the Board's philosophy on executive compensation
- Monitor trends and changes in comparison groups and industry practices
- Work with management to ensure that executive compensation practices maintain an appropriate and sustainable balance between competitive forces and Alameda Hospital budget constraints