Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT

BOARD OF DIRECTORS

AGENDA

Monday, October 4, 2010 – 6:00 p.m.

Location: Alameda Hospital (Dal Cielo Conference Room)

2070 Clinton Avenue, Alameda, CA 94501

Office of the Clerk: (510) 814-4001

Regular Meeting

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

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

II. Roll Call — Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A. Approval of Closed Session Minutes

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

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

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

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

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

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

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

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

A. Announcements from Closed Session — Jordan Battani

VI. Consent Agenda

A. Approval of September 13, 2010 Regular Meeting Minutes **ACTION ITEM** [enclosure] (PAGES 3-15)

B. Acceptance of August 31, 2010 Financial Statements **ACTION ITEM** [enclosure] (PAGES 16-35)

C. Approval of 2009-2013 Goals and Objectives – FYE 2011 Update **ACTION ITEM**

VII. Regular Agenda

A. President's Report — Jordan Battani

1) Announcement of Special Board Meeting Scheduled for October 11, 2010

B. Finance and Management Committee Report

1) Committee Report – September 29, 2010 — Jordan Battani

2) FY 2010 Audit Report **ACTION ITEM** [enclosure] (PAGES 36-64) — Rick Jackson, CPA

C. Chief Executive Officer's Report

1) Approval of 2011 Executive Performance Metrics **ACTION ITEM** — Deborah E. Stebbins

2) Approval of Plan to Mitigate Wage Roll-Back for Non Represented and Exempt Employees for FY 2010 **ACTION ITEM** [enclosure] (PAGES 65-66) — Deborah E. Stebbins

3) Follow-Up on Board President's Report of September 13, 2010 Regarding City of Alameda — Deborah E. Stebbins

4) Monthly Statistics

D. Community Relations and Outreach Report

1) Committee Report – September 28, 2010 — Robert Bonta

E. Medical Staff President Report — Alka Sharma, MD

VIII. General Public Comments

IX. Board Comments

X. Adjournment

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

Draft

Minutes of the Board of Directors

September 13, 2010

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

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

Legal Counsel Present:
Thomas Driscoll, Esq.

Medical Staff Present:
Alka Sharma, MD

Guests:

Excused:

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 6:16 p.m.	
II. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
III. Adjourn into Executive Closed Session	At 6:17 p.m. the meeting adjourned to Executive Closed Session.	
IV. Closed Session Agenda		
V. Regular Agenda	A. Announcements from Closed Session The meeting was reconvened into Open Session at 8:41 p.m. 1. Closed Session Minutes –July 12, 2010 and July 23, 2010 2. Board Quality Committee (BQC) Report – May 2010 3. Medical Executive Committee Report and Approval of Credentialing Recommendations	 The Closed Session Minutes for July 12, 2010 and July 23, 2010 were approved. The May 2010 BQC report was accepted as presented. The Medical Executive Committee Report and Credentialing Recommendations were approved as presented below.

Appointments – Medical Staff

Name	Specialty	Affiliation
○ John Carney, MD	Pathology	Western Labs
○ Carelton Nibley, MD	Cardiology	Arrhythmia Specialists
○ Barry Samuel, MD	Anesthesiology	Island Anesthesia

Reappointments – Medical Staff

Name	Specialty	Status	Appointment Period
○ Peter Candell, MD	Family Medicine	Active	09/01/10 – 08/31/10
○ Deepti Hemrajani, MD	Internal Medicine	Courtesy	10/01/10 – 09/30/12
○ W. Steve Lowery, MD	Pulmonary Medicine Internal Medicine	Active	10/01/10 – 09/30/12
○ Lamont Paxton, MD	Vascular Surgery	Courtesy	10/01/10 – 09/30/12
○ Michael Silpa, MD	Gastroenterology	Active	10/01/10 – 09/30/12

Resignations

Name	Specialty
○ Catherine Covey, MD	Nephrology
○ Richard Brown, MD	Ophthalmology
○ Carla DiGiulio, CRNA	Nurse Anesthetist
○ Raymond Gardner, MD	Ophthalmologist
○ Daniel Newburn, MD	Anesthesiology
○ Jimmy Pak, MD	Vascular Surgery
○ Ingrid Pampalone, PA-C	Physician Assistant (Emergency Medicine)
○ Richard Reid, MD	Emergency Medicine
○ John Roberts, MD	Urology
○ Austin Spitzer, MD	General Surgery
○ Carlos Torres-Roig, CRNA	Nurse Anesthetist
○ Kay Tran, PA-C	Physician Assistant (Vascular Surgery)
○ Jun Yang, MD	Orthopedics

VI. Consent Agenda	A. Approval of July 12, 2010 Regular Meeting Minutes B. Approval of July 23, 2010 Special Meeting Minutes C. Approval of Resolution 2010- 3H – Notice of General Election D. Approval of Administrative Policies and Procedures E. Acceptance of June 30, 2010 Financial Statements F. Acceptance of July 31, 2010 Financial Statements G. 2010 Biennial Review and Approval of the Conflict of Interest Code	Rob Bonta made a motion to approve the consent Agenda as presented. Michael McCormick seconded the motion. The motion carried unanimously.
VII. Regular Agenda	A. Presidents Report 1. Discussion on Posting and/or Public Distribution of Committee Materials Ms. Battani stated that the district had recently had several requests for committee materials, specifically the Finance Committee. The District's current practice is to post the Board Agenda/Packet online on the hospital website along with the the agendas for the Board designated committees (Finance and Management & Community Relations & Outreach). The meeting materials for the board designated committees have not been posted on the website. She has spoken with the District Clerk and CEO and has proposed that we begin to post the committee meeting materials on the website. Director Bonta thought that we should be doing this as well and continue to archive them so that the public can access the material. Director McCormick asked if the reason we were not posting the packets online was a question of space on the website. Director Battani stated that it was not an issue of space on the website but just a matter of not the current practice of posting the committee materials, as we have just recently begun to post the Board packets/materials.	Staff will begin to post the Board designated committee packets on the website.

Director Williams made a request that if we have a constituent that has special needs, the District makes needed alternate accommodations, such as copying and mailing information, for those persons. The District has and will continue to process special requests for materials from any constituent or community member.

Director Bonta stated that the District has made a lot of progress in making materials available to the community. A lot of the sub-committee materials and reports make their way to the website through the Board packet materials. Updates from the committees are also available on film from the monthly Board meetings.

2. Follow-Up to City Council Presentation – September 7, 2010

Ms. Battani summarized the follow-up items from the City Council presentation on September 7, 2010 as outlined in her memorandum.

At the request of City Council, the Board of Directors and Management will plan to present briefings/updates to the City Council on a routine basis to be determined.

Council Members Tam and Matarrese identified two areas as opportunities for collaboration between the two governmental entities; evaluation of use of AFD ambulances for BLS level transfers and evaluation of the VA plans for creation of a new outpatient facility in Alameda. The Board requested that hospital management contact city representatives regarding the ambulance evaluation. The Board also requested that hospital management investigate this opportunity to collaborate with the VA on the outpatient clinic.

Council Member Matarrese suggested a broader activity of reviewing growth plans for the hospital in terms of economic development plan for the City and also extended the invitation again to create a standing committee between the City/District. The Board requested that Management contact city representative to invite a presentation from the Economic Development task force to present at the District Board Meeting. Ms. Battani also asked for periodic updates regarding collaborative initiatives with the city.

B. Chief Executive Officer's Report

1. Consideration of District Board Meeting Calendar

Ms. Stebbins requested that the District Board Meeting calendar be revised to eliminate the 3rd Tuesday of the month (7:30 a.m.) District Board meeting going forward.

The Board agreed to revise the calendar and cancel the 7:30 a.m. 3rd Tuesday on the month District Board meeting. Staff will send out a new calendar of meeting dates through the end of 2011.

2. Monthly Statistics

Ms. Stebbins reported on the monthly statistics as stated below, noting the increased number of surgeries by our surgeons. Director Bonta asked what contributed to the increased number of surgeries. Management responded that eye surgeries and GI surgeries saw significant increases. Block scheduling also contributed to some of the increase.

	August Preliminary	August Budget	July Budget
Average Daily Census	84.5	85.4	80.2
Acute	29.06	28.9	27.0
Subacute	33.5	33.5	32.7
South Shore	21.9	23	20.6
Patient Days	2,619	2,649	2,486
ER Visits	1,450	1,520	1,415
OP Registrations	1,983	2,172	1,991
Total Surgeries	229	198	181
Inpatient Surgeries	55	51	52
Outpatient Surgeries	174	147	129

3. November 2, 2010 Election Update

Ms. Stebbins reported that there are four candidates for three open seats on the City of Alameda Health Care District Board. There will be a LOWV forum scheduled for the candidates on October 16.

	4. Update on City Approval of VA Clinic and Columbarium Ms. Stebbins reported that at a recent City Council meeting, the City approved the building of a VA outpatient clinic and columbarium on Alameda Point.	
	5. Approval to Enter into a Management Services Agreement with Accelecare Wound Centers, Inc. Kerry Easthope, Associate Administrator presented a recommendation requesting that the Board approve entering into a Management Services Agreement with Accelecare Wound Care Centers. The Finance and Management Committee has recommended that the Board approve this contract. The contract term is for 5 years and includes shared management responsibilities and shared upfront investment costs in the facility. There has been interest from the Medical Staff as well as other physicians who have expressed interest in being the Medical Director of the center. There are only two other wound care clinics in the area (John Muir and Doctors Medical Center). The clinic will be operated under the Hospital's license. A financial performance for the first full year is estimated to contribute approximately $193,000 and will ramp up gradually over the next four years to approximately $500,000 positive contribution margin. Director Battani asked if the 400 patients per year was the capacity of the facility in terms of staffing and equipment. Mr. Easthope stated the 400 patients is running a full clinic that operates 5 days a week (M-F) with two hyper baric oxygen chambers with one physician at any given time at the clinic plus supporting staff. Director Williams asked what the exclusivity radius was. Mr. Easthope stated that the radius was by zip code indicated on page 25 of the contract or 97 of the Board packet. Ms. Stebbins stated that marketing to physicians and physician offices will be critical to the success of the program. Director McCormick asked when we should break even based on the pro forma. Mr. Easthope stated that year 2 is estimated to be break even. He also asked what Kaiser's contribution margin was. Ms. Stebbins stated that this program could make up about ½ of the contribution margin that Kaiser was contributing. The pro forma does not include any spin-off revenue. Director Williams asked what the market assessment and needs assessment of the community and surrounding areas.	Director Deutsch made a motion to enter into a Management Services Agreement with Accelecare Wound Centers, Inc. Director Bonta seconded the motion. The motion carried unanimously.

	Mr. Easthope stated that Accelecare has done extensive research based on the area, demographics, and market share for this type of service. The 250 patients in year one is for new patients into the program or approximately 2,500 visits per year. Director Williams asked if affiliating with Accelecare help with our ability to secure financing. Mr. Easthope stated that Accelcare has funds available to help with the build-out, but the cost of their capital would be much greater than what the hospital could get through other institutions. Ms. Stebbins stated that our intent would be to finance the tenant improvements through short term available cash or tapping into our Line of Credit. Mr. Neapolitan also added that the hospital could use part of the $2.5 million capital leasing for PACS to build out the space for the program. Ms. Battani clarified that we would not be going out to get new financing for this project, but would use existing avenues to fund the project. Director Deutsch asked what Aceelcare's commitment to advertising, was including going out to physician offices. Management stated that Accelecare provides the copy for the flyers, brochures, etc. and that the Program Director, provided through Accelecare, would be responsible for the marketing to physician offices and following up with them as well. Director Bonta asked if the program is successful after the five year term of the contract, does the current agreement account for what are options are for going forward. Mr. Easthope stated that the contract would be renegotiated at the end of the term, as the contract does not allow of automatic renewal beyond the five years. Director Bonta asked if the $519,000 margin in year five is maximum capacity at the clinic. Mr. Easthope stated that the program would be considered full capacity based on one physician, five days per week. By entering into a contract with Acclecare now, the Hospital can utilize their expertise in the design of the center, help develop physician the panel, and help with the selection of the Medical Director.	

C. Facilities Report

1. Seismic Update

Mr. Easthope summarized the work being done in regards to seismic compliance. Weekly meetings with the construction management firm, architects and engineers are occurring. OSHPD Plan submittal is on track with Increment 1submitted on June 30, 2010 and Increment 2 being submitted on September 14, 2010. Mr. Easthope reviewed key dates noting the following estimated timeframes:

- Board Seismic Budget Approval 11/01/10
- Issue Notice of Construction RFQ 11/18/10
- Finalize Cal Mortgage Financing 01/15/11
- Estimated Plan Approval/ Permits 03/04/11
- Complete pre-construction enabling moves 03/15/11
- Contractor Selection 03/28/11
- Estimated Start of Construction 04/22/11
- Estimated Certificate of Occupancy 08/24/12
- Estimated Decommission Date 01/01/13

Mr. Easthope stated that a final budget will be brought to the Board in November. The Budget currently is estimated at $10,213,010. Updates will be given to the Board every month thereafter.

SB 499 Status Report on seismic compliance have been submitted as required by the State. There may be another opportunity to apply for an extension, to 2030, on the NPC3 (Non-Structural Performance Category). We currently have a permit to bring the NPC3 up to 2013 standards.

2. New Program Development – Wound Care Program Space Planning

Mr. Easthope stated that the hospital is currently in lease negotiations for a potential site for the Wound Care Program and have been working with Cushman Wakefield. The space is at 815 Atlantic Avenue for approximately 10,000 sq./ft.

3. Diagnostic Imaging – Picture Archiving and Communications System (PACS)

Mr. Easthope stated that the PACS project continues to progress forward.

D. Community Relations and Outreach Report

1. Committee Report – July 27, 2010

Director Bonta stated that when they met the last time the committee focused on the 3B program which was developed. The 3 B's stand for Blood Glucose, Blood Pressure and Body Mass Index. These quick screenings will be offered to local businesses and at community events.

The committee discussed a series of meetings with the business associations and other community groups. Since then, hospital management has had many of those meetings and the response has been positive. Ms. Stebbins will report on the status of those meetings.

The committee heard an overview of the different outreach activities to the community that the hospital will be participating in, including, the Park Street Art and Wine Fair and the Webster Street Jam. Hospital management gave a presentation on the hospital to the residents at Independence Plaza. Director Bonta also stated that the Annual Health Fair will be held October 23, 2010.

The community newsletter will be going out at the end of the month to 30,000 households. The newsletter is an annual publication to update the community on the hospital.

At the last committee meeting, Ms. Stebbins gave a CEO update in which she told the committee of the Hospital's financial performance for the year. Director Bonta stated that the hospital has had its second year in a row with a financial surplus. She also updated the committee on the Medi-Cal contract and seismic planning as well.

The committee did not have a meeting in August, but will meet at the end of September.

2. Status of Outreach to Businesses and Non-Profit Organizations

Ms. Stebbins reported that management has had meetings with the local business associations (WABA, GABA and PISBA). Ms. Stebbins stated that she had a great meeting with the College of Alameda and will be exploring way to work with the college on various programs and services for faculty and students. She stated that she also met with the Boys and Girls and discussed ways to work with them at their new facility. Ms. Stebbins stated that she wants to meet with the school district as well and explore ways to work with them on building a healthier Alameda.

Director Williams wanted to thank staff for being at the Webster Street Jam. Director Battani asked to send a letter of thanks to those who volunteered their time.

E. Finance and Management Committee Report

1. Committee Report – August 25, 2010

Director McCormick stated that Mr. Neapolitan will be giving a year end summary and audit update in a moment. The Finance and Management Committee discussed 2 months of financials.

Director McCormick stated that as the fiscal year end closes it can bring about some interesting discussions and things we should be proud of. He stated that in 1894 the institution was capitalized for 25,000. In today's dollars it would have been $612 million. In 2002 the parcel tax was $298 and if the district was formed today, it would be $350. So in the short and long term, it shows that an ongoing institution, such as the hospital, is a valuable piece of real estate and offers valuable services to the community.

FYE 2010 gave an excess of revenue over expenses of $1.8 million. Total Alameda physician surgery went up by 21% in June with an increase in August as well. It looks like the hospital is on its way to recover from the loss from April 2010 and the termination of the Kaiser contract.

2. FY 2010 Year end Summary and Audit Update

Mr. Neapolitan reviewed the key elements of the year-end financial statements and audit update.

Field work of the financial audit was completed by Rick Jackson of TCA Partners with only minor type of adjustments.

As Director McCormick stated, the year ended with a profit of $1.8 million as a result of some creative things that happened in the year, like participation in the IGT program that was beneficial to the organization. Inpatient volumes for the year were 4% below budget. We continue to see strong emergency room volumes for the year, along with increased Alameda physician surgical volume. Outpatient registrations were below budget due to the lower than anticipated volumes at the clinic. The hospital saw a large improvement in net patient revenue (up 7% from prior year) due to an improved clinical documentation program that began in January, the IGT program, and continued review of the managed care contracts.

On the expense side, we continue to manage expenses well. The average cost per adjusted patient day at the hospital is one of the lowest in the county. The average cost per adjusted patient day in the county is $3,000 and the hospital averages at $1,388.

FTEs per adjusted patient day is 6.0 in the county and is 2.6 at Alameda Hospital.

Mr. Neapolitan reviewed some of the key performance ratios that will also be presented by the auditor, Rick Jackson. Improvements have been made in IBIDA (income before interest and depreciation and amortization) since 2009, increasing from 3.62% to 4.5%. Current ratio has gone from 1.55 to 1.22 meaning more current assets than current liabilities. Days of cash on hand, while still very tight, have also improved since 2009 from 13.6 to 20.4. Net days in receivables declined from 57.3 to 51.8.

Rick Jackson will be at the Finance and Management Committee on September 29 to present the audit and then back to the full Board on October 4 for final approval of the FYE 2010 Financial Statements.

3. Cal-Mortgage Financing Discussions

Mr. Neapolitan stated that Gary Hicks has presented to both the Finance and Management and Community Relations Committee financing options for the Hospital/District for seismic and new program development. As a recap, several types of financing were reviewed from tax exempt financing to government obligation bonds to Cal-Mortgage financing. Cal Mortgage Financing seems to be the best option at this time. On August 2, the hospital submitted a pre-application to Cal-Mortgage for a project in the amount of $16.2 million. Hospital Management went to Sacramento to meet with staff from Cal-Mortgage to present the background on the hospital as well as strategic initiatives for growth and why Alameda Hospital is essential to the community. Currently the Hospital is in the process of preparing a feasibility study to return to Cal-Mortgage for further review before submitting a final application for review by the committee.

	F. Medical Staff President's Report Director Deutsch gave the Medical Staff President's Report on behalf of Dr. Alka Sharma. He reported that the resignations on the Medical Staff were by physicians that were not active on the Medical Staff.	
VIII. General Public Comments	None.	
IX. Board Comments	Director Bonta commented on a great Foundation event on Saturday, September 11, 2010. He said it was a great location, great remarks from staff and community members and overall a successful event. Director Battani wished to extend a thank you to Tony Corica for the special 25th Anniversary presentation.	
X. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 10:09 p.m.

Attest:

Jordan Battani
President

Robert Bonta
Secretary

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING AUGUST 31, 2010

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

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
AUGUST, 2010

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

Financial Overview as of August 31, 2010

- Gross patient revenue for the month of August was less than budget by $506,000 or 2.4%. Inpatient revenue was less than budgeted by 1.9% and outpatient revenue was 3.3% less than budgeted for the month. However, on an adjusted patient day basis gross patient revenue was only 0.8% less than budgeted at $5,310 compared to a budgeted amount of $5,352 for August.

- Total patient days for the month were 2,619 compared to the prior month's total patient days of 2,486 and the prior year's 2,542 total patient days. The average daily acute care census was 29.1 compared to a budget of 28.9 and an actual average daily census of 26.7 in the prior month; the average daily Sub-Acute census was 33.5 versus a budget of 33.5 and 32.7 in the prior month and the Skilled Nursing program had an average daily census of 21.9 versus a budget of 23.0 and prior month census of 20.6, respectively.

- Emergency Care Center (ECC) visits were 1,450 or 4.6% less than the budgeted 1,520 visits and were 6.5% less than the prior year's visits of 1,550.

- Total surgery cases exceeded budgeted expectations for the month at 229 cases versus the budgeted 198 cases. The current month's surgical volume was 44% greater than the same month prior year's 159 cases.

- Outpatient registrations were 8.7% below budgeted targets at 2,172.

- Combined excess expenses over revenue (loss) for August was $127,000 versus a budgeted excess of revenues over expenses (profit) of $149,000. This brings our year-to-date loss to $314,000 versus a budget profit of $278,000.

  - Total assets increased by $309,000 from the prior month as a result of an increase in current assets of $319,000, a decrease in net fixed assets of $22,000 and an increase in restricted contributions of $12,000. The following items make up the increase in current assets:

  - Total unrestricted cash and cash equivalents for August decreased by $325,000. This decrease was primarily the result of the use of one twelfth of the parcel tax revenues to cover current month operating expenses. As a result day's cash on hand decreased to 9.2 at August 31, 2010 from July's 11.1 days.

  - Net patient accounts receivable increased in August by $731,000 compared to increase of $205,000 in July. Day's in outstanding receivables increased to 66.7 in August from 65.7 at July 31, 2010. This increase in day's outstanding was primarily the result of an increase in gross accounts receivable of $1,709,000 resulting from the increase in inpatient acute care activity versus the prior month. Cash collections in August totaled $4.3 million compared to $4.7 million in July.

  - Other assets decreased by $106,000 primarily as a result of a decrease in other receivables of $109,000. The net

decrease in other receivables was the result of several items which included:

- The receipt of $292,000 of parcel tax funds related to the 2009/2010 parcel tax revenues decreased the other receivable amount in August.
- The accrual of $180,000 for the estimated 2010/2011 intergovernmental transfer that is expected during the fiscal year increased the other receivable balance in August.
- The use of $28,000 of accrued forfeiture amounts to offset required pension contributions decreased the other receivable balance in August.

- Total liabilities increased by $423,000 compared to a decrease of $668,000 in the prior month. This increase in the current month was the result of the following:

  - Accounts payable and accrued expenses increased by $609,000 while payroll and accrued expenses increased by an additional $337,000. As a result of this increase of $946,000, the average payment period increased in August to 64.6 from 60.0 as of July 31, 2010.

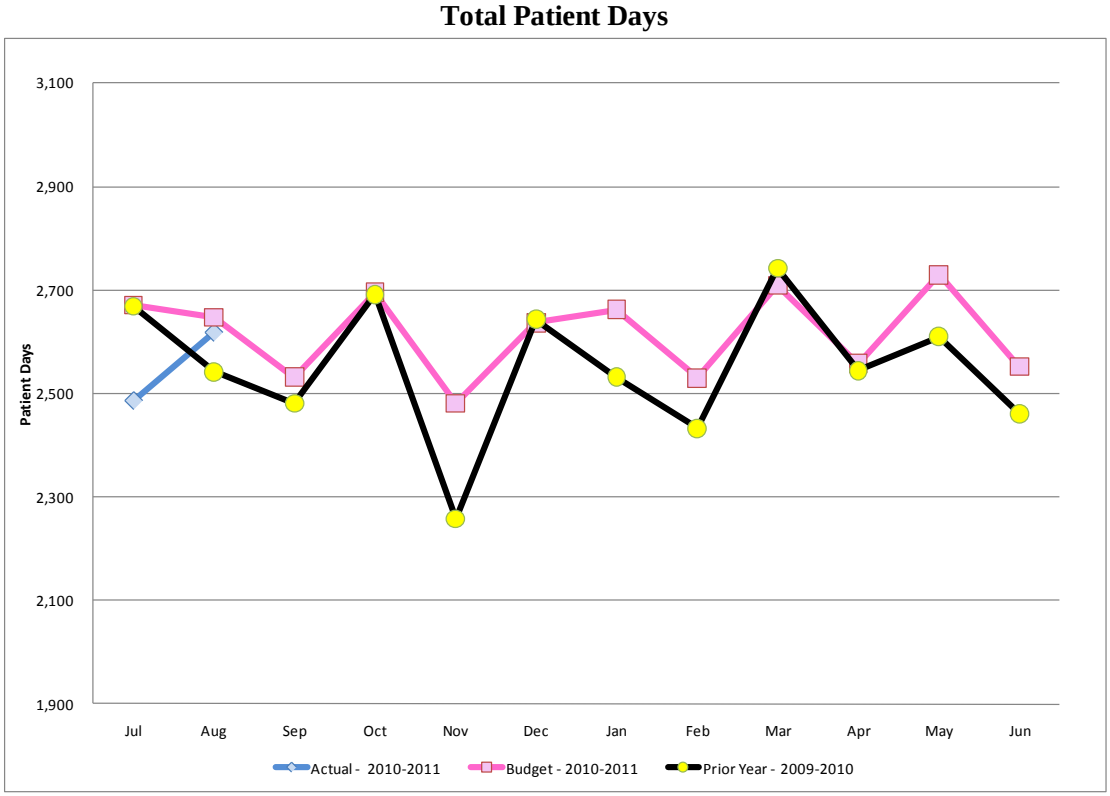
  - Payroll and benefit related accruals increased by $337,000 from the prior month. This increase was primarily the result of an increase in accrued payroll and related payroll tax accruals of $416,000 offset by a reduction in accrued time off of $110,000.

  - Other liabilities decreased by $478,000 of the amortization of one month's deferred revenue related to the 2010/2011 parcel tax revenues.

Volumes

The combined actual daily census was 84.5 versus a budget of 85.4. The current months slightly lower than budgeted census was the result of lower than budgeted census in the skilled nursing unit which as 4.8% below budgeted expectations. The acute care program was slightly better than budget by 0/6% with an average daily census of 29.1 versus the budgeted 28.9. The Sub-Acute program was equal to budgeted expectations with an average daily census of 33.5. In the Skilled Nursing unit the average daily census was 4.6%% lower than budgeted with an average daily census of 21.9 versus a budgeted census of 23.0.

Total patient days in August were only 1.1% less than budgeted and were 3.0% greater than prior year volumes. The graph below shows the total patient days by month for fiscal year 2011.

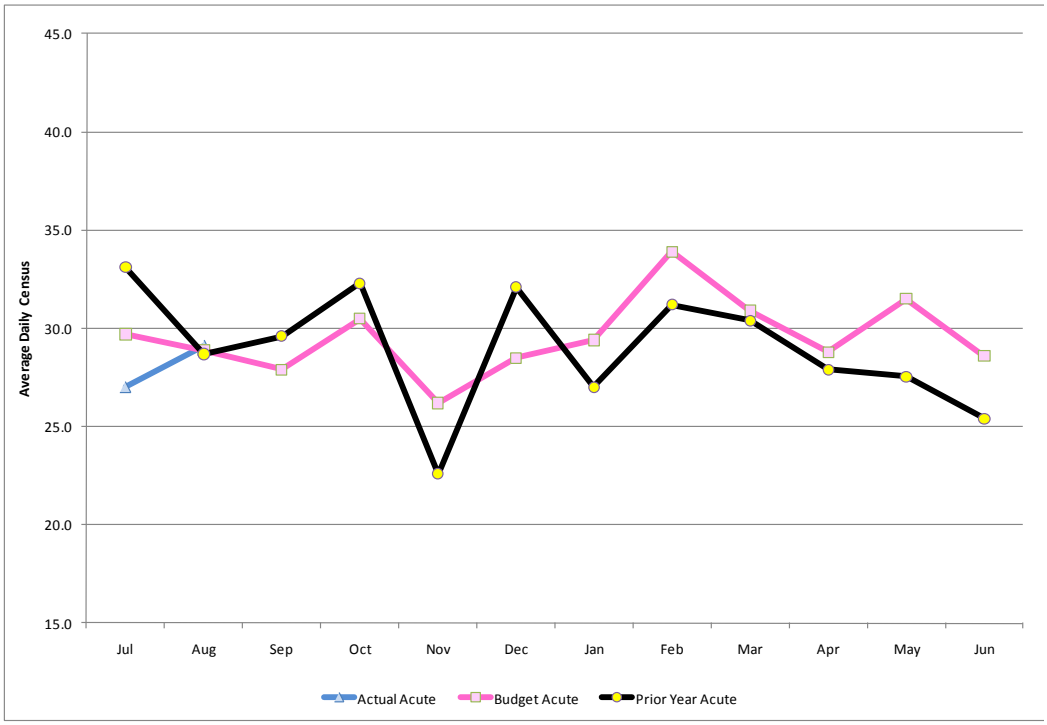


The various inpatient components of our volumes for the month of August are discussed in the following sections.

Acute Care

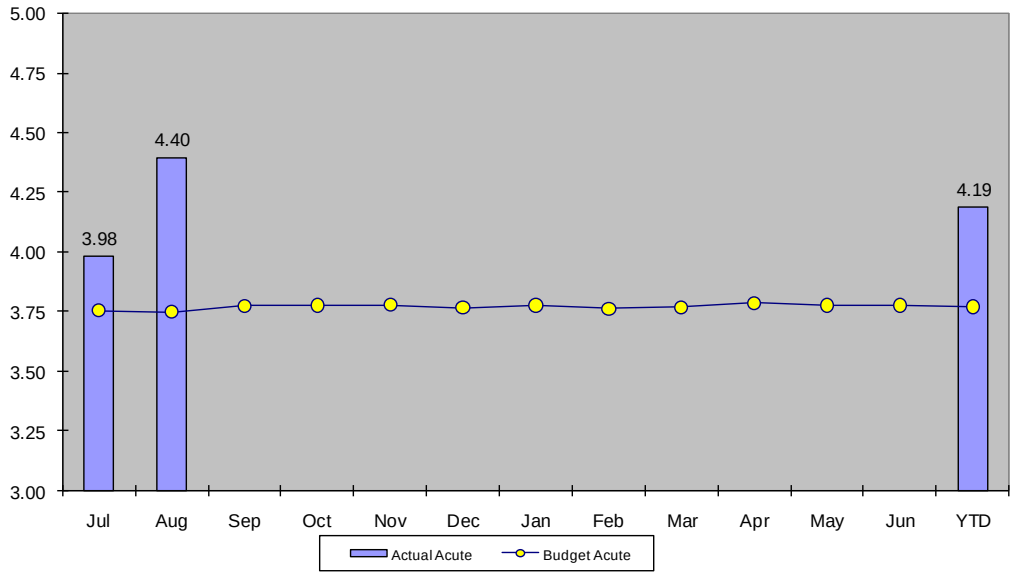
The acute care patient days were 0.6% (5 days) greater than budgeted and were 1.3% greater than the prior year's average daily census of 28.7. The acute care program was comprised of Critical Care Unit (3.9 ADC, 7.6% unfavorable to budget), Definitive Observation Unit (8.9 ADC, 20.2% unfavorable to budget) and Med/Surg Units (16.2 ADC, 20.0% favorable to budget). The graph on the following page shows the inpatient acute care census by month for the current fiscal year.

Inpatient Acute Care Average Daily Census



The average length of stay (ALOS) increased from that of the prior month to 4.4 days for the month of August versus the budgeted FY 2011 average of 3.75. The graph below shows the month ALOS by month and the budgeted ALOS for fiscal year 2011.

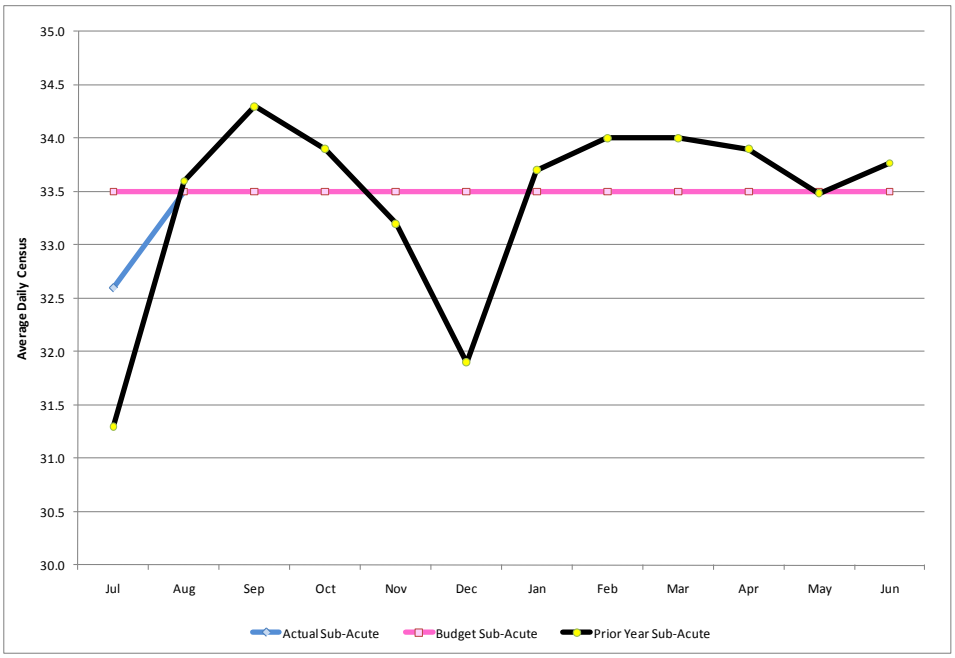
Average Length of Stay



Sub-Acute Care

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

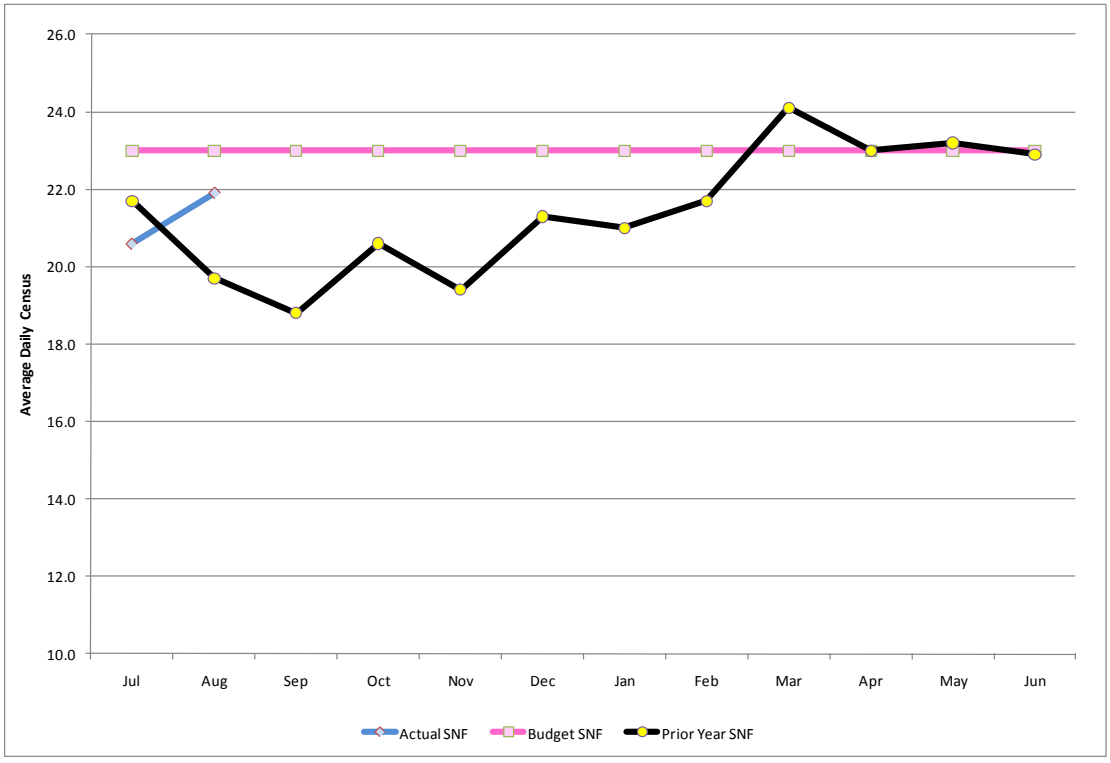
Sub-Acute Care Average Daily Census



Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were 4.8% or 33 patient days less than budgeted for the month of August. Comparing performance to the prior year this program was slightly greater than August 2009 with an average daily census of 21.9 versus 19.7. The following graph shows the Skilled Nursing Unit average daily census as compared to budget and the prior year by month.

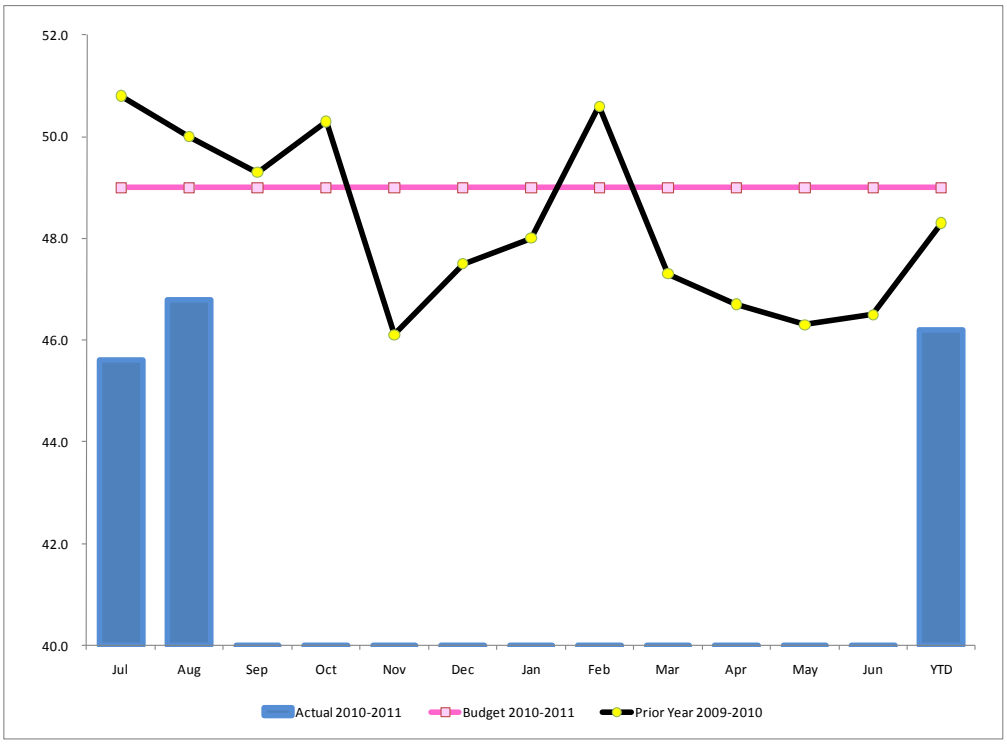
Skilled Nursing Unit Average Daily Census



Emergency Care Center (ECC)

Emergency Care Center visits in August totaled 1,450 and were 4.6% less than budgeted for the month and 15.2% of these visits resulted in inpatient admissions versus 16.5% in July. In August there were 280 ambulance arrivals versus 271 in the prior month, an increase of 3.3%. Of the 273 ambulance arrivals in the current month 154 or 55.0% were from Alameda Fire Department (AFD) ambulances. This much lower percentage of AFD ambulance arrivals than has previously been reported was the result of a correction to the report used to gather this data by ECC staff as the report was not including all non AFD ambulances that were received by the ECC. The corrected data indicates that on average the AFD ambulances account for approximately two-thirds of the total ambulance arrivals to the ECC. The graph below shows the Emergency Care Centers average visits per day for fiscal year 2011 as compared to budget and the prior year performance.

Emergency Care Center Visits per Day

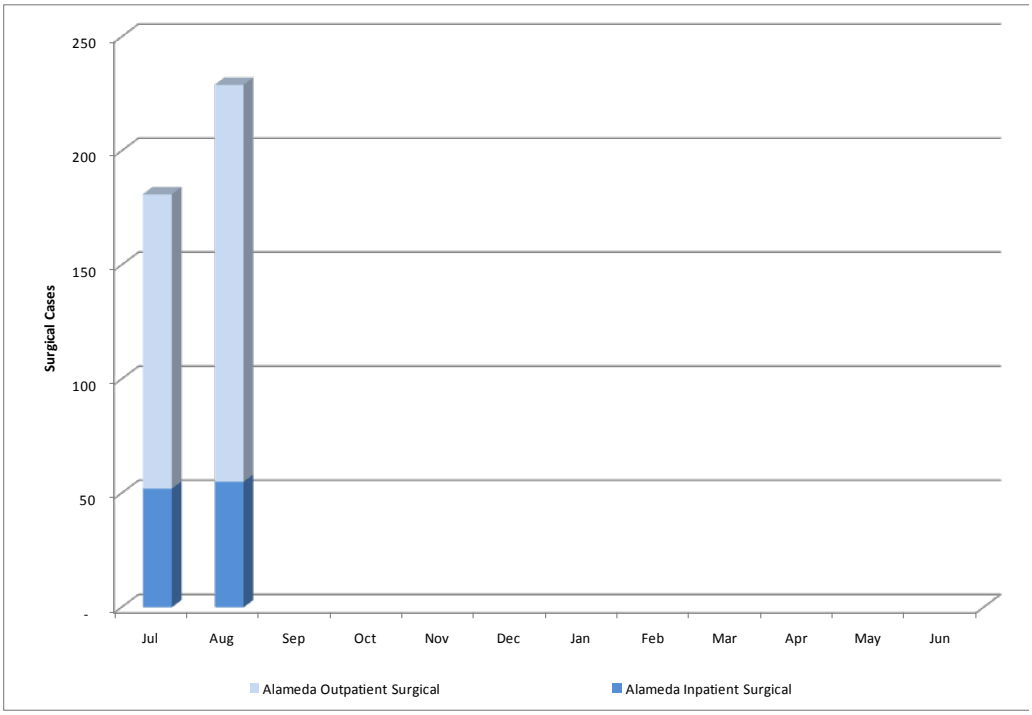


Surgery

Surgery cases were 229 versus the 198 budgeted and 159 in the prior year. In August, surgery cases increased over the prior month by 26.5%. The increase of 48 cases over the prior month was the result of an increase 46 outpatient cases. Inpatient and outpatient cases totaled 55 and 174 versus 52 and 129 in July, respectively. The increase from the prior month was driven by increases in Ophthalmology cases (30) and GI cases (24). These increases were offset by decreased in General Surgical cases (5).

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

Surgical Cases

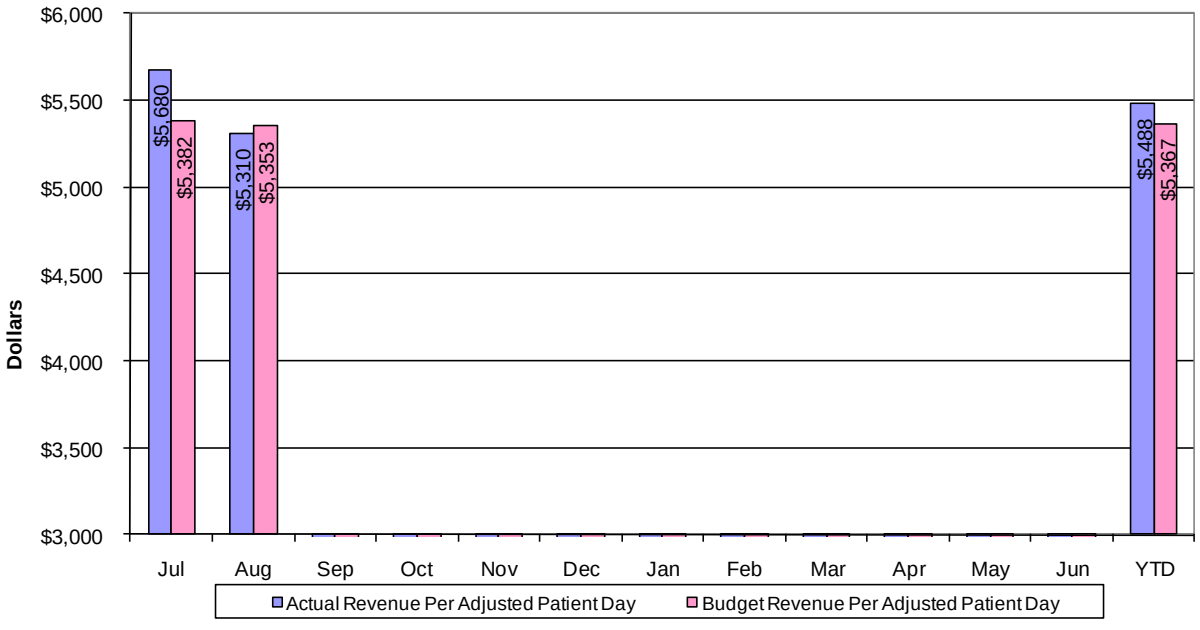


Income Statement

Gross Patient Charges

Gross patient charges in August were less than budgeted by $506,000. This unfavorable variance was comprised of unfavorable variances of $262,000 and $244,000 in inpatient and outpatient revenues respectively. On an adjusted patient day basis total patient revenue was $5,310 versus the budgeted $5,352 or a slightly unfavorable variance of 0.6% from budget for the month of August.

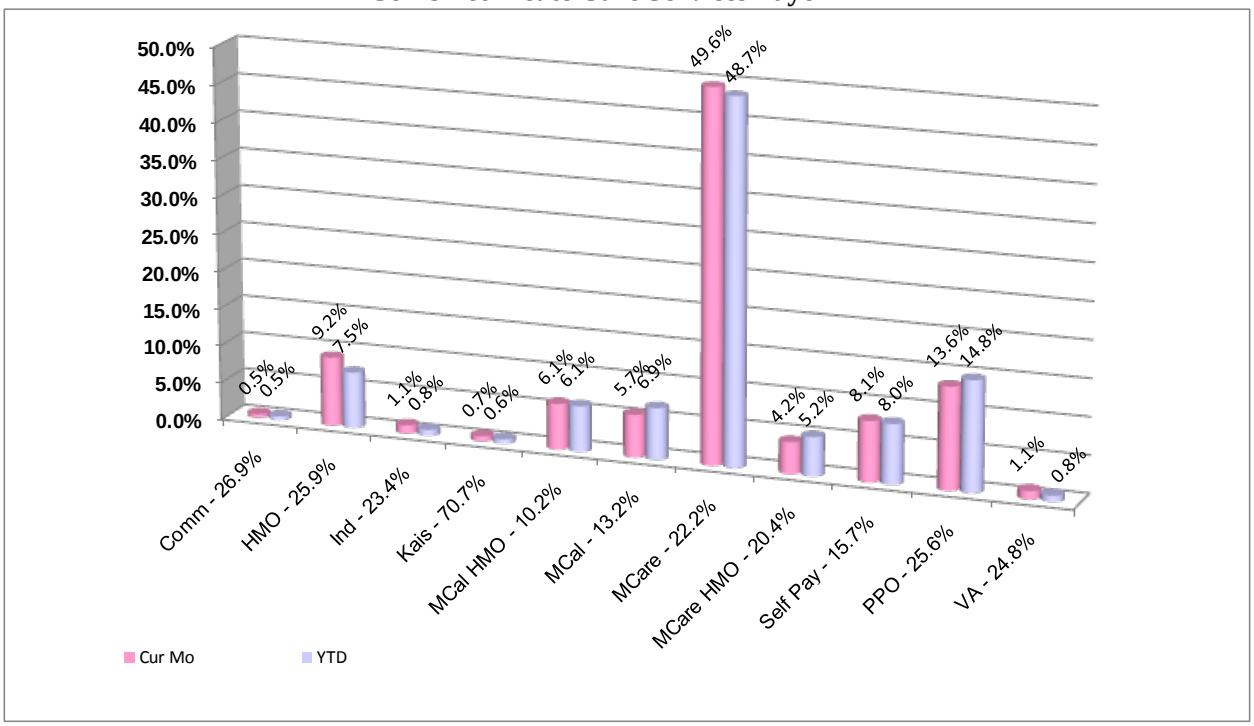
Gross Charges per Adjusted Patient Day



Payor Mix

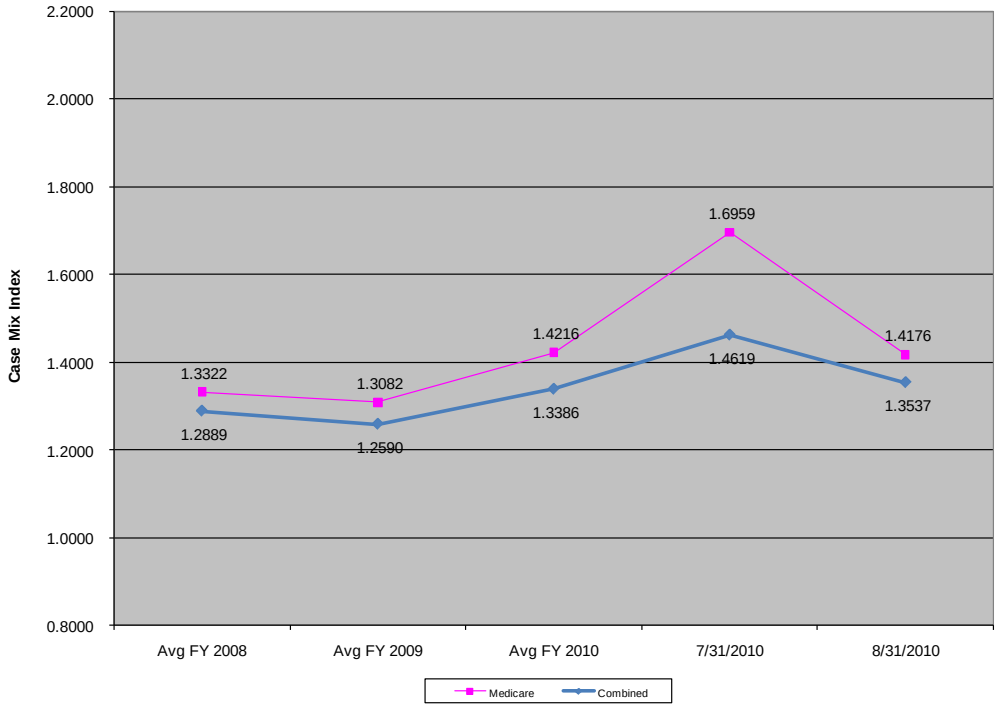
Combined inpatient and outpatient acute care Medicare and Medicare Advantage total gross revenue in August made up 53.8% of the months total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 22.8%, Medi-Cal Traditional and Medi-Cal HMO utilization at 11.8% and self pay at 8.1%. The graph below shows the percentage of gross revenues generated by each of the major payors for the current month and fiscal year to date as well as the current months estimated reimbursement for each payor for the combined inpatient and outpatient acute care services.

Combined Acute Care Services Payor Mix



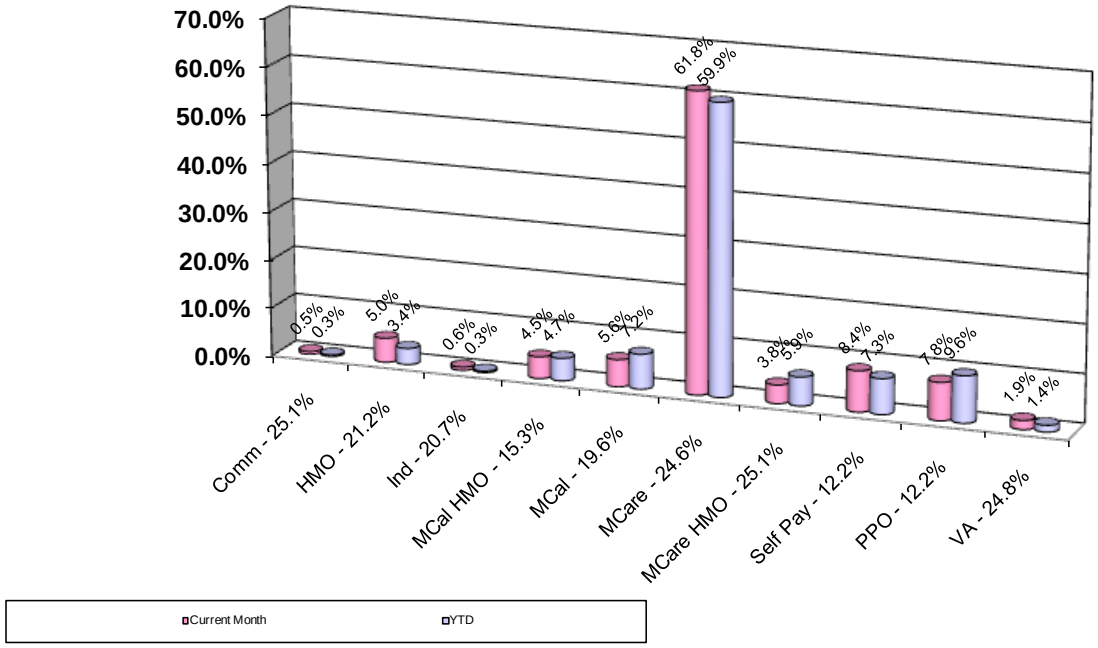
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 65.6% of our total inpatient acute care gross revenues followed by HMO/PPO at 12.8%, Medi-Cal and Medi-Cal HMO was 10.1% and self pay comprised 8.4% of gross inpatient acute care revenue. The hospitals overall Case Mix Index (CMI) decreased to 1.3537 from 1.4619 in the prior month while the Medicare CMI decreased over the prior month from 1.6959 in July to 1.4176 in August. In August there was one (1) outlier case in the month. The overall Medicare reimbursement declined to 24.6% in August versus 25.6% in July as a result of the decline in level of patient acuity during the month of August. The graph on the following page shows the CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

Case Mix Index Comparison



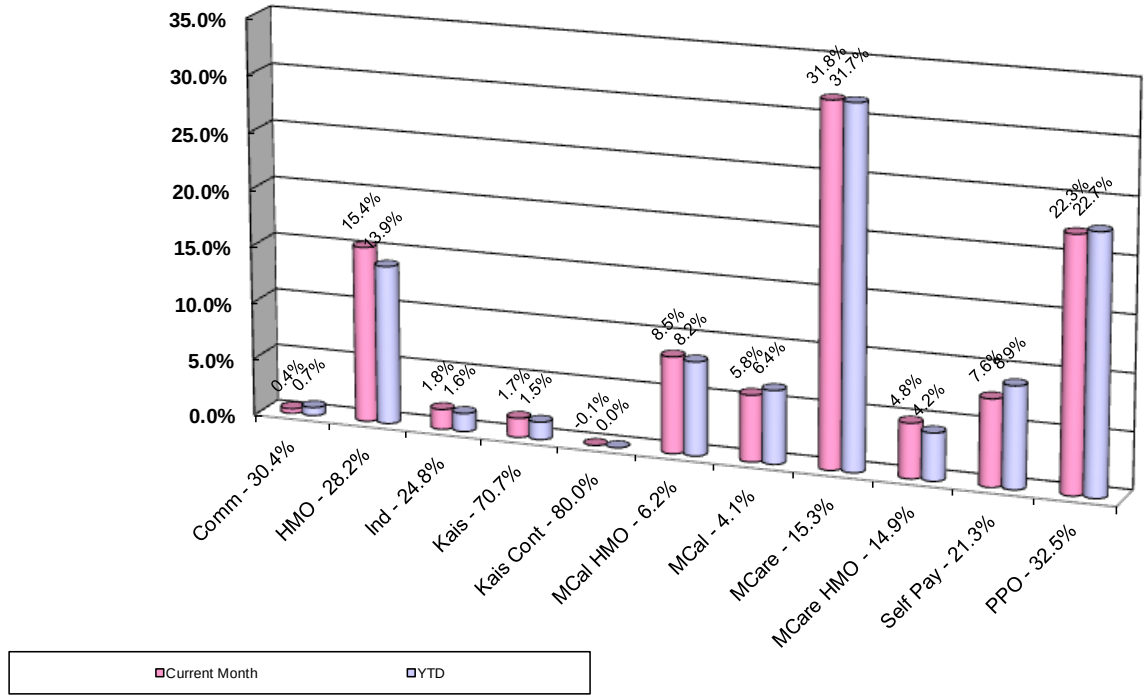
The overall net inpatient revenue percentage increased slightly from the prior month to 21.7% in August versus 21.2% in July despite the change in the Medicare acuity levels and increased Medi-Cal and self pay revenues. The graph below shows inpatient acute care current month and year to date payor mix and current month estimated net revenue percentages for fiscal year 2011.

Inpatient Acute Care Payor Mix



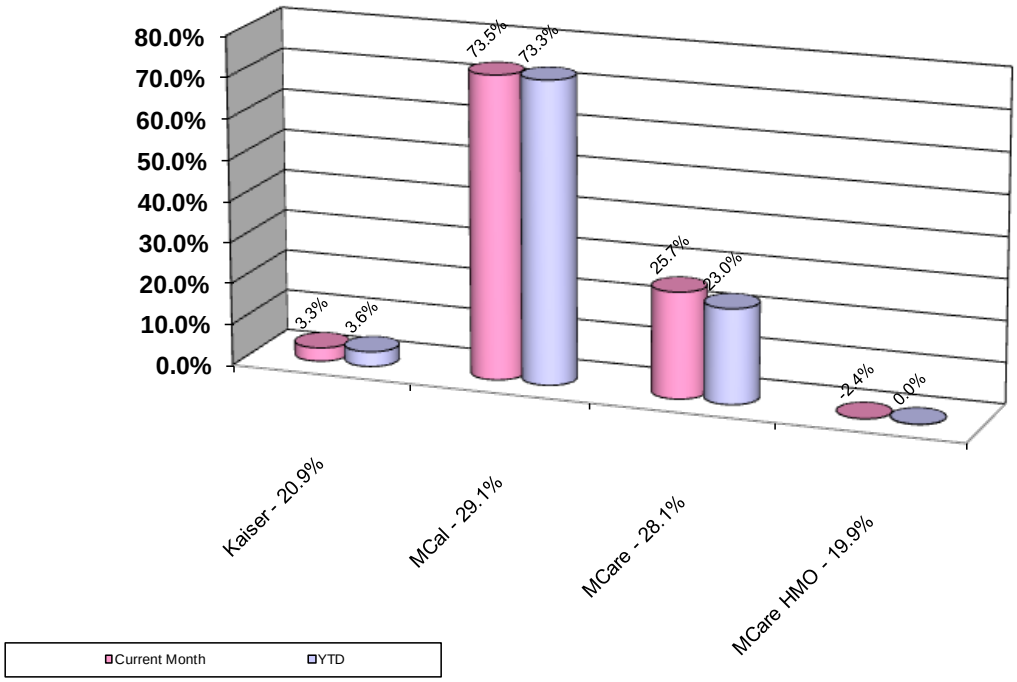
The outpatient gross revenue payor mix for August was comprised of 37.7% HMO/PPO, 36.6% Medicare and Medicare Advantage, 14.3% Medi-Cal and Medi-Cal HMO, and 7.6% self pay. The graph below shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

Outpatient Services Payor Mix



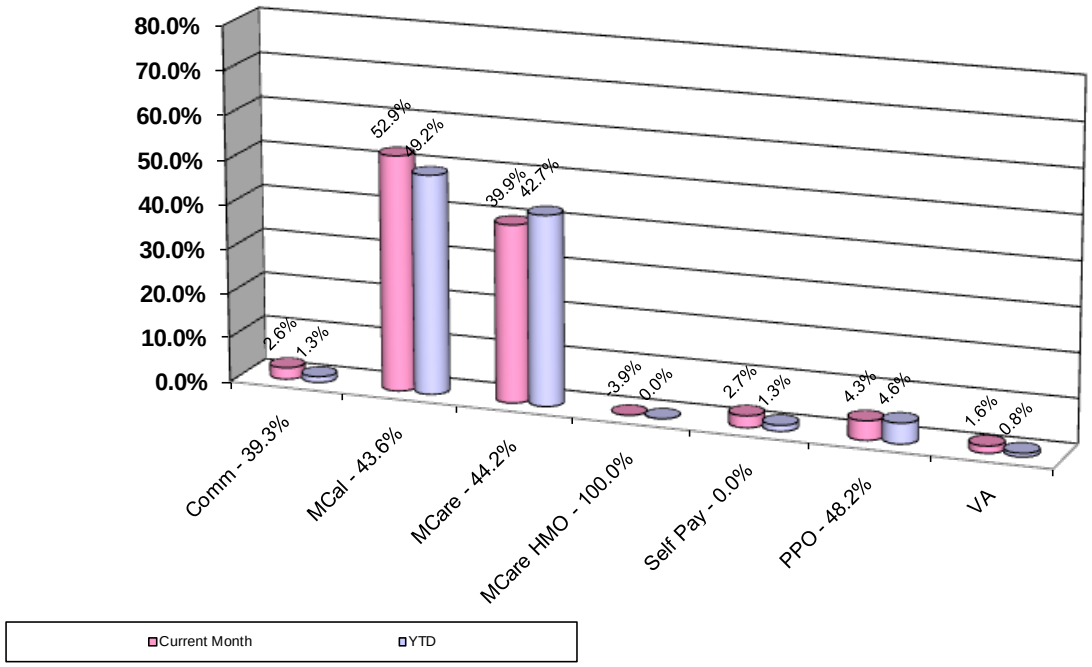
In August the Sub-Acute care program again was dominated by Medi-Cal utilization of 73.5% versus 73.2% in July. The graph on the following page shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.

Inpatient Sub-Acute Care Payor Mix



In August the Skilled Nursing program was again comprised primarily of Medi-Cal at 52.9% and Medicare at 39.9%. 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

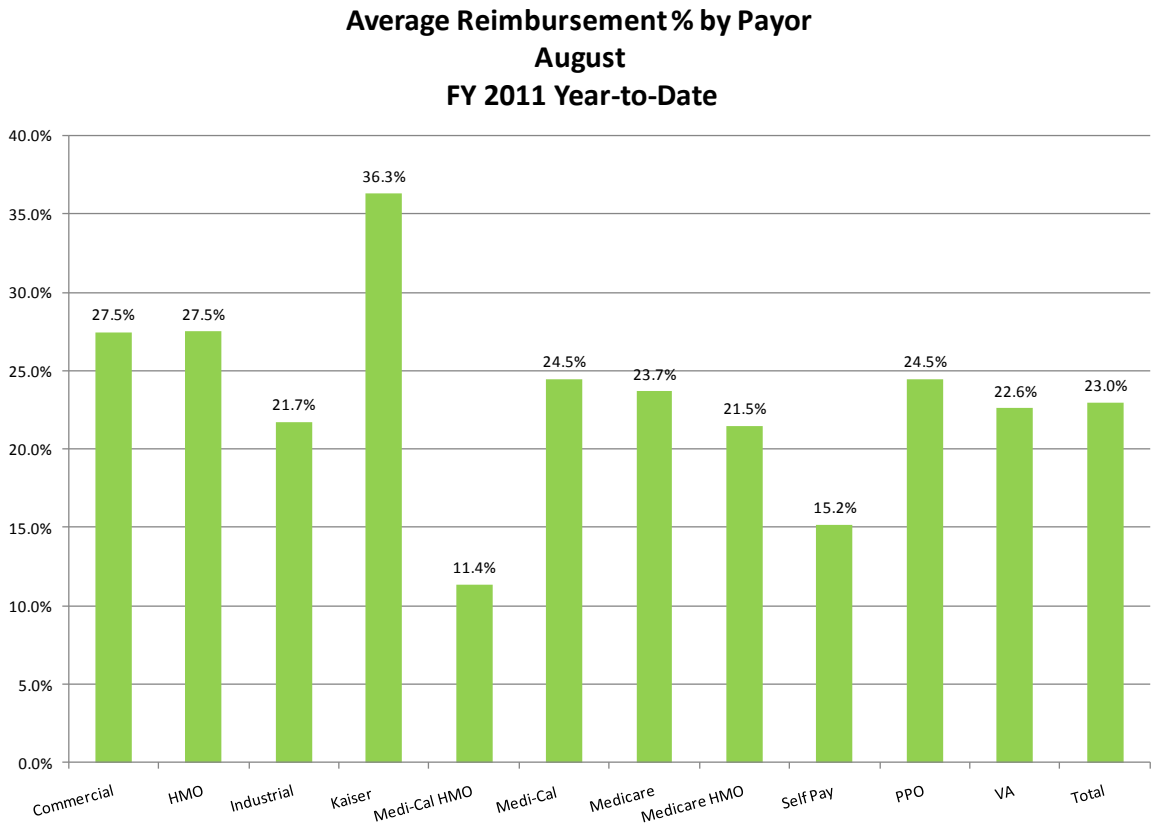


Deductions from Revenue

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 August contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 75.5% versus the budgeted 75.6%.

Net Patient Service Revenue

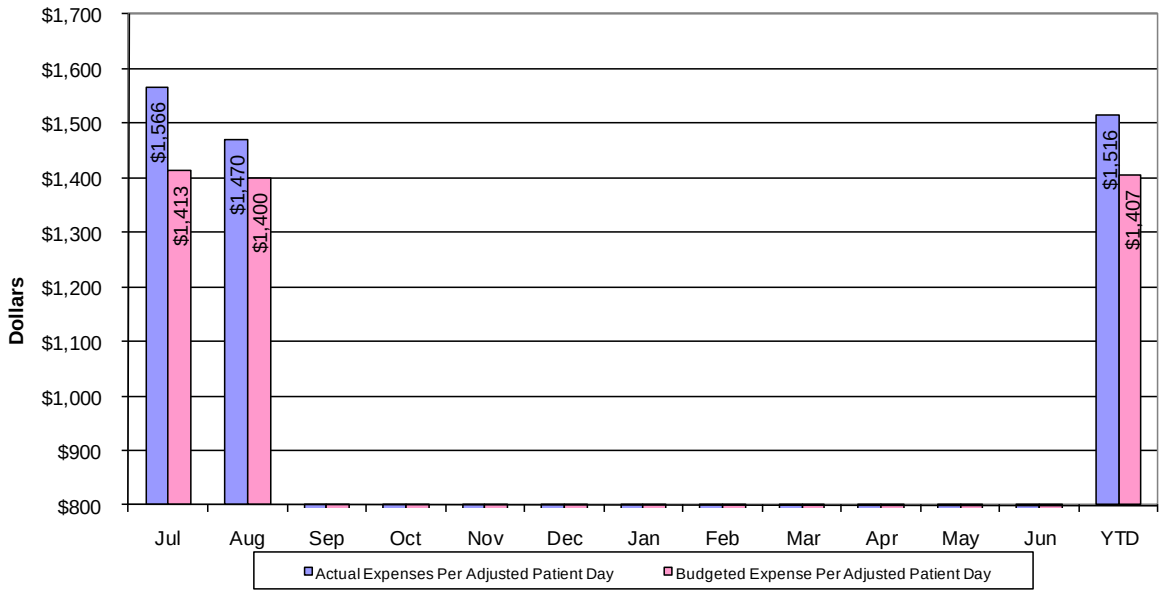
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. The graph on the following page shows the level of reimbursement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



Total Operating Expenses

Total operating expenses were greater than the fixed budget by $189,000 or 3.4%. On an adjusted patient day basis, our cost per adjusted patient day was $1,470 which was $70 per adjusted patient day unfavorable to budget. This variance in expenses per adjusted patient day was primarily the result of an unfavorable variance in supply costs experienced in the month of August. The graph on the following page shows the hospital operating expenses on an adjusted patient day basis for the 2011 fiscal year by month and is followed by explanations of the significant areas of variance that were experienced in the current month.

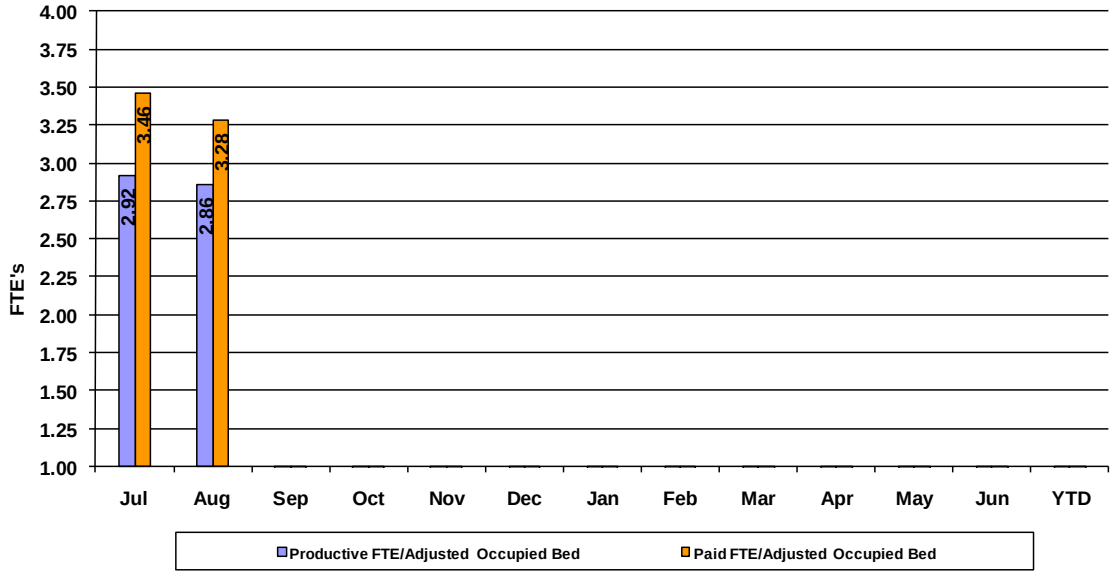
Expenses per Adjusted Patient Day



Salary and Registry Expenses

Salary and registry costs combined were unfavorable to the fixed budget by $158,000 and were unfavorable to budgeted levels on a per adjusted patient day basis in July by $52. The current month's unfavorable variance in salary costs was comprised of unfavorable variances of $69,000 and $88,000 in productive and non-productive salary costs. On an adjusted occupied bed basis, productive FTE's were unfavorable to budget by 2.8% at 2.9 FTE's versus the budgeted 2.8 FTE's. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2011 by month and year to date.

FTE's per Adjusted Occupied Bed



In looking at the productive and non-productive components the productive variance was primarily related to nursing cost centers (CCU, DOU and 3 West) and accounted for $49,000 of the $69,000 unfavorable variance. In reviewing this with nursing management it was determined that in addition to overstaffing in various nursing departments that additional staffing had been used for administrative functions. Effective immediately nursing

managers will be reviewing staffing coverage by shift to ensure that staffing levels are more effectively adjusted to required staffing levels on the units.

Non-productive salary costs were over budget by $88,000 on a departmental level. However, this particular line item does not include the adjustment for utilization of paid time off. Had this adjustment been reflected against this line item the variance would have been a favorable variance of $22,000.

Benefits

Benefits were favorable to the fixed budget by $154,000 or 17.6%. On an adjusted patient day basis benefits were favorable to budget by $35 or 16.3%. This favorable variance was primarily the result of the utilization of paid time off which resulted in a favorable variance from budget of $110,000 in accrued time off benefits. Additionally, group health and worker's compensation benefit costs were lower than budgeted by $51,000 and $25,000, respectively. These favorable variances were offset by unfavorable variances in retirement plan contributions and payroll tax costs of $29,000 and $18,000, respectively.

Supplies

Supply costs were $186,000 unfavorable to the fixed budget and were $50 unfavorable to budget on an adjusted patient day basis. The primary cause of the unfavorable variance from the fixed budget was from unfavorable variances of $74,000 and $100,000 in surgical supplies and pharmacy supplies, respectively.

In the surgical supply category the unfavorable variance was primarily the result of greater than budgeted utilization of prosthesis supplies which were $84,000 greater than budgeted. While inpatient orthopedic cases are relatively equal to the prior year average, the year-to-date average number of outpatient cases has increased by 80% over the prior year.

In the pharmacy component of supplies expense pharmaceutical costs were higher than budgeted as a result of increased utilization of pharmaceuticals in the inpatient and outpatient IVT programs. Inpatient programs generated an additional $128,000 of patient charges while the IVT program generated an additional $133,000 of patient charges.

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

ALAMEDA HOSPITAL
KEY STATISTICS
AUGUST 2010

	ACTUAL AUGUST 2010	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	AUGUST 2009	YTD AUGUST 2010	YTD FIXED BUDGET	VARIANCE	%	YTD AUGUST 2009
Discharges:										
Total Acute	205	239	(34)	-14.2%	220	415	484	(69)	-14.3%	504
Total Sub-Acute	2	1	1	100.0%	-	3	3	-	0.0%	3
Total Skilled Nursing	10	13	(3)	-23.1%	11	21	26	(5)	-19.2%	21
	217	253	(36)	-14.2%	231	439	513	(74)	-14.4%	528
Patient Days:										
Total Acute	901	896	5	0.6%	889	1,737	1,816	(79)	-4.4%	1,914
Total Sub-Acute	1,038	1,038	-	0.0%	1,042	2,050	2,076	(26)	-1.3%	2,013
Total Skilled Nursing	680	713	(33)	-4.6%	611	1,318	1,426	(108)	-7.6%	1,284
	2,619	2,647	(28)	-1.1%	2,542	5,105	5,318	(213)	-4.0%	5,211
Average Length of Stay										
Total Acute	4.40	3.75	0.65	17.2%	4.04	4.19	3.75	0.43	11.6%	3.80
Average Daily Census										
Total Acute	29.06	28.90	0.17	0.6%	28.68	28.02	29.29	(1.27)	-4.4%	30.87
Total Sub-Acute	33.48	33.48	-	0.0%	33.61	33.06	33.48	(0.42)	-1.3%	32.47
Total Skilled Nursing	21.94	23.00	(1.10)	-4.8%	19.71	21.26	23.00	(1.74)	-7.6%	20.71
	84.48	85.39	(0.93)	-1.1%	82.00	82.34	85.77	(1.69)	-2.0%	84.05
Emergency Room Visits	1,450	1,520	(70)	-4.6%	1,550	2,865	3,040	(175)	-5.8%	3,124
Outpatient Registrations	1,983	2,172	(189)	-8.7%	2,607	3,974	4,391	(417)	-9.5%	5,068
Surgery Cases:										
Inpatient	55	51	4	7.8%	64	107	103	4	3.9%	134
Outpatient	174	147	27	18.4%	429	303	290	13	4.5%	868
	229	198	31	15.7%	493	410	393	17	4.3%	1,002
Kaiser Inpatient Cases	-	-	-	-	13	-	-	-	-	31
Kaiser Eye Cases	-	-	-	-	168	-	-	-	-	317
Kaiser Outpatient Cases	-	-	-	-	153	-	-	-	-	337
Total Kaiser Cases	-	-	-	-	334	-	-	-	-	685
% Kaiser Cases	0.0%	0.0%			67.7%	0.0%	0.0%			68.4%
Adjusted Occupied Bed	127.64	129.91	2.27	1.7%	145.90	123.00	129.83	(6.83)	-5.3%	147.70
Productive FTE	365.67	362.18	(3.49)	-1.0%	379.91	359.07	357.64	(1.43)	-0.4%	391.10
Total FTE	419.02	412.20	(6.82)	-1.7%	427.61	418.06	415.02	(3.04)	-0.7%	446.14
Productive FTE/Adj. Occ. Bed	2.86	2.79	(0.08)	-2.8%	2.60	2.92	2.75	(0.16)	-6.0%	2.65
Total FTE/ Adj. Occ. Bed	3.28	3.17	(0.11)	-3.5%	2.93	3.40	3.20	(0.20)	-6.3%	3.02

ALAMEDA HOSPITAL
Balance Sheet
August 31, 2010

	August 31,2010	July 31,2010	Unaudited June 30, 2010
Assets			
Current assets:			
Cash and cash equivalents	$ 1,685,140	$ 2,009,710	$ 3,498,655
Net Accounts Receivable	10,494,127	9,763,541	9,558,147
Net Accounts Receivable %	22.90%	22.13%	21.97%
Inventories	1,144,782	1,148,880	1,149,706
Est.Third-party payer settlement receivable	420,987	397,772	374,557
Other assets	7,354,283	7,460,669	7,091,461
Total Current Assets	21,099,319	20,780,572	21,672,526
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate	499,942	487,591	476,630
Total Non-Current Assets	499,942	487,591	476,630
Fixed Assets:			
Land	877,945	877,945	877,945
Depreciable capital assets, net of accumulated depreciation	6,130,474	6,152,867	6,115,790
Total fixed assets, net of accumulated depreciation	7,008,419	7,030,812	6,993,735
Total Assets	$ 28,607,680	$ 28,298,975	$ 29,142,890
Liabilities and Net Assets			
Current Liabilities:			
Current portion of long term debt	$ 413,003	$ 415,082	$ 417,152
Accounts payable and accrued expenses	6,195,642	5,586,952	6,112,295
Payroll and benefit related accruals	5,063,883	4,726,452	4,351,133
Est.Third-party payer settlement payable	500,000	500,000	500,000
Other liabilities	5,417,553	5,902,815	6,382,701
Total Current Liabilities	17,590,081	17,131,301	17,763,281
Long-Term Liabilities:			
Debt borrowings net of current maturities	1,200,734	1,236,307	1,271,886
Total Long-Term Liabilities	1,200,734	1,236,307	1,271,886
Total Liabilities	18,790,815	18,367,608	19,035,167
Net Assets			
Unrestricted Funds	9,246,923	9,373,776	9,561,093
Restricted Funds	569,942	557,591	546,630
Net Assets	9,816,865	9,931,367	10,107,723
Total Liabilities and Net Assets	$ 28,607,680	$ 28,298,975	$ 29,142,890

Statements of Operations
August 31, 2010
$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,619	2,647	(28)	-1.1%	2,542	5,105	5,318	(213)	-4.0%	5,211
Discharges	217	253	(36)	-14.2%	231	439	513	(74)	-14.4%	528
ADC (Average Daily Census)	84.5	85.4	(0.90)	-1.1%	82.0	82	85.8	(3.44)	-4.0%	84.0
CMI (Case Mix Index)	1.3537				1.3788	1.4078				1.3575
Revenues										
Gross Inpatient Revenues	$ 13,906	$ 14,168	$ (262)	-1.9%	$ 14,403	$ 28,027	$ 28,544	$ (517)	-1.8%	$ 29,210
Gross Outpatient Revenues	7,121	7,365	(244)	-3.3%	11,224	13,816	14,603	(788)	-5.4%	22,122
Total Gross Revenues	21,027	21,533	(506)	-2.4%	25,628	41,843	43,148	(1,305)	-3.0%	51,333
Contractual Deductions	15,204	15,476	272	1.8%	19,592	30,084	30,983	899	2.9%	38,486
Bad Debts	495	646	151	23.4%	114	1,214	1,314	100	7.6%	800
Charity and Other Adjustments	167	161	(6)	-3.5%	43	379	328	(50)	-15.3%	191
Net Patient Revenues	5,161	5,250	(89)	-1.7%	5,878	10,166	10,522	(356)	-3.4%	11,855
Net Patient Revenue %	24.5%	24.4%			22.9%	24.3%	24.4%			23.1%
Net Clinic Revenue	26	28	(1)	-5.4%	-	68	56	12	22.3%	-
Other Operating Revenue	10	14	(4)	-26.1%	35	19	28	(9)	-31.4%	56
Total Revenues	5,198	5,292	(94)	-1.8%	5,914	10,254	10,606	(352)	-3.3%	11,911
Expenses										
Salaries	3,012	2,854	(157)	-5.5%	3,248	6,043	5,702	(341)	-6.0%	6,466
Registry	178	177	(1)	-0.7%	146	348	355	7	1.9%	388
Benefits	720	874	154	17.6%	998	1,616	1,770	154	8.7%	1,937
Professional Fees	307	313	7	2.1%	308	614	627	13	2.0%	661
Supplies	877	690	(186)	-27.0%	911	1,544	1,408	(136)	-9.7%	1,820
Purchased Services	394	375	(18)	-4.8%	391	774	768	(6)	-0.8%	777
Rents and Leases	70	70	(1)	-1.0%	67	122	139	17	12.2%	132
Utilities and Telephone	73	73	0	0.2%	65	117	146	30	20.2%	141
Insurance	29	36	7	18.9%	47	65	71	6	8.6%	92
Depreciation and amortization	82	73	(9)	-11.6%	101	165	147	(18)	-12.2%	201
Other Opertaing Expenses	81	97	16	16.4%	80	154	174	21	11.8%	172
Total Expenses	5,822	5,633	(189)	-3.4%	6,362	11,562	11,307	(255)	-2.3%	12,789
Operating gain (loss)	(624)	(341)	(283)	-83.1%	(448)	(1,309)	(702)	(607)	86.6%	(877)
Non-Operating Income / (Expense)										
Parcel Taxes	478	477	1	0.2%	477	956	954	2	0.2%	954
Investment Income	2	-	2	0.0%	2	4	-	4	0.0%	4
Interest Expense	(7)	(9)	2	21.9%	(9)	(14)	(19)	4	-23.8%	(18)
Other Income / (Expense)	25	22	3	14.6%	20	49	44	4	9.8%	39
Net Non-Operating Income / (Expense)	498	490	8	1.6%	490	995	980	15	1.5%	980
Excess of Revenues Over Expenses	$ (127)	$ 149	$ (276)	-185.2%	$ 42	$ (314)	$ 278	$ (593)	-212.9%	$ 103

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

August 31, 2010

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,511	$ 3,522	$ (10)	-0.3%	$ 3,184	$ 3,677	$ 3,551	$ 127	3.6%	$ 3,190
Gross Outpatient Revenues	1,798	1,831	(33)	-1.8%	2,482	1,813	1,817	(4)	-0.2%	2,416
Total Gross Revenues	5,310	5,352	(43)	-0.8%	5,666	5,490	5,367	123	2.3%	5,605
Contractual Deductions	3,839	3,847	8	0.2%	4,332	3,947	3,854	(93)	-2.4%	4,203
Bad Debts	125	160	36	22.1%	25	159	163	4	2.5%	87
Charity and Other Adjustments	42	40	(2)	-5.2%	10	50	41	(9)	-21.6%	21
Net Patient Revenues	1,303	1,305	(2)	-0.1%	1,300	1,334	1,309	25	1.9%	1,295
Net Patient Revenue %	24.5%	24.4%			22.9%	24.3%	24.4%			23.1%
Net Clinic Revenue	7	7	(0)	-3.9%	-	9	7	2	29.0%	-
Other Operating Revenue	3	3	(1)	-24.9%	8	2	3	(1)	-27.7%	6
Total Revenues	**1,312**	**1,315**	**(3)**	-0.2%	**1,307**	**1,346**	**1,320**	**26**	2.0%	**1,301**
Expenses										
Salaries	760	710	(51)	-7.2%	718	793	709	(84)	-11.8%	706
Registry	45	44	(1)	-2.3%	32	46	44	(2)	-3.5%	42
Benefits	182	217	35	16.3%	221	212	220	8	3.7%	212
Professional Fees	77	78	0	0.6%	68	81	78	(3)	-3.3%	72
Supplies	221	172	(50)	-29.0%	202	203	175	(27)	-15.7%	199
Purchased Services	99	93	(6)	-6.5%	86	102	96	(6)	-6.4%	85
Rents and Leases	18	17	(0)	-2.7%	15	16	17	1	7.4%	14
Utilities and Telephone	18	18	(0)	-1.3%	14	15	18	3	15.8%	15
Insurance	7	9	2	17.6%	10	9	9	0	3.6%	10
Depreciation and Amortization	21	18	(2)	-13.4%	22	22	18	(3)	-18.3%	22
Other Operating Expenses	20	24	4	15.1%	18	20	22	2	7.0%	19
Total Expenses	**1,470**	**1,400**	**(70)**	-5.0%	**1,407**	**1,517**	**1,407**	**(110)**	-7.9%	**1,396**
Operating Gain / (Loss)	**(158)**	**(85)**	**(73)**	-86.0%	**(99)**	**(171)**	**(87)**	**(84)**	97.0%	**(96)**
Net Non-Operating Income / (Expense)	**126**	**122**	**4**	**3.2%**	**108**	**130**	**122**	**9**	**7.1%**	**107**
Excess of Revenues Over Expenses	**$ (32)**	**$ 37**	**$ (69)**	-186.5%	**$ 9**	**$ (41)**	**$ 35**	**$ (76)**	-217.5%	**$ 11**

Audited Financial Statements

CITY OF ALAMEDA
HEALTH CARE DISTRICT

Dba ALAMEDA HOSPITAL

June 30, 2010

Audited Financial Statements

CITY OF ALAMEDA HEALTH CARE DISTRICT

June 30, 2010

Management's Discussion and Analysis

CITY OF ALAMEDA HEALTH CARE DISTRICT

June 30, 2010

The management of the City of Alameda Health Care District (the Hospital) has prepared this annual discussion and analysis in order to provide an overview of the Hospital's performance for the fiscal year ended June 30, 2010 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's historical financial performance as a whole in addition to providing a prospective look at revenue growth, operating expenses, and capital development plans. This discussion should be reviewed in conjunction with the audited financial statements for the fiscal year ended June 30, 2010 and accompanying notes to the financial statements to enhance one's understanding of the Hospital's financial performance.

Volumes and Statistics

- Acute care patient days were 10,579 for fiscal year 2010 as compared to 11,787 for the prior year. Discharges were 2,802 for the current year versus 2,812 for the prior year resulting in lengths of stay of 3.78 for 2010 as compared to 4.19 for 2009.

- Sub-acute and skilled nursing days were 20,028 for fiscal year 2010 as compared to 18,676 for fiscal year 2009, equaling an average daily census of 54.9 for 2010 versus 51.2 for 2009.

- Overall combined occupancy for the Hospital, including the sub-acute and skilled nursing programs, was 52.1% for the year ended June 30, 2010 versus 51.8% for the year ended June 30, 2009.

- There were 4,912 cases during fiscal year 2010 (683 inpatient and 4,229 outpatient cases) as compared to 5,885 cases for the prior fiscal year (690 inpatient and 5,195 outpatient cases). Surgery cases for fiscal year 2010 were lower than the prior year due to the expiration of the Kaiser Outpatient Surgery Services contract in accordance with the terms of the contract on March 31, 2010. Kaiser's decision to end this five-year relationship was the result of their desire to move services previously provided in non-Kaiser facilities back into Kaiser-owned facilities. Kaiser cases were 2,969 in 2010 versus 4,009 in 2009.

- Outpatient registrations decreased by 869 registrations over the prior year (29,079 for 2010 versus 29, 948 for 2009). This decrease in outpatient registrations was the result of the expiration of the Kaiser Outpatient Surgery Services contract.

- Emergency room visits were 17,624 in the fiscal year 2010 as compared to 17,337 for the prior year.

- FTE's per adjusted occupied bed were 3.11 for 2010 versus 2.93 for the prior year.

Financial Highlights

During fiscal year 2010, the health care industry continued to face operational and financial challenges. At the local, regional and national levels, health care institutions continue to experience serious cost and payment pressures dictated by federal and state health care reforms, and from both governmental payors (Medicare and Medi-Cal) and private insurance carriers.

The continued uncertainty surrounding current economic conditions continues to place challenges on the health care market. As the economy has continued to be uncertain during this past fiscal year, there continues to be inflationary pressures on medical supplies, devices and pharmaceuticals. Employers have reduced healthcare coverage for employees and increased deductibles during recent years and are now trying to determine the impact that health care reform will place upon their operating margins. Unemployment rates across the nation continue to remain at very high levels and, with these increased unemployment levels, there is a strong likelihood that there will be corresponding increases in uncompensated care and bad debt in upcoming years.

Despite these challenges and the expiration of the Kaiser Outpatient Surgery Services contract, the Hospital was able to continue to improve its financial performance overall during fiscal year 2010. Some of the factors that contributed to the Hospital's improved financial performance include:

- The increase in utilization of the 26-bed skilled nursing facility which opened in August, 2008 that added to the Hospital's continuum of care for residents of Alameda.
- The disproportionate share/intergovernmental transfer program which added approximately $2.1 million to fiscal year 2010 net patient revenue.
- The added volume and referral pattern of the Alameda Hospital Physicians Community Clinic at the Alameda Town Center which opened in January, 2009. The Clinic continues to provide additional primary care and specialty physician care services to the community.
- Continued focus on ensuring that Hospital operating expenses are maintained at optimal levels while ensuring that each department delivers the highest quality of care to our patients.

These factors resulted in the following highlights:

- Net assets increased by $2,017,000 in 2010 as compared to $730,000 in 2009
- Net patient service revenues increased by $4,712,000 or 7.5% while total operating expenses increased by $3,397,000 or 4.9% over the prior fiscal year.

- The Hospital's operating loss, before parcel tax revenue, decreased to $4,127,000 for fiscal year 2010 as compared to $5,414,000 for fiscal year 2009.

- Current assets increased by $1,248,000 while current liabilities decreased by $197,000 over the prior fiscal year. This resulted in an improvement of the current ratio at June 30, 2010 to 1.23 as compared to 1.15 for the prior year.

- Net days in patient accounts receivable were 51.5 at June 30, 2010 as compared to 58.3 at June 30, 2009.

- Total assets increased by $1,334,000 over the prior fiscal year. Total operating cash and cash equivalents increased by $1,691,000 over the prior year (see the *Statements of Cash Flows* for changes).

The Hospital's financial statements consist of three statements: balance sheet; statement of revenues, expenses, and changes in net assets; and statement of cash flows. These financial statements and related notes provide information about the activities of the Hospital, including resources held by the Hospital but restricted for specific purposes by contributors, grantors, or enabling legislation.

The balance sheet includes all of the Hospital's assets and liabilities, using the accrual basis of accounting, as well as an indication about which assets can be used for general purposes and which are designated for a specific purpose.

The statement of revenues, expenses and changes in net assets reports all of the revenues earned and expenses incurred during the time period indicated. Nets assets (the difference between total assets and total liabilities) is one way to measure the financial health of the Hospital.

The statement of cash flows reports the cash provided by and used by the Hospital's operating activities, as well as other cash sources such as investment income and cash payments for capital additions and improvements. This statement provides meaningful information on how the Hospital's cash was generated and how it was used during the fiscal year.

Balance Sheet - Assets

For the fiscal year ended June 30, 2010, the Hospital's total unrestricted and restricted cash and investments totaled $4.2 million as compared to $2.5 million in the prior fiscal year. At June 30, 2010, day's cash on hand was 21.6 as compared to 13.6 for the prior year. The Hospital's goal is to maintain sufficient cash and cash equivalent balances to pay all short-term liabilities and to be able to expand services available to the community.

During the year, the Hospital added $1,244,000 in capital assets most of which was for major moveable equipment and various minor construction and improvement projects on the Hospital's campus. The Hospital has close to a dozen projects in process at year end for various renovations and equipment improvements.

Balance Sheet - Liabilities

As previously discussed, the Hospital's current liabilities decreased by $197,000 from the prior year. Changes were comprised of minor decreases in trade payables by $88,000, decreases in deferred revenues by $787,000, increases in third party payor settlements by $193,000, decreases in health insurance claims by $102,000 and increases in accrued payroll and related liabilities of $585,000.

Balance Sheet - Net Assets

The Hospital reports its net assets in three categories:

- ***Invested in capital assets net of related debt***: Total investment in Hospital property and equipment (capital assets) net of accumulated depreciation and outstanding debt borrowings related towards the purchase of those capital assets.

- ***Restricted by contributors***: Resources the Hospital is legally or contractually obligated to spend in accordance with restrictions placed by donors and/or external third parties that have placed a time limit or purpose restriction on the use of the asset.

- ***Unrestricted net assets***: All other funds available for use by the Hospital to meet general obligations and to fund current operating expenses.

Statement of Revenues, Expenses and Changes in Net Assets

The statement of revenues, expenses and changes in net assets presents the operating results of the Hospital, as well as the nonoperating revenues and expenses. Activities are reported as either operating or nonoperating. The use of long-lived assets, referred to as capital assets, is reflected in the financial statements as depreciation, which amortizes the cost of the asset over its expected useful life.

Gross Patient Charges

The Hospital charges all patients equally based on its established pricing structure for the services rendered.

Acute inpatient gross charges increased by $1.6 million from fiscal year 2009 due mainly to price increases as acute care patient days decreased by 1,208 days in fiscal year 2010. The subacute and skilled nursing unit charges increased in fiscal year 2010 by $1.9 million due mainly to patient day increases of 1,352.

Outpatient gross charges decreased by $7.4 million as a result of the expiration the loss of the Kaiser Outpatient Surgery Services contract as previously discussed.

Deductions From Revenue

Deductions from revenue are comprised of contractual allowances and provisions for bad debts. Contractual allowances are computed deductions based on the difference between gross charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare and Medi-Cal and other third party payors such as Blue Cross.

The provision for bad debts for fiscal year 2010 and fiscal year 2009 were $6.3 million and $7.6 million, respectively. As a percentage of gross patient charges, the allowance has decreased from 2.7% in fiscal year 2008 to 2.3% in fiscal year 2010.

Contractual allowances and the provision for bad debts (as a percentage of gross patient charges) were 75.7% for fiscal year 2010 as compared to 77.7% for fiscal year 2009. The decrease in contractual allowances was due primarily to programs such as the disproportionate share program as previously discussed (approximately 1%) and by increases in reimbursement from third party contracts and slight increases from government based programs.

Net Patient Service Revenues

Net patient service revenues are the difference between gross patient charges and deductions from revenue. Net patient service revenues increased by $4.7 million as a result of price increases, volume changes and improved reimbursement from government agencies and third parties.

Operating Expenses

Total operating expenses were $72.1 million for fiscal year 2010 compared to $68.7 million for fiscal year 2009. This 4.9% increase is due primarily to:

- A $1.8 million or 8.8% increase in salaries, wages, registry and benefits from the prior year. Total full time equivalents (FTE's) were 442.3 in 2010 versus 430.0 in 2009, a 2.6% increase over the prior year. The increase was a combination of: (1) staffing increases to support increased patient volumes in the skilled nursing unit; (2) previously negotiated wage increases under the terms of various collective bargaining unit agreements offset by a 5% wage reduction for all non-represented management and staff that was implemented in February, 2010; and (3) the reduction to staffing levels that previously supported the Kaiser Outpatient Surgery Services contract.

- Other variable expenses such as professional fees, supplies and purchased services increased during the year by approximately $1.6 million while other expenses (rent, insurance, utilities, depreciation and other operating expenses) decreased slightly by approximately $18,000.

Statement of Cash Flows

The statement of cash flows presents the information related to cash inflows and outflows summarized by operating capital, and noncapital financing and investing activities. It also summarizes information about cash receipts and cash payments during the year and is presented in various categories. The statement also helps users assess the Hospital's ability to: (1) generate net cash flows; (2) meet its obligations as they become due; and (3) meet its need for external financing.

The main sections of the statement of cash flows include:

- ***Operating activities***: This section reflects operating cash flows and the net cash provided or used by the operating activities of the Hospital.

- ***Noncapital financing activities***: This section shows the cash received and spent for non operating, non investing, and non capital purposes.

- ***Capital and related financing activities***: This section reflects the sources and uses of cash for the acquisition of capital related items and other debt borrowings.

- ***Investing activities***: This section reflects the cash flows from investing activities and shows the purchases, proceeds, and interest received from investing activities.

Economic Factors and Next Fiscal Year's Budget

The Hospital's board approved operating and capital budgets for fiscal year ending June 30, 2011 at the July, 2010 Board meeting. For fiscal year 2011, the Hospital is budgeted to increase its net assets by approximately $491,000. The increase is due to several assumptions:

- A conservative increase in inpatient volumes for fiscal year 2011 was budgeted for the skilled nursing program while inpatient acute and subacute care services were projected to remain at levels experienced during fiscal year 2010.

- Outpatient registrations, after elimination of the registrations generated from the Kaiser Outpatient Surgery Services contract, are projected to increase over the prior year as utilization of operating room services by Alameda-based surgeons are expected to increase by approximately 28% over current levels. Outpatient radiology services are also expected to increase substantially as next year projections are driven by the addition of new digital mammography equipment and a new Picture Archiving and Communication System (PACS) that will allow digital images to be served out to various clinical settings.

- The Alameda Medical Offices located in the Towne Center are anticipated to continue to grow as a result of the addition of more primary care physician options and the addition of a general surgeon in February, 2010. In addition to this clinical location, the Hospital will be adding a new Wound Care program that is anticipated to open during the third quarter of fiscal year 2011.

- Gross revenues and net revenues are budgeted to increase as a result of the volume changes, the addition of new programs and services, an annual price increase, and continuing improvements in third party payor contracts.

- Operating expenses are expected to decrease by approximately 5% over 2010 levels. This decrease in operating expenses is primarily the result of adjusting staffing levels and surgical supply utilization in the operating room to the projected surgical volumes for fiscal year 2011.

Management is confident that, despite the challenges that confront Alameda Hospital, continued operational improvements that have been made to date, and the opportunities that are on the horizon, will allow Alameda Hospital to be successful into the future.

TCA Partners, LLP

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Report of Independent Auditors

The Board of Directors
City of Alameda Health Care District
Alameda, California

We have audited the accompanying balance sheets of the City of Alameda Health Care District (the Hospital) as of June 30, 2010 and 2009, and the related statements of revenues, expenses, and changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. Our audits included consideration of internal controls over financial reporting as a basis of designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal controls over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the City of Alameda Health Care District at June 30, 2010 and 2009, and the changes in its net assets and its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Management's discussion and analysis is not a required part of the financial statements but is supplementary information required by accounting principles generally accepted in the United States of America. We have applied limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

TCA Partners, LLP

September 8, 2010

Balance Sheets

CITY OF ALAMEDA HEALTH CARE DISTRICT

	June 30	
	2010	2009
Assets		
Current assets:		
Cash and cash equivalents	$ 3,725,769	$ 2,034,709
Patient accounts receivable, net of allowances	9,558,147	10,069,536
Other receivables	6,669,235	6,206,763
Estimated third party payor settlements	374,557	351,648
Inventories	1,149,706	1,291,072
Prepaid expenses and deposits	453,871	729,301
Total current assets	21,931,285	20,683,029
Assets limited as to use	476,630	468,209
Capital assets, net of accumulated depreciation	7,314,870	7,237,461
Total assets	$ 29,722,785	$ 28,388,699
Liabilities and Net Assets		
Current liabilities:		
Current maturities of debt borrowings	$ 450,831	$ 447,948
Accounts payable and accrued expenses	6,112,296	6,200,897
Accrued payroll and related liabilities	4,351,133	3,765,683
Deferred revenues	5,736,951	6,524,800
Estimated third party payor settlements	500,000	306,588
Health insurance claims payable (IBNR)	645,750	747,912
Total current liabilities	17,796,961	17,993,828
Debt borrowings, net of current maturities	1,236,831	1,722,417
Total liabilities	19,033,792	19,716,245
Net assets:		
Invested in capital assets, net of related debt	7,314,870	7,195,316
Restricted, by contributors	476,630	468,209
Unrestricted	2,897,493	1,008,929
Total net assets	10,688,993	8,672,454
Total liabilities and net assets	$ 29,722,785	$ 28,388,699

See accompanying notes and auditor's report

Statements of Revenues, Expenses and Changes in Net Assets

CITY OF ALAMEDA HEALTH CARE DISTRICT

	Year Ended June 30	
	2010	2009
Operating revenues		
Net patient service revenue	$ 67,778,668	$ 63,066,682
Other operating revenue	157,493	185,056
Total operating revenues	67,936,161	63,251,738
Operating expenses		
Salaries and wages	37,493,274	35,025,781
Registry	2,029,651	2,685,554
Employee benefits	10,115,302	10,102,828
Professional fees	3,447,118	3,270,038
Supplies	9,984,917	9,106,288
Purchased services	4,668,189	4,132,484
Building and equipment rent	843,137	662,854
Utilities and phone	836,617	840,808
Insurance	496,418	533,366
Depreciation and amortization	1,163,436	1,415,682
Other operating expenses	984,815	890,175
Total operating expenses	72,062,874	68,665,858
Operating income (loss)	(4,126,713)	(5,414,120)
Nonoperating revenues (expenses)		
District tax revenues	5,762,661	5,764,021
Investment income	28,988	48,073
Interest expense	(97,191)	(143,167)
Rent and other income	255,108	234,037
Grants and contributions	193,686	241,463
Total nonoperating revenues (expenses)	6,143,253	6,144,427
Increase (decrease) in net assets	2,016,539	730,307
Net assets at beginning of the year	8,672,454	7,942,147
Net assets at end of the year	$ 10,688,993	$ 8,672,454

See accompanying notes and auditor's report

Statements of Cash Flows

CITY OF ALAMEDA HEALTH CARE DISTRICT

	Year Ended June 30	
	2010	2009
Cash flows from operating activities:		
Cash received from patients and third-parties on behalf of patients	$ 68,460,560	$ 60,700,314
Cash received from operations, other than patient services	107,172	89,572
Cash payments to suppliers and contractors	(24,264,829)	(23,708,594)
Cash payments to employees and benefit programs	(47,023,126)	(44,496,500)
Net cash provided by operating activities	(2,720,223)	(7,415,208)
Cash flows from noncapital financing activities:		
District tax revenues	5,762,661	5,764,021
Grants, contributions and other nonoperating revenues	448,794	475,500
Net cash provided by noncapital financing activities	6,211,455	6,239,521
Cash flows from capital financing activities:		
Purchase and donations of capital assets, net of loss on disposals	(1,240,845)	(864,139)
Proceeds from debt borrowings		2,260,000
Principal payments on debt borrowings	(482,703)	(2,915,497)
Interest payments on debt borrowings	(97,191)	(143,167)
Net cash provided by (used in) capital financing activities	(1,820,739)	(1,662,803)
Cash flows from investing activities:		
Net change in assets limited as to use	(8,421)	134,608
Investment income	28,988	48,073
Net cash provided by (used in) investing activities	20,567	182,681
Net increase (decrease) in cash and cash equivalents	1,691,060	(2,655,809)
Cash and cash equivalents at beginning of year	2,034,709	4,690,518
Cash and cash equivalents at end of year	$ 3,725,769	$ 2,034,709

See accompanying notes and auditor's report

Statements of Cash Flows (continued)

CITY OF ALAMEDA HEALTH CARE DISTRICT

	Year Ended June 30	
	2010	2009
Reconciliation of operating income to net cash provided by operating activities:		
Operating income (loss)	$ (4,126,713)	$ (5,414,120)
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	1,163,436	1,415,682
Provision for bad debts	6,338,492	7,563,989
Changes in operating assets and liabilities:		
Patient accounts receivables	(5,827,103)	(9,689,003)
Other receivables	(462,472)	475,576
Inventories	141,366	(242,569)
Prepaid expenses and deposits	275,430	(141,524)
Accounts payable and accrued expenses	(88,601)	(856,176)
Accrued payroll and related liabilities	585,450	632,109
Estimated third party payor settlements	170,503	(241,354)
Deferred revenues	(787,849)	(827,060)
Health insurance claims payable (IBNR)	(102,162)	(90,758)
Net cash provided by operating activities	$ (2,720,223)	$ (7,415,208)

See accompanying notes and auditor's report

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES

Reporting Entity: The City of Alameda Health Care District, (d.b.a. Alameda Hospital), heretofore referred to as (the Hospital) is a public entity organized under Local Hospital District Law as set forth in the Health and Safety Code of the State of California. The Hospital is a political subdivision of the State of California and is generally not subject to federal or state income taxes. The Hospital is governed by a five-member Board of Directors, elected from within the district to specified terms of office. The Hospital is located in Alameda, California. It operates a 100-bed acute care facility, a 35-bed sub acute unit within the Hospital and another 26-bed skilled nursing facility adjacent to the Hospital campus which began operations in August, 2008. The Hospital provides health care services primarily to individuals who reside in the local geographic area.

Basis of Preparation: The accounting policies and financial statements of the Hospital generally conform with the recommendations of the audit and accounting guide, *Health Care Organizations*, published by the American Institute of Certified Public Accountants. The financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board (GASB). For purposes of presentation, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operational revenues and expenses.

The Hospital uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on GASB Statement Number 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, as amended, the Hospital has elected to apply the provisions of all relevant pronouncements as the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

Management's Discussion and Analysis: Effective July 1, 2002, the Hospital adopted the provisions of GASB 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments* (Statement 34), as amended by GASB 37, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments: Omnibus*, and Statement 38, *Certain Financial Statement Note Disclosures*. Statement 34 established financial reporting standards for all state and local governments and related entities. Statement 34 primarily relates to presentation and disclosure requirements. One of the main components of these new provisions allows the inclusion of a management's discussion and analysis to accompany the financial statement presentation.

The management's discussion and analysis is a narrative introduction and analytical overview of the Hospital's financial activities for the year being presented. This analysis is similar to the analysis provided in the annual reports of organizations in the private sector. As stated in the opinion letter, the management's discussion and analysis is not a required part of the financial statements but is supplementary information and therefore not subject to audit procedures or the expression of an opinion on it by auditors.

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Use of Estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amount of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents and Investments: The Hospital considers cash and cash equivalents to include certain investments in highly liquid debt instruments, when present, with an original maturity of a short-term nature or subject to withdrawal upon request. Exceptions are for those investments which are intended to be continuously invested. Investments in debt securities are reported at market value. Interest, dividends and both unrealized and realized gains and losses on investments are included as investment income in nonoperating revenues when earned.

Patient Accounts Receivable: Patient accounts receivable consist of amounts owed by various governmental agencies, insurance companies and private patients. The Hospital manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectibility and providing for allowances on their accounting records for estimated contractual adjustments and uncollectible accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

Inventories: Inventories are consistently reported from year to year at cost determined by average costs and replacement values which are not in excess of market. The Hospital does not maintain levels of inventory values such as those under a first-in, first out or last-in, first out method.

Assets Limited as to Use: Assets limited as to use include contributor restricted funds, amounts designated by the Board of Directors for replacement or purchases of capital assets, and other specific purposes, and amounts held by trustees under specified agreements. Assets limited as to use consist primarily of deposits on hand with local banking and investment institutions, and bond trustees.

Capital Assets: Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 40 years for buildings and improvements, and 3 to 10 years for major moveable equipment. The Hospital periodically reviews its capital assets for value impairment. As of June 30, 2010 and 2009, the Hospital has determined that no capital assets are impaired.

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Compensated Absences: The Hospital's employees earn vacation benefits at varying rates depending on years of service. Employees also earn sick leave benefits. Both benefits can accumulate up to specified maximum levels. Employees are not paid for accumulated sick leave benefits if they leave either upon termination or before retirement. However, accumulated vacation benefits are paid to an employee upon either termination or retirement. Accrued vacation liabilities as of June 30, 2010 and 2009 are $2,646,428 and $2,378,301, respectively.

Risk Management: The Hospital is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters. In the case of employee health coverage, the Hospital is self-insured for those claims and is discussed further in the footnotes.

Net Assets: Net assets are presented in three categories. The first category is net assets "invested in capital assets, net of related debt". This category of net assets consists of capital assets (both restricted and unrestricted), net of accumulated depreciation and reduced by the outstanding principal balances of any debt borrowings that were attributable to the acquisition, construction, or improvement of those capital assets.

The second category is "restricted" net assets. This category consists of externally designated constraints placed on those net assets by creditors (such as through debt covenants), grantors, contributors, law or regulations of other governments or government agencies, or law or constitutional provisions or enabling legislation.

The third category is "unrestricted" net assets. This category consists of net assets that do not meet the definition or criteria of the previous two categories.

Net Patient Service Revenues: Net patient service revenues are reported in the period at the estimated net realized amounts from patients, third-party payors and others including estimated retroactive adjustments under reimbursement agreements with third-party programs. Normal estimation differences between final reimbursement and amounts accrued in previous years are reported as adjustments of current year's net patient service revenues.

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Charity Care: The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues. Services provided are recorded as gross patient service revenues and then written off entirely as an adjustment to net patient service revenues.

District Tax Revenues: The Hospital receives approximately 9% of its financial support from property taxes. These funds are used to support operations and meet required debt service agreements. They are classified as non-operating revenue as the revenue is not directly linked to patient care. Property taxes are levied by the County on the Hospital's behalf during the year, and are intended to help finance the Hospital's activities during the same year. The County has established certain dates to levy, lien, mail bills, and receive payments from property owners during the year. Property taxes are considered delinquent on the day following each payment due date.

Grants and Contributions: From time to time, the Hospital receives grants from various governmental agencies and private organizations. The Hospital also receives contributions from related foundation and auxiliary organizations, as well as from individuals and other private organizations. Revenues from grants and contributions are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or capital acquisitions. These amounts, when recognized upon meeting all requirements, are reported as components of the statement of revenues, expenses and changes in net assets.

Operating Revenues and Expenses: The Hospital's statement of revenues, expenses and changes in net assets distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, which is the Hospital's principal activity. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Nonoperating revenues and expenses are those transactions not considered directly linked to providing health care services.

Reclassifications: Certain financial statement amounts as presented in the prior year financial statements have been reclassified in these, the current year financial statements, in order to conform to the current year financial statement presentation.

NOTE B - CASH AND CASH EQUIVALENTS

As of June 30, 2010 and 2009, the Hospital had deposits invested in various financial institutions in the form of cash and cash equivalents in the amounts of $4,201,199 and $2,501,718 respectively. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code (CGC), except for $250,000 per account that is federally insured.

The CGC and the Hospital's investment policy do not contain legal or policy requirements that would limit the exposure to custodial risk for deposits. Custodial risk for deposits is the risk that, in the event of the failure of a depository financial institution, the Hospital would not be able to recover its deposits or will not be able to recover collateral securities that are in possession of an outside party.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the Hospital's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the Hospital's deposits. California law also allows financial institutions to secure Hospital deposits by pledging first trust deed mortgage notes having a value of 150% of the Hospital's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the Hospital.

NOTE C - NET PATIENT SERVICE REVENUES

The Hospital has agreements with third-party payors that provide for payments at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare: Payments for inpatient acute care services rendered to Medicare program beneficiaries are based on prospectively determined rates, which vary accordingly to the patient diagnostic classification system. Outpatient services are paid under an outpatient classification system subject to certain limitations. Certain reimbursement areas are still subject to final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. At June 30, 2010, cost reports through June 30, 2007 have been final settled.

Medi-Cal: For traditional Medi-Cal (non-HMO) services, payments for inpatient services rendered to patients were made based on reasonable costs through May 5, 2010. Effective May 6, 2010, the Hospital entered into a contract under the Selective Provider Contracting Program administered by the California Medical Assistance Commission (CMAC), to receive payments for inpatient services based upon an established rate. The Hospital was paid at an interim rate with final settlement determined after submission of annual cost reports and audits thereof by Medi-Cal. At June 30, 2010, cost reports through June 30, 2008, have been final settled. Outpatient payments are based on a pre-determined fee schedule and Medi-Cal HMO services are paid on a pre-determined rate and are not subject to cost reimbursement

NOTE C - NET PATIENT SERVICE REVENUES (continued)

Other: Payments for services rendered to other than Medicare and Medi-Cal patients are based on established rates or on agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations which provide for various discounts from established rates.

Net patient service revenues summarized by service line are as follows:

	2010	2009
Inpatient acute and inpatient ancillary services	$136,389,616	$134,838,882
Long-term care routine services	27,982,345	26,062,608
Outpatient acute services	114,502,502	121,919,175
Gross patient service revenues	278,874,463	282,820,665
Less deductions from revenue and related allowances	(211,095,795)	(219,753,983)
Net patient service revenues	$ 67,778,668	$ 63,066,682

Medicare and Medi-Cal revenue accounts for approximately 40% of the Hospital's net patient revenues for each year. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

NOTE D - CONCENTRATION OF CREDIT RISK

The Hospital grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the Hospital and management does not believe that there are any credit risks associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the Hospital. Concentration of patient accounts receivable at June 30, 2010 and 2009 were as follows:

	2010	2009
Medicare	$ 12,868,587	$ 13,381,412
Medi-Cal	10,226,623	13,770,546
Other third party payors	10,358,059	12,793,302
Self pay and other	10,051,064	5,510,776
Gross patient accounts receivable	43,504,333	45,456,036
Less allowances for contractual adjustments and bad debts	(33,946,186)	(35,386,500)
Net patient accounts receivable	$ 9,558,147	$ 10,069,536

NOTE E - OTHER RECEIVABLES

Other receivables as of June 30, 2010 and 2009 were comprised of the following:

	2010	2009
Alameda County property taxes	$ 6,027,398	$ 6,014,003
Kaiser contract receivable	141,183	70,092
Pension plan forfeitures	165,579	
Rents receivable	5,342	6,857
Other various receivables	329,733	115,811
	$ 6,669,235	$ 6,206,763

NOTE F - ASSETS LIMITED AS TO USE

Assets limited as to use as of June 30, 2010 and 2009 were comprised of the following:

	2010	2009
Cash and cash equivalents restricted by contributors	$ 476,630	$ 468,209

NOTE G - CAPITAL ASSETS

The Hospital received two parcels of improved rental-real estate by court order dated December 3, 2003, pursuant to the terms of the Alice M. Jaber 1992 Trust. As successor to the former non-profit Alameda Hospital, the Hospital has agreed to abide by the terms of the Trust Agreement. The Trust Agreement and the will of Alice M. Jaber require the Hospital to account for the property as part of the Abraham Jaber and Mary A. Jaber Memorial Fund. Among other things, the Hospital is prohibited from selling all or any portion of the parcels received until after the death of certain named family members and, if the property is sold, it may not be sold to any descendant, spouse or relative to the third degree of any such descendant of a named family member. The net carrying value of this property is $1,149,625 and $1,187,302 at June 30, 2010 and 2009, respectively.

NOTE G - CAPITAL ASSETS (continued)

Capital assets as of June 30, 2010 and 2009 were comprised of the following:

	Balance at June 30, 2009	Transfers & Additions	Reclasses & Retirements	Balance at June 30, 2010
Land and land improvements	$ 1,376,954			$ 1,376,954
Buildings and improvements	23,657,283	$ 323,053		23,980,336
Equipment	18,449,576	615,032		19,064,608
Construction-in-progress	533,294	294,356		827,650
Totals at historical cost	44,017,107	1,232,441		45,249,548
Accumulated depreciation for:				
Land and land improvements	(258,275)	(4,509)		(262,784)
Buildings and improvements	(20,530,813)	(382,946)		(20,913,759)
Equipment	(15,990,558)	(767,577)		(16,758,135)
Total accumulated depreciation	(36,779,646)	(1,155,032)		(37,934,678)
Capital assets, net	$ 7,237,461	$ 77,409	$	$ 7,314,870

	Balance at June 30, 2008	Transfers & Additions	Reclasses & Retirements	Balance at June 30, 2009
Land and land improvements	$ 1,369,164	$ 7,790		$ 1,376,954
Buildings and improvements	23,646,900	10,383		23,657,283
Equipment	18,100,350	349,226		18,449,576
Construction-in-progress	38,526	494,768		533,294
Totals at historical cost	43,154,940	862,167		44,017,107
Accumulated depreciation for:				
Land and land improvements	(254,335)	(3,940)		(258,275)
Buildings and improvements	(20,124,793)	(406,020)		(20,530,813)
Equipment	(14,986,808)	(1,003,750)		(15,990,558)
Total accumulated depreciation	(35,365,936)	(1,413,710)		(36,779,646)
Capital assets, net	$ 7,789,004	$ (551,543)	$	$ 7,237,461

NOTE H - DEBT BORROWINGS

As of June 30, 2010 and 2009, debt borrowings were as follows:

	2010	2009
Note payable to a bank; principal ant interest at 4.80% due in monthly installments of $42,460 each 15th of the month through February 15, 2014; collateralized by Hospital receivables:	$ 1,672,867	$ 2,089,343
Capital lease due to a financial institution; principal and interest at 2.57% due in monthly installments of $4,155 each 21st of the month through February 10, 2010; collateralized by Hospital property:		35,187
Note payable to a bank; principal and interest at 5.75% due in monthly installments of $2,146 at month's end through January 31, 2011; collateralized by Hospital property:	14,795	38,877
Other various debt borrowings		6,958
	1,687,662	2,170,365
Less current maturities of debt borrowings	(450,831)	(447,948)
	$ 1,236,831	$ 1,722,417

Future principal maturities for debt borrowings for the next succeeding years are: $450,831 in 2011; $457,605 in 2012; $480,509 in 2013; and $298,717 in 2014.

Line of Credit: The Hospital has a $1,500,000 bank line of credit available at year end with a variable interest rate. Any advances on this line are due at the time of maturity and interest is due and payable monthly. There were no borrowings under this line of credit agreement as of June 30, 2010.

NOTE I - RELATED PARTY TRANSACTIONS

The Alameda Hospital Foundation (the Foundation), has been established as a nonprofit public benefit corporation under the Internal Revenue Code Section 501 c (3) to solicit contributions on behalf of the Hospital. Substantially all funds raised except for funds required for operation of the Foundation, are distributed to the Hospital or held for the benefit of the Hospital. The Foundation's funds, which represent the Foundation's unrestricted resources, are distributed to the Hospital in amounts and in period determined by the Foundation's Board of Trustees, who may also restrict the use of funds for Hospital property and equipment replacement or expansion, reimbursement of expenses, or other specific purposes. Donations in this regard were $165,000 and $165,000 for the years ended June 30, 2010 and 2009 respectively. The Foundation is not considered a component unit of the Hospital as the Foundation, in the absence of donor restrictions, has complete and discretionary control over the amounts, the timing, and the use of its donations to the Hospital.

NOTE J - RETIREMENT PLANS

Contributions to Retirement Plans: Total contributions to all of the retirement plans for the years ended June 30, 2010 and 2009 were approximately $1,775,000 and $1,977,000, respectively.

Defined Contribution Plan: Effective January 1, 2005, the Hospital established and began to administer a noncontributory defined contribution retirement plan covering employees who have completed one year of service in which they worked at least 1,000 hours and are not covered under a collective bargaining agreement. Benefit provisions are contained in plan documents and can be amended by the Board of Directors. The Hospital contributes 6% of eligible employee earnings to this plan. The Hospital also contributes to four union-sponsored defined contribution retirement plans as required under collective bargaining agreements with the Hospital.

Defined Benefit Plan: The Hospital provides retirement benefits under a noncontributory, single-employer defined benefit pension plan (the Plan) for employees not covered under collective bargaining agreements and who have completed one year of continuous service during which they worked at least 1,000 hours. The Plan, administered by the Hospital, provides benefits based on each employee's years of service and annual compensation through December 31, 2004. The Plan's annual pension cost and net pension assets for the years ended June 30, 2010 and 2009 are as follows:

	2010	2009
Annual required contribution	$ 118,361	$ 128,149
Interest on net pension asset	(5,818)	(6,072)
Adjustment to net pension obligation	11,196	11,143
Annual pension cost	123,739	133,220
Contributions made	(168,000)	(128,149)
Increase (decrease) in net pension obligation	(44,261)	5,071
Net pension (asset) liability at the beginning of the year	(116,369)	(121,440)
Net pension (asset) liability at the end of the year	$ (160,630)	$ (116,369)

Benefits under the Plan vest 100% upon five years of service. Upon normal retirement at age 65, participants are entitled to monthly retirement benefits based upon their average compensation and years of credited service. Participants, who have attained the age the latter of age 55 or the date upon which the employee's age and years of service add up to 65, may elect early retirement with benefits determined as of the early retirement date, actuarially reduced. Participants may elect to receive their benefits as a lump sum, life annuity, or joint and survivor annuity upon retirement.

NOTE J - RETIREMENT PLANS (continued)

Pursuant to the Hospital's right to amend, terminate or discontinue making contributions to the Plan, the Hospital's Board of Directors resolved to freeze participation in and benefit obligations under the Plan as of December 31, 2004 and then established a new defined contribution plan in lieu thereof. Retirement benefits earned through December 31, 2004 will be paid as required by the Plan.

The Hospital is required to contribute the actuarially determined amounts necessary to fund benefits for its participants. The actuarial methods and assumptions used are those adopted by the Hospital. The Hospital's required employer contribution rates for 2010 and 2009 do not apply as the Plan has been frozen and has no covered payroll.

The required contribution for the year ended June 30, 2010, was determined as part of the July 1, 2009 actuarial valuation using the unit credit actuarial cost method. The actuarial valuation method was changed from the entry age normal method in 2005 because benefit accruals under the Plan were frozen at December 31, 2004. The actuarial assumptions include an investment rate of return of 8% and no salary increases in the future. The actuarial value of the Plan's assets was equal to the fair value of the assets. The Plan's unfunded actuarial accrued liability is being amortized as a level dollar using a fixed amortization period of 15 years. The remaining amortization period at July 1, 2009 was 13 years. Below is three-year trend information followed by a schedule of funding progress:

Three-Year Trend Information:

Year Ended June 30	Annual Pension Cost (APC) in $	Percentage of APC Contributed	Net Pension Obligation (Asset) in $
2008	$ 52,078	86.4%	$ (121,440)
2009	$ 133,220	100.0%	$ (116,369)
2010	$ 123,739	100.0%	$ (160,630)

Schedule of Funding Progress:

Valuation Date	Accrued Liability in $	Actuarial Value of Assets in $	Unfunded Accrued Liability (UAAL) in $	Funded Ratio Percentage	Annual Covered Payroll	UAAL as a % of Payroll
7/1/07	$ 2,379,072	$ 1,796,040	$ 583,032	75.5%	N/A	N/A
7/1/08	$ 2,700,503	$ 1,370,353	$ 1,330,150	50.7%	N/A	N/A
7/1/09	$ 2,671,515	$ 1,499,904	$ 1,171,611	56.1%	N/A	N/A

NOTE K - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of June 30, 2010 and 2009, the Hospital had recorded $827,650 and $533,294, respectively, as construction-in-progress representing cost capitalized for various remodeling, major repair, and expansion projects on the Hospital's premises. No interest was capitalized under FAS 62 during the years ended June 30, 2010 and 2009. Estimated cost to complete these projects as of June 30, 2010 are considered minor.

Operating Leases: The Hospital leases various equipment and facilities under operating leases expiring at various dates. Total building and equipment rent expense for the years ended June 30, 2010 and 2009, were $843,137 and $662,854, respectively. Future minimum lease payments for the succeeding years under operating leases as of June 30, 2010, that have initial or remaining lease terms in excess of one year are not considered material.

Litigation: The Hospital may from time-to-time be involved in litigation and regulatory investigations which arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters existing as of June 30, 2010 will be resolved without material adverse effect on the Hospital's future financial position, results from operations or cash flows.

Risk Management Insurance Programs: The Hospital self-insures medical and dental costs up to $100,000 per employee per year under a noncontributory plan. The Hospital also maintains claims-made insurance coverage for its medical malpractice and general liability risks up to $20 million per claim and $20 million in the annual aggregate. Deductible levels are at $10,000 per medical malpractice claim and $25,000 per general liability claim.

The reserves for self-insured risk include provisions for estimated medical and dental, a former self-insured workers' compensation plan and medical malpractice and general liability costs for both uninsured reported claims and for claims incurred but not reported (IBNR), in accordance with projections based upon several factors including past experience. While such claims reserves are based upon these factors, there is a possibility that a material change will occur in the near term. Such estimates are continually monitored, reviewed, and adjusted accordingly with differences reported in the current year operations. While the ultimate amount of medical, dental, workers' compensation and medical and general liability claims is dependent upon future developments, management believes that the associated liabilities recognized in the financial statements are adequate to cover such claims.

Health Insurance Portability and Accountability Act: The Health Insurance Portability and Accountability Act (HIPAA) was enacted August 21, 1996, to ensure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Management believes the Hospital is in compliance with HIPAA as of June 30, 2010 and 2009.

NOTE K - COMMITMENTS AND CONTINGENCIES (continued)

Health Care Regulation: The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statues and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

RAC Audits: Hospitals in California are subject to nationwide Medicare claim audits by Recovery Audit Contractors (RAC's). In March, 2007, RAC auditors examined certain Medicare claims for services provided to Medicare beneficiaries during the years end June 30, 2003, and thereafter. Pursuant to this review, RAC auditors reviewed medical records and compared them to billing records for "perceived" discrepancies. This audit resulted in a recovery process of Medicare payments which to date have been $352,280. It is anticipated that additional recoveries of approximately $200,000 may be collected in the future and which the Hospital has recorded as a liability as of June 30, 2010. The Hospital does have appeal rights for RAC audit findings.

Seismic Retrofit: The California Hospital Facilities Seismic Safety Act (SB 1953) specifies certain requirements that must be met at various dates in order to increase the probability that a California hospital can maintain uninterrupted operations following a major earthquake. By January 1, 2013, all general acute care buildings must be life-safe. Management is in process of developing a plan to bring the Hospital into compliance by the required deadlines.

NOTE L - HOSPITAL COMPONENT UNITS

The City of Alameda Health Care District (District) owns and operates Alameda Hospital (the Hospital). In addition to the Hospital, the District operates CW&S Investment Company, LLC (CW&S), a wholly-owned for-profit subsidiary. The District also controls the City of Alameda Health Care Corporation (AHCC), a charitable, non-profit corporation for which the District is the sole voting member. CW&S owns a skilled nursing facility located on the property adjacent to the Hospital that is leased to the Hospital. AHCC has no operating activities. The financial results for the years ended June 30, 2010 and 2009 of these component units are included within the financial statements of the Hospital. Net assets of these units were $581,436 for 2010 and $558,395 for 2009. Net increase in assets for these units were $23,041 for 2010 and $49,096 for 2009. The financial impact of these component units on the Hospitals's combined financial statements is not considered material and therefore further disclosure of financial detail is not considered necessary.

NOTE M - FAIR VALUE OF ASSETS AND LIABILITIES

The Hospital adopted Statement of Financial Accounting standards No. 157, *Fair Value Measurements* (FAS 157). FAS 157 fair value establishes a framework for measuring fair value and expands disclosures about fair value measurements. FAS defines fair value as the price that would be received to sell an asset in an orderly transaction between market participants at the measurement date. FAS 157 establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices in active markets for identical assets or liabilities;

Level 2: Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities;

Level 3: Unobservable inputs for the assets or liabilities that are supported by little or no market activity and that are significant to the fair value of the underlying assets or liabilities.

The following is a description of the valuation methodologies used for assets measured at fair value on a recurring basis and recognized in the Hospital's balance sheets, as well as the classification pursuant to the valuation hierarchy.

Financial Instruments: Where quoted market prices are available in an active market, investments are classified within Level 1 of the valuation hierarchy. Level 1 instruments include a variety of financial instruments as listed below. There are no Level 2 or Level 3 types within the balance sheet of the Hospital. The following table summarizes the financial instruments measured at fair value on a recurring basis in accordance with FAS 157 as of June 30, 2010:

	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Other Unobservable Inputs (Level 3)
Money market securities	$ 593,848	$ 593,848		
Totals of financial instruments	$ 593,848	$ 593,848		

NOTE N - CHARITY CARE AND COMMUNITY BENEFIT SERVICES

The Hospital maintains records to identify and monitor the level of charity care and community service it provides. These records include the amount of collections foregone, (based on established rates), for services and supplies furnished under its charity care and community service policies. In addition, the Hospital provides services to other medically indigent patients under certain government public aid reimbursement programs. The following is a summary of the Hospital's charity care and community benefit foregone collections for the years ended June 30, 2010 and 2009, in terms of services to the poor and benefits to the broader community:

	2010	2009
Benefits for the poor:		
Traditional charity care	$ 1,294,078	$ 1,117,378
Unpaid Medi-Cal and other public aid programs	7,348,917	7,167,070
Total quantifiable benefits for the poor	8,642,995	8,284,448
Benefits for the broader community:		
Unpaid Medicare program charges	76,043,551	74,174,087
Total quantifiable benefits for the broader community	76,043,551	74,174,087
Total quantifiable community benefits	$ 84,686,546	$ 82,458,535

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: October 4, 2010

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

FROM: Deborah E. Stebbins, Chief Executive Officer

SUBJECT: Wage Roll-Back Recognition Bonus for all Non-Represented personnel

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Recommendation:

Hospital Administration is recommending that the District Board of Directors authorize the payment of a "Recognition Bonus" to all employees who participated in the 5% wage roll-back in February 2010 as part of the Kaiser recovery plan. The total number of affected employees is 218 with a total bonus payment amount of $185,998, including taxes & benefits. An amount of $185,000 has already been recorded in the FY 2010 audited financials. It is proposed that this bonus payment be made on Friday, October 8, 2010.

Background:

The Board of Director's approved a five percent (5%) wage roll-back , effective February 1, 2010, as part of the recovery plan developed in response to Kaiser's decision to take their surgical procedures back in-house.

While the initial recovery plan included a wage-roll back for all classifications, the Unions ultimately did not agree to decrease their wages so the wage-roll back was exclusive to the non-represented and management employees.

However, it is recognized that the three Unions with which we have negotiated new contracts, have agreed to "no wage increase" contracts and also agreed to other concessions to the Group Health Plan that contributed to the recovery plan.

Discussion:

Administration and the District's Board of Directors recognize the personal contribution made by all non represented employees and management personnel in accepting a 5% wage roll-back effective February 1, 2010.

Since that time, the hospital was able to participate in a special Inter-Governmental Transfer (IGT) program with the state and federal governments that provided an

additional $2.1 million dollars to the hospital's net revenue in fiscal year 2010. This $2.1 million was a one time payment that resulted from the hospital being willing to enter into a one year Medi-Cal contract with the State of California. The IGT program contributed to the hospital recording an audited profit after the inclusion of annual parcel tax revenues of $1.8 million in fiscal year 2010.

Although the hospital still has significant improvement to be made to its monthly financial performance, Administration and the Board feel it is important to provide recognition in the form of a one time bonus payment to those employees who participated in the wage roll-back.

The criteria for the bonus payment are as follows:

- The employee was hired before February 1, 2010 and is still working at the hospital as of the date of the bonus payment.
- The employee participated in the 5% wage roll back.
- Payment amount is based upon the average hours worked between 2/1/10 and 9/3/10, using the following parameters:

Per Diem employees working a minimum commitment:	$200.00
Employees working less than half time:	$400.00
Employees working part time (half time and 3/5ths):	$600.00
Employees working 4/5ths to full time:	$1,000.00

The Administrative Team has made a commitment to review the Hospital's financial position again in July of 2011 to determine what, if any, adjustment to our employee's base rate of pay could be made at that time.