Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

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

Monday, October 6, 2008

***CLOSED SESSION – 5:30 p.m. OPEN SESSION –7:30 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.

I. Call to Order — Robert Deutsch, MD

II. Roll Call — Kristen Thorson

III. General Public Comments

IV. Closed Session **(Expected to start at approximately 6:00 p.m. and expected to last 1.5 hours)**

1) Approval of Closed Session Minutes –September 8, 2008

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

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

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

5)	Discussion of Report Involving Trade Secrets	H & S Code Sec. 32106
6)	Quality Improvement Committee Report (QIC)	H & S Code Sec. 32155
6)	Public Employee Performance Evaluation Title: Chief Executive Officer	Gov't Code Sec 54957

V. Reconvene to Public Session **(Expected to start at approximately 7:30 p.m.)**

1) Announcements from Closed Session — Robert Deutsch, MD

VI. Consent Agenda

1. Approval of September 8, 2008 Minutes **ACTION ITEM** [enclosure]
2. Biennial Review and Approval of City of Alameda Health Care District Conflict of Interest Code #2008-0Y **ACTION ITEM** [enclosure]
3. Approval for the Formation of a Pension Committee and Reallocation of Fund from Fixed Income to Balanced Portfolio **ACTION ITEM** [enclosure]

VII. Regular Agenda

1. Finance and Management Committee Report — David A. Neapolitan
   - Acceptance of August Financial Statements **ACTION ITEM** [enclosure]
   - Fiscal Year (FY) 2008 Audit Presentation [enclosure] — Rick Jackson, TCA Partners
   - Acceptance of FY 2008 Audit **ACTION ITEM**
2. Information Systems Overview Presentation — Robert Lundy-Paine
3. Strategic Planning and Community Relations Committee Report — Robert Bonta

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

   - September Statistics and Updates
   - OIG Survey Update
   - Appraisal for South Shore (625 Willow Street) Building
   - Opening Discussions with Local 250

5. Medical Staff President Report — Steve Lowery, MD

   - Approval of the Proposed Revision to Article 1, Section B, Admission Exceptions, of the Medical Staff Rules and Regulations
     ACTION ITEM [enclosure]

6. General Public Comments

7. Board Comments

8. Adjournment

The next regularly scheduled board meeting will be on Monday, November 3, 2008.
Closed Session will begin at 6:00 p.m. Open Session will follow at approximately 7:30 p.m.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors
September 9, 2008

Directors Present:
Jordan Battani
Robert Bonta
Jeptha Boone, M.D.
Robert Deutsch, MD
Steve Wasson

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

Medical Staff Present:
Steve Lowery, M.D.

Legal Counsel Present:

Excused:
Thomas Driscoll, Esq.

Submitted by: Kristen Thorson

Topic	Discussion	Action / Follow-Up
1. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 6:00 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that all Directors were present.	
3. General Public Comments	None at this time.	
4. Closed Session	At 6:02 p.m. the meeting adjourned Executive Closed Session.	
5. Reconvene to Public Session & Adjournment	Director Battani reconvened the meeting into public session at 7:45 p.m. and made the following closed session announcements.	
6. Closed Session Announcements	**[1] Minutes** **[2] Quality Improvement Committee**	[1] The Closed Session Minutes for the June 30, 2008 meeting were approved. [2] The Quality Improvement Committee Report for June and July was accepted as presented.

Topic	Discussion	Action / Follow-Up
7. Consent Agenda	**[1] Approval of Minutes** ▪ August 4, 2008 **[2] Biennial Review and Approval of City of Alameda Health Care District Conflict of Interest Code #2008-0Y** **[3] Approval of Aesthetic Upgrades to 501 South Shore Center West**	Director Bonta removed item 2 from the consent agenda for discussion and clarification. Management will check with legal counsel on the reason why the detail in the disclosure categories was omitted from the revised version. Dr. Boone moved to approve the balance of the consent calendar (items 1 & 3). Director Bonta seconded the motion. The motion carried unanimously.
8. Regular Agenda	**[1]Finance and Management Committee Report** *Acceptance of the July 2008 Financial Statements* CFO David Neapolitan presented the July 2008 Financial Statements as presented noting a profit for the month of $57,276. Mr. Neapolitan also reviewed the key statistics and daily key indicators for the month of July. Having no questions from the Board, Mr. Neapolitan asked for acceptance of the financial statements. *Audit Update* TCA Partners completed the field review the first week of August. Management and auditor continue to work on several open issues. The operating loss for the year is a loss of $2.3 million. Mr. Neapolitan stated that the Auditor felt that the accounts receivable reserves were on target and would not need to be adjusted. The draft audit report will be presented to the Finance and Management Committee on September 24, 2008 and to the Board for final approval on October 6, 2008. After discussion with legal counsel and auditor, due to the size of the Board of Directors and the size of our facility, management informed the Board there would not be a need for separate Audit Committee. Instead audit related issues will be reported to the Finance and Management Committee. **[2] Asian Health Services Presentation** Alice Cheng, RN presented to the Board of Directors a summary of the activities and projects surrounding the Asian Health Services and Outreach Program. A copy of the presentation is available in Administration for review. The Board of Directors thanked Ms. Cheng for her work with the Asian outreach program and efforts.	Director Boone moved to accept the July 2008 Financial Statements as presented. Director Wasson seconded the motion, the motion carried unanimously.

Topic	Discussion	Action / Follow-Up
	[3] Strategic Planning and Community Relations Report. Rob Bonta reported on the last committee meeting of September 5, 2008. A draft plan was presented to the committee that included Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, Critical Success Factors, and goals for 6 key areas of focus. The meeting was very productive with input from those in attendance. The next meeting has not yet been determined but Mr. Bonta will keep the Board informed and provide additional lead time prior to the next meeting.	
	[4] Chief Executive Officer's Report Deborah E. Stebbins reported on the following items: *Governance Institute Membership* Ms. Stebbins presented to the Board information about becoming a member of the Governance Institute. The Governance Institute is a leadership development organization for governing bodies such as the Board of Directors. Director Boone recommended the organization highly and said that prior Boards attended conferences and seminars and thought that they were very worthwhile. Along with educational opportunities, the Governance institute also offers tools and resources. Dr. Deutsch thought that a presentation by a representative of the Governance Institute to the Board of Directors would be valuable prior to making a decision. *Board Election / Transition* With the recent Board election and upcoming transition, Ms. Stebbins recommended to the Board that they may think about contacting different service organization within the city to host candidate forums with the Health Care District to inform the public about the hospital. Since there will not be a formal election, this would give the Board Members an opportunity to report to the public in a different setting other than Board meetings. Management will contact Rotary, League of Women Voters, and the Alameda Chamber of Commerce. *Employee Recognition Event*: The Employee Tenure Recognition Event will be held on September 23, 2008. The Hospital will be recognizing employees with 5, 10, 15, 20, 25, 30, and 35 years of service. All Board members are invited to attend.	Director Deutsch made a motion to move forward with the Governance Institute Membership by allowing the Institute to make a presentation at an upcoming Board meeting. Director Bonta seconded the motion. The motion carried unanimously.

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action / Follow-Up</th></tr>
<tr><td></td><td>
<u>Statistics</u>:
<table>
<tr><th></th><th>August</th><th>August Budget</th><th>July Actual</th></tr>
<tr><td>Average Daily Census</td><td>82.60</td><td>84.39</td><td>65.10</td></tr>
<tr><td>Patient Days</td><td>2,227</td><td>2,259</td><td>2,018</td></tr>
<tr><td>ER Visits</td><td>1,336</td><td>1,436</td><td>1,378</td></tr>
<tr><td>OP Registrations</td><td>2,441</td><td>2,626</td><td>2,554</td></tr>
<tr><td>Total Surgeries</td><td>448</td><td>382</td><td>548</td></tr>
</table>
<u>Community Relations/Foundation</u>
The Annual Report to the Community Newsletter will be mailed to Alameda residents on approximately September 22, 2008.

The Foundation will be having their annual fundraiser on September 13, 2008. The fundraising goal for the event is $85,000 and 225 persons attending. Last year the event raised $74,000 with 205 people attending.

[5] Medical Staff President Report
Dr. Lowery reported that the Medical staff committees did not meet in August, thus there is no formal report this month.
</td><td></td></tr>
<tr><td>8. General Public Comments</td><td>None at this time.</td><td></td></tr>
<tr><td>10. Board Comments</td><td>None at this time.</td><td></td></tr>
<tr><td>11. Adjournment</td><td></td><td>A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 9:00 p.m.</td></tr>
</table>

Attest: _____ _____

Jordan Battani — President

Robert Bonta — Secretary

DISTRICT BOARD/MINUTES/REG.090808

CONFLICT OF INTEREST CODE #2008-0Y

CITY OF ALAMEDA HEALTH CARE DISTRICT

1. Standard Code of FPPC

The Political Reform Act (Government Code section 81000, *et seq*.) requires state and local government agencies to adopt and promulgate conflict of interest codes. The City of Alameda Health Care District ("District") is therefore required to adopt such a code.

The Fair Political Practices Commission ("FPPC") has adopted a regulation (2 California Code of Regulations section 18730) which contains the terms of a standard conflict of interest code, which may be incorporated by reference in an agency's code, and which may be amended by the FPPC to conform to amendments in the Political Reform Act following public notice and hearing.

2. Adoption of Standard Code of FPPC

Therefore, the terms of 2 California Code of Regulations section 18730 and any amendments or revisions adopted by the FPPC are hereby incorporated by reference. This regulation and the attached Appendix designating officials and employees and establishing disclosure categories shall constitute the Conflict of Interest Code of the District. This code shall take effect when approved by the Alameda County Board of Supervisors.

3. Filing of Statements of Economic Interests

Designated employees and public officials who manage public investments shall file statements of economic interests with the Secretary to the Board of Directors of the District. The agency shall make all statements available for public inspection and reproduction, pursuant to Government Code Section 81008.

APPROVED AND ADOPTED by the City of Alameda Health Care District on the __th day of _____, 2008.

_____
Jordan Batttani
President, Board of Directors

ATTEST:
_____
Robert Bonta
Secretary, Board of Directors

APPENDIX TO
CONFLICT OF INTEREST CODE
OF THE
CITY OF ALAMEDA HEALTH CARE DISTRICT

Preamble

Any person designated in Section I of this Appendix who is unsure of any right or obligation arising under this Code may request a formal opinion or letter of advice from the FPPC or an opinion from the District's General Counsel. (Gov. Code § 83114; 2 CCR § 18730(b)(11).) A person who acts in good faith in reliance on an opinion issued to him or her by the FPPC shall not be subject to criminal or civil penalties for so acting, provided that all material facts are stated in the opinion request. (Gov. Code § 83114(a).)

Opinions rendered by General Counsel do not provide any statutory defense to an alleged violation of conflict of interest statutes or regulations. The prosecuting agency may, but is not required to, consider a requesting party's reliance on General Counsel's opinion as evidence of good faith. In addition, the District may consider whether such reliance should constitute a mitigating factor to any disciplinary action that the District may bring against the requesting party under Government Code section 91003.5.

I.

Designated Employees

Designated Employees	Categories Disclosed
Members of the District Board of Directors	All
Chief Executive Officer	All
Chief Operating Officer	All
Chief Financial Officer	All
General Counsel	All
Consultants[1]	---

[1] With respect to consultants, the CEO may determine in writing that a particular consultant, although a "designated employee," is hired to perform a range of duties that are limited in scope and thus is not required to comply with all the written disclosure requirements described in these categories. Such determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The CEO's determination is a public record and shall be retained for public inspection by the District in the same manner as this Conflict of Interest Code. Nothing herein excuses any such consultant from any other provision of this Conflict of Interest Code.

II. Persons Who Manage Public Investments

The Treasurer of City of Alameda Health Care District has been annually delegated responsibility for making public investments on behalf of the District, and reviewing and annually presenting the investment policy of the District to the Board of Directors for informational purposes. The Treasurer is therefore obligated to file a statement of economic interests under Government Code section 87200, rather than the conflict of interest code.

III. Disclosure Categories

Designated employees shall report all reportable investments, business positions and income, including gifts, loan and travel payments, as specified above, in:

1. Accounting or auditing services
2. Banks and savings and loans
3. Computer hardware or software, or computer services or consultants
4. Communications equipment or services
5. Educational and medical services and materials
6. Entities or persons who have filed claims against the District or have claims pending against the District
7. Insurance brokers and agencies
8. Insurance adjusting, claims auditing or administration, or underwriting services
9. Medical equipment, facilities, and supplies
10. Office equipment or supplies
11. Personnel and employment companies and services
12. Printing or reproduction services, publications, and distribution
13. Securities, investment or financial services companies
14. Title insurance and escrow
15. Interests in Real Property

DISTRICT BOARD/POLICIES AND CODES/2008-0y.CONFLICT OF INTEREST CODE.

Date: October 1, 2008

To: City of Alameda Health Care District Board of Directors

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Management of Frozen Alameda Hospital Retirement Plan

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The purpose of this memorandum is to request Board approval for several actions relating to the oversight and investment management of the Alameda Hospital Retirement ("Echo") Plan established in November 2002 and frozen in January 2005.

Background:

In 1959, Alameda Hospital installed a defined benefit plan ("Alameda Hospital Retirement Plan") covering all hospital employees with the exception of those employees covered under alternative plans through their collective bargaining contracts. In July 2002, prior to the vote to make the Hospital a District Hospital, management terminated the Alameda Hospital Retirement Plan and purchased annuity contracts for all participants through Principal Life Insurance Company.

In November, 2002, immediately after the election to convert to District Hospital status, the Echo Plan was installed with very similar benefits to the original defined benefit plan.

In January 2005, the Alameda Hospital Echo Plan was frozen with Board Approval and at the recommendation of Delta One Consultants. The Echo plan was replaced by a 401(a) defined contribution plan in which the employer contributes 6% of the annual compensation for each employee after one year of employment. These contributions are made to Diversified Investment Advisors and each employee directs how these funds are to be invested through our broker, Stark-Miller Associates. In addition, employees can make their own pre-tax contributions to a 457(b) fund, which is also administered by Stark-Miller, up to an amount allowable under the tax laws.

Over the years, several cash contributions were made to the Echo Plan, including:

2002	$ 350,000
2004	580,000
2005	700,000
2006	200,000
2008 (September)	45,000

The total balance in the Echo Plan as of September 24, 2008 is $1,379,000, which includes investment earnings on the cumulative deposits minus benefit payments. Note that some of these contributions were made even after the fund was frozen since liabilities continue to exist for the beneficiaries. These contributions are invested in a very conservative fixed income fund managed by Union Bank of California.

Legally, District hospitals, are not subject to higher ERISA pension funding requirements. Whereas ERISA requires a minimum of 80% funding at the beginning of a plan year with a target of 100% funding over a seven (7) year time horizon of estimated pension liabilities, government entity pension plans have no minimum funding requirements. The last actuarial analysis completed this year showed that the frozen Echo Plan is currently about 69% funded in relation to its projected liabilities. In addition, probably as many as 80% of the beneficiaries will begin to draw down on their retirement benefits within the next 15 years.

For these reasons, management believes that it would be prudent to begin to fund this account on a more aggressive basis with a goal of completing 100% funding of liabilities within a 15-year time frame. In addition, management has met with HighMark Capital Management, Inc., the investment management subsidiary of Union Bank of California, to discuss the current fixed income portfolio in which the fund is invested. Based on their experience in managing similar pension portfolios, HighMark recommends that it would prudent to invest the pension funds in what they call a "Balanced – Balanced Income" portfolio, comprised of 40-60% equity, 40-60% fixed income with a small percentage in cash to cover transactions by the investment manager. Over the long-term, HighMark projects that the Balanced Fund investment will generate an average annual rate of return of 6.5-7% instead of the 3-4% average return generated by fixed income fund.

Management recommends the following to the Board of Directors regarding the funding and disposition of the frozen Echo Plan:

1. The Board should establish a Pension Committee directly accountable to the Board of Directors and comprised of one Board member plus three members of the executive staff: the CEO, CFO and Director of Human Resources. A formal committee charge will be drafted and brought back to the Board for approval. At a minimum, the Pension Committee will meet at least twice a year and will oversee the investment results for the frozen Echo Plan, review annual actuarial projections for the total liability of the fund, evaluate satisfaction with the Plan's investment manager and, when appropriate, evaluate the overall design of our other retirement planning options available to our employees.

2. Authorize management to direct HighMark Capital Management to change our portfolio of investments from a fixed income fund with a projected average annual return of 3-4% to a balanced fund portfolio with estimated average return of 6.5-7%. This transition will occur over approximately a 3 month period. In addition the Pension Committee will draft and recommend an on-going pension investment policy to the Board. A draft policy provided by HighMark for our consideration is attached (Attachment A).

3. Establish a plan to increase the additions to the fund by approximately $140,000 per year, which should allow the fund to reach 100% funding of the current estimated liability in a 15 year timeframe, by which time a majority of the beneficiaries will have reached retirement age.

In summary, management concludes that implementation of the recommendations while in excess of pension funding levels required by law for the district, provide a more aggressive and prudent approach to increasing the funding level for the estimated Echo Plan liabilities.

INVESTMENT GUIDELINES DOCUMENT

Alameda Hospital Pension Plan

Draft

Investment Guidelines Document

Overview

You have hired Union Bank of California (UBOC) to manage some or all of your investment assets. UBOC has appointed HighMark Capital Management, Inc. (HCM) as investment manager for your account. In order to properly manage your account HCM requires that you confirm the investment guidelines and other information for your account, as set forth in this document. HCM will rely on this information in managing your account.

Executive Summary

Client Name: Alameda Hospital

Background: This Investment Guidelines Document (IGD) has been prepared for Alameda Hospital. As of July 2008, the Plan was underfunded by approximately $580,000. The Plan is currently frozen to new participants. Prior to October 2008, the Plan was 100% invested in a Stable Value Fund. In October 2008, the Plan developed an investment policy that recognized, and allowed for the inclusion of equities within the asset allocation of the Plan.

Investment Authority: Full Investment Authority

Account Number(s): To be determined

Risk Tolerance: Moderate to high

Time Horizon: Long-Term

Investment Objective: The primary objective is to maximize total Plan return, subject to the risk and quality constraints set forth below. The Plan's targeted rate of return is 7.0%. The Investment objective selected is the Balanced Objective. The asset allocation ranges for this objective are listed below:

Strategic Ranges:
0 - 20% Cash
30 - 50% Fixed Income
50 - 70% Equity

Communication Schedule: Committee meetings at least twice a year to discuss performance and investment strategy.

HCM Portfolio Manager: Andrew Brown. 415-705-605
Andrew.Brown@Uboc.com

HCM Back up -Portfolio Manager: Delbert Chang, CFA 415-705-7603
Delbert.Chang@Uboc.com

UBOC Administrative Officer: John Fulton, 415-273-2508
John.Fulton@Uboc.com

The managing director of HighMark Capital Management is Kevin Rogers, he can be contacted at 949-553-2580.

Portfolio Constraints

Income Needs/Cash Flow Required: **To be determined**

Document/Legal Restrictions: None.

Unique Needs and Circumstances: None

Client(s) Signature: _____ **Date:** _____

Client(s) Signature: _____ **Date:** _____

CONSENT

HCM Portfolio Manager: _____ **Date:** _____

UBOC Administrative Officer: _____ **Date:** _____

Detailed Information for Investment Guidelines Document

Overview

The purpose of this Investment Guidelines document (IGD) is to assist you and your Portfolio Manager in effectively supervising, monitoring and evaluating the investment of your portfolio. Your investment program is defined in the various sections of the IGD by:

1. Stating in a written document your attitudes, expectations, objectives and guidelines for the investment of all assets.

2. Setting forth an investment structure for managing your portfolio. This structure includes various asset classes, investment management styles, asset allocation and acceptable ranges that, in total, are expected to produce an appropriate level of overall diversification and total investment return over the investment time horizon.

3. Encouraging effective communications between you and your Portfolio Manager.

4. Complying with all applicable fiduciary, prudence and due diligence requirements experienced investment professionals would utilize, and with all applicable laws, rules and regulations from various local, state, and federal entities that may impact your assets

Diversification

Your Portfolio Manager is responsible for maintaining the balance between fixed income and equity securities based on the asset allocation. The following parameters shall be adhered to in managing the portfolio:

Fixed Income

- The intermediate and long-term fixed income investments (greater than one-year in maturity) shall constitute no more than 50%, nor less than 20% of the total Plan assets.
- The high-yield portion of the Plan shall constitute no more than 8%, and as little as 0% of the total Plan assets.
- The convertible bond exposure shall constitute no more than 8%, and as little as 0% of the total Plan assets.
- The short-term fixed income investments shall constitute no more than 30%, and as little as 0% of the total Plan assets.
- The target fixed income exposure should average 35% over a market cycle (three to five years.

Equity

- The domestic core equity investments of the Plan shall constitute no more than 50% nor less than 20% of the total Plan assets.
- The domestic mid-capitalization equity investments of the Plan shall constitute no more than 12%, and as little as 0% of the total Plan assets.

- The domestic small capitalization equity investments of the Plan shall constitute no more than 20% nor less than 5% of the total Plan assets.
- The international equity investments of the Plan shall constitute no more than 20% and as little as 0% of the total Plan assets.
- The real estate investments of the Plan shall constitute no more than 10% and as little as 0% of the total Plan assets.
- The target equity exposure should average 60% over a market cycle (three to five years.

Permitted Asset Classes and Security Types

The following asset classes and security types have been approved by HighMark for use in client portfolios:

Asset Classes

- Fixed Income
  - Domestic Bonds
  - Non-U.S. Bonds
- Equities
  - Domestic
  - Non-U.S.
  - Emerging Markets
  - REITs
- Cash and Cash Equivalents

Security Types

- Equity Securities
  - Domestic listed and unlisted securities
  - Equity and equity-related securities of non-US corporations, in the form of American Depository Receipts ("ADRs")
- Equity Mutual Funds
  - Large Cap Core, Growth and Value
  - Mid Cap Core, Growth and Value
  - Small Cap Core, Growth and Value
  - International and Emerging Markets
  - REITs
- Exchange Traded Funds (ETFs)
- Fixed Income Securities
  - Government/Agencies
  - Mortgage Backed Bonds
  - Corporate Bonds and Notes
- Fixed Income Mutual Funds
  - Corporate
  - Government
  - High Yield
  - International and Emerging Market
  - Convertible
  - Preferred
- Closed end funds
- Cash and Cash Equivalents
  - Money Market Mutual Fund
  - Commercial Paper

- CDs and Bankers Acceptance

Prohibited assets

- Precious metals
- Venture Capital
- Short sales
- Purchases of Letter Stock, Private Placements, or direct payments
- Leveraged Transactions
- Commodities Transactions Puts, calls, straddles, or other option strategies, except as permitted above
- Purchases of real estate, with the exception of REITs
- Derivatives, with exception of ETFs

Rebalancing Procedures

From time to time, market conditions may cause your asset allocation to vary from the established target. To remain consistent with the asset allocation guidelines established by this Investment Guidelines document, your Portfolio Manager will rebalance the portfolio on a quarterly basis.

Performance objectives

- Total Plan. To exceed over a market cycle (three to five years) a policy index composed of 5% 3-Month Treasury bills, 35% Lehman Brothers Aggregate Bond Index, 40% S&P500 Stock Index, 10% Russell 2000 Stock Index, and 10% the Morgan Stanley Capital Index EAFE Index.

- Fixed Income: To exceed over a market cycle the annualized return of
  - The Lehman Brothers Aggregate Bond Index
  - The median return of a universe of actively managed fixed income funds
- Domestic Core Equities: To exceed over a market cycle the annualized rate of return of
  - The S&P500 Index
  - The median return of a universe of actively managed equity funds
- Domestic Small Capitalization Stocks: to exceed over a market cycle the annualized rate of return of
  - The Russell 2000 Stock Index
  - The median return of a universe of actively managed small cap equity funds

- International equities: To exceed over a market cycle the annualized rate of return of
  - The MSCI EAFE Index
  - The median return of a universe of actively managed international equity funds.

The investment objectives stated in this document represent desired results that are long-term in nature, covering a period of three to five years. Any shortfalls should be explainable in terms of general economic and capital market conditions. Investment performance will be measured on a total return basis including gains, losses, and income.

Duties of Responsibilities of Portfolio Manager

Your portfolio manager is expected to manage your portfolio in a manner consistent with this Investment Guidelines document and in accordance with State and Federal law and the Uniform Prudent Investor Act. HighMark Capital Management is a registered investment advisor and shall act as such until you decide otherwise.

Your portfolio manager shall be responsible for:

1. Designing, recommending and implementing an appropriate asset allocation consistent with the investment objectives, time horizon, risk profile, guidelines and constraints outlined in this statement.
2. Advising the committee about the selection of and the allocation of asset categories.
3. Identifying specific assets and investment managers within each asset category.
4. Monitoring the performance of all selected assets.
5. Recommending changes to any of the above.
6. Periodically reviewing the suitability of the investments, being available to meet with the committee at least once each year, and being available at such other times within reason at your request.
7. Preparing and presenting appropriate reports.
8. Informing the committee if changes occur in personnel that are responsible for portfolio management or research.

You shall be responsible for:

1. The oversight of the investment portfolio.
2. Providing your portfolio manager with all relevant information on the Plan, and shall notify him or her promptly of any changes to this information.
3. Advising your portfolio manager of any change in the Plan's circumstances, such as a change in the actuarial assumptions, which could possibly necessitate a change to your overall risk tolerance, time horizon or liquidity requirements; and thus would dictate a change to your overall investment objective and goals for the portfolio.
4. Monitoring performance by means of regular reviews to assure that objectives are being met and that the policy and guidelines are being followed.

The committee expressed a desire to add to their duties. This section might be an appropriate section to further clarify the responsibilities of the Alameda Hospital Pension Committee.

Communication

As a matter of course, your portfolio manager shall keep you apprised of any material changes in HighMark Capital's outlook, recommended investment policy and tactics. In addition, your portfolio manager shall meet with you no less than annually to review and explain the portfolio's investment results and any related issues. Your portfolio manager shall also be available on a reasonable basis for telephone communication when needed.

Any material event that affects the ownership of HighMark Capital Management or the management of the portfolio must be reported immediately to you.

Reporting

TO BE DETERMINED

Disclosures

Union Bank of California, N.A. and HighMark Capital Management, Inc. are wholly owned subsidiaries of UnionBanCal Corporation. Investments are not deposits or bank obligations, are not guaranteed by any government agency, and involve risk, including loss of principal. When investing in mutual funds (including ETFs) please read the prospectuses carefully.

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED

FINANCIAL STATEMENTS

FOR THE

PERIOD ENDING

08/31/08

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

ALAMEDA HOSPITAL

City of Alameda Health Care District

August 31, 2008

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ALAMEDA HOSPITAL

August 31, 2008

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, 2008 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, 2008

- Total assets on the balance sheet decreased by $599,054 from the prior month as a result of a decrease of $1,862,824 of cash and cash equivalents, $351,142 of other assets and $123,396 of amortization of property plant and equipment costs offset by an increase of $1,695,765 in net patient accounts receivable.

- Total cash and cash equivalents for August decreased by $1,862,824 and reflect 10.0 days of cash on hand compared to 26.0 in the prior month. The decrease in cash and cash equivalents was primarily the result of the State of California's mandate to not make payments in the month of August and its inability to finalize the State's budget for 2008 / 2009 and increased payment of past due accounts payable accounts.

- Net patient accounts receivable increased in August by $1,695,765 compared to a decrease of $130,575 in July. Accounts receivable days were 61 compared to 51 in the prior month primarily as a result the delay of Medi-Cal payments in August.

- Total liabilities decreased by $563,305 compared to a decreased by $1,068,860 in the prior month. This decrease was primarily the result of the amortization of one month of fiscal year 2009's parcel tax proceeds in the amount of $477,000.

- Accounts payable at August 31st was $4,856,131, which represents a decrease of $554,392 from the prior month. As a result, days in accounts payable decreased to 79 compared to prior month which was at 83.

- Combined gross revenue was greater than budget by $129,091 or 0.6%. The majority of this variance was the result of higher than anticipated outpatient services in the month of August than was budgeted. Net patient revenue was slightly less than budgeted, $80,569 or 1.6%. The total patient days were 2,234 and included 315 patient days from the addition of the South Shore facility on August 17th compared to the prior month of 2,018 and a prior year of 1,972 days. Inpatient revenue was less than budgeted by 1.3% while outpatient revenue was greater than budgeted by 3.2%. The combined average revenue per adjusted patient day was $5,586 compared to a budgeted amount of $5,600. The average daily acute census was 29.3 compared to 33.0 in the prior month; the average daily Sub-Acute census was 32.6 versus 32.1 in the prior month and the newly added South Shore unit had an average daily census of 21.0 for the month of August.

- ER visits were 1,336 or 7.0% less than the budgeted 1,436 visits. ER visits were also lower than the prior year's August visits of 1,471 or 9.2%.

- Total surgery cases were 2.5% greater than budget, with Kaiser surgical cases making up 293 or 65% of the total cases. Additionally, Kaiser gross charges decreased to $3.5 million which dropped the estimated break-even point to 271 cases in August.

- Combined excess revenue over expense was $21,686 versus a combined budgeted excess of revenues over expenses of $14,748. This brings the year-to-date excess of revenues over expenses to $78,961 or 180.9% better than budget.

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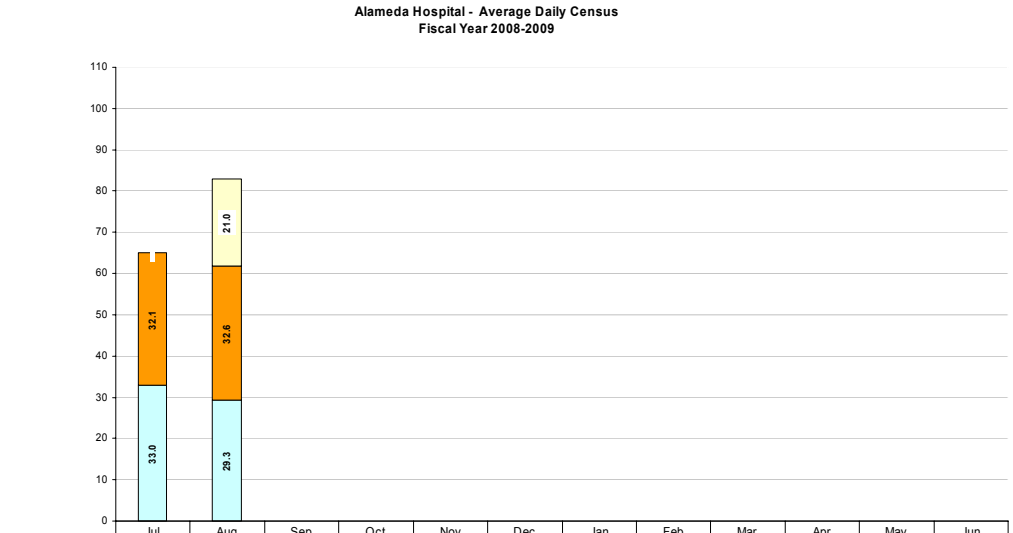
Volumes

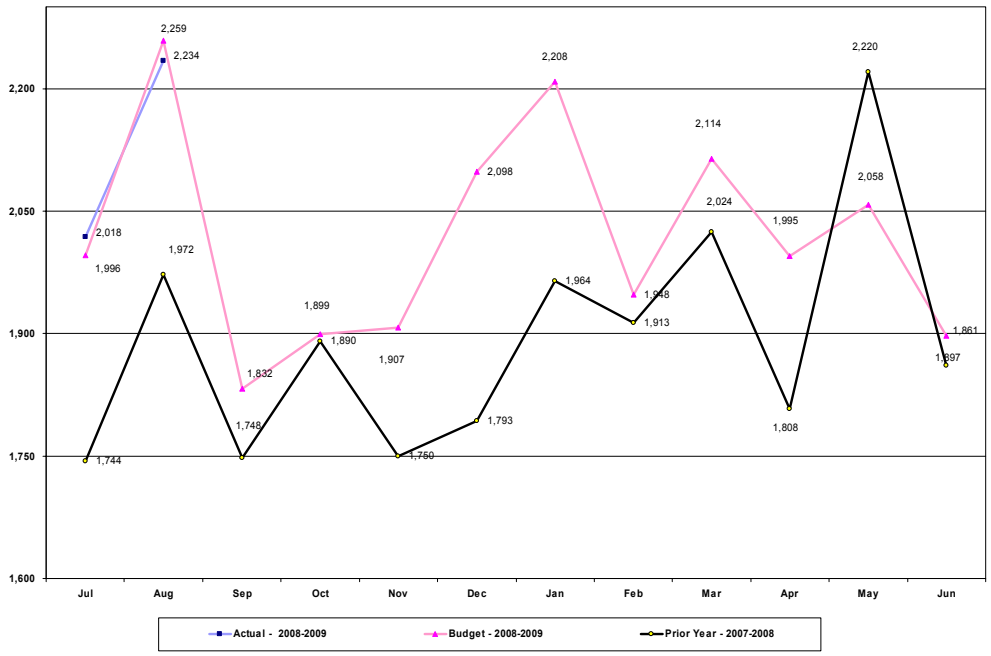
Overall actual daily census was 82.9 versus a budget of 83.2. Acute average daily census was 29.3 versus a budget of 30.1, Sub-Acute average daily census was 32.6 versus a budget of 33.1 and the newly added South Shore unit had an average daily census of 21.0 versus a budget of 20.0.



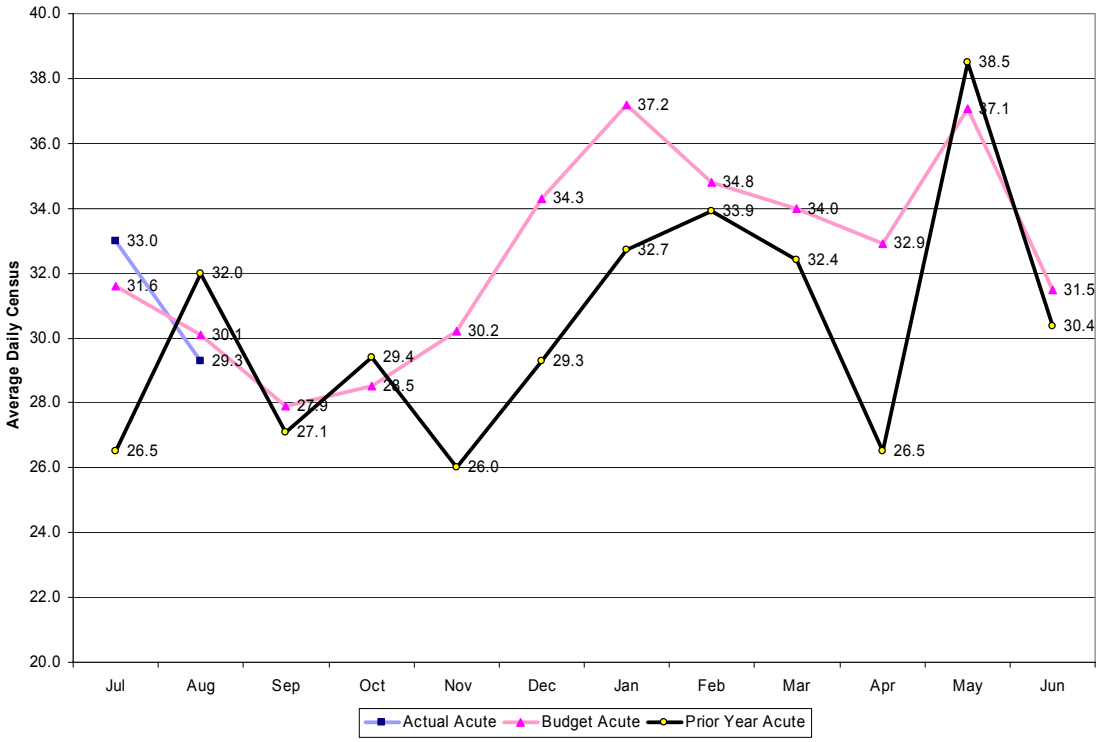
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Actual SNF		21.0										
Actual Sub-Acute	32.1	32.6										
Actual Acute	33.0	29.3										

Actual	65.1	82.9										
Budget	64.4	83.2										

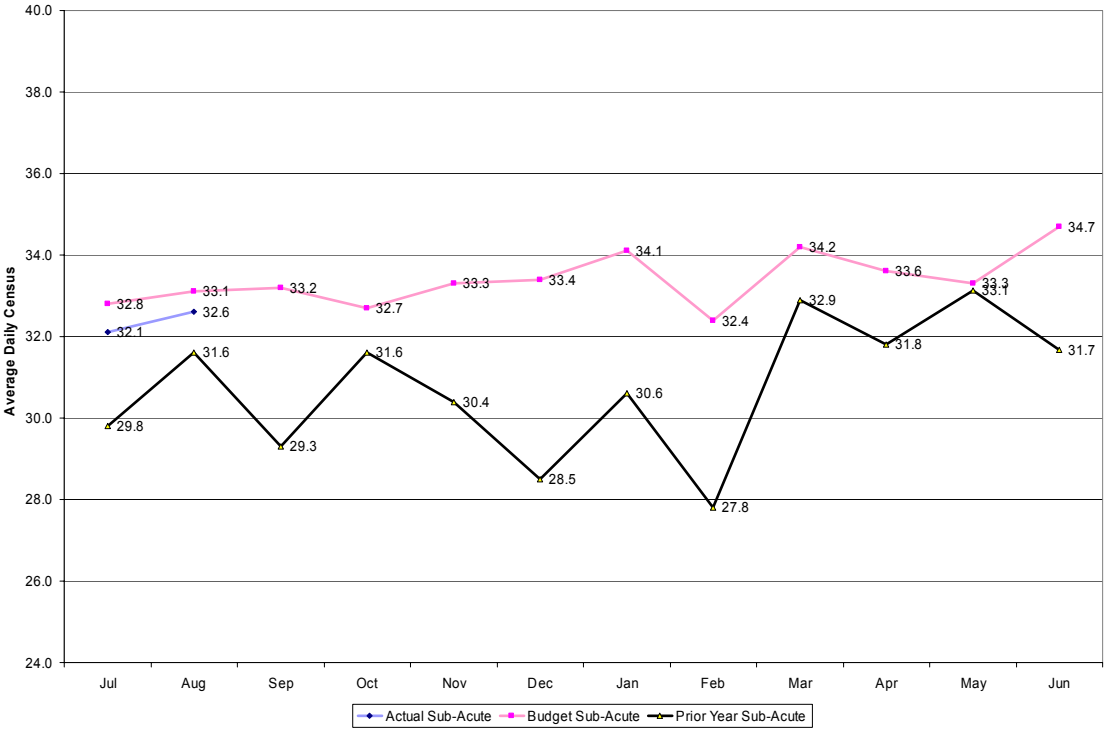
Total patient days in August were 13.3% greater than August 2007 and 1.1% less than budget.



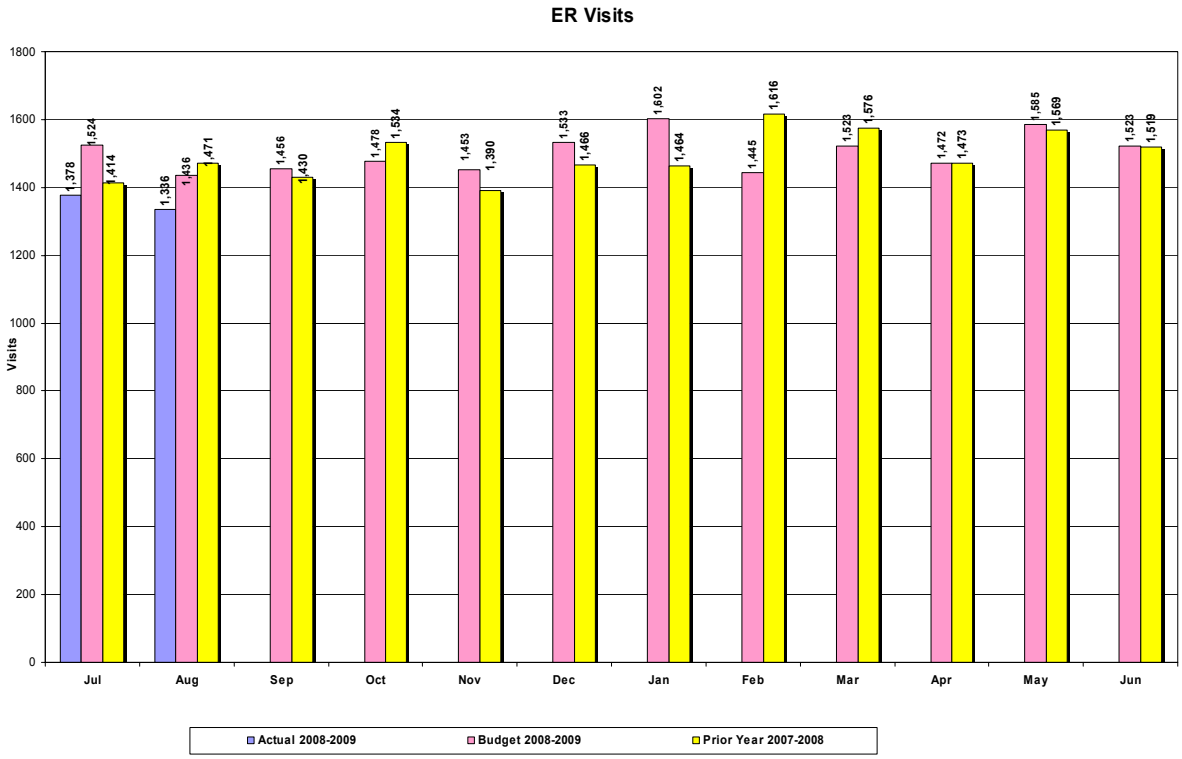
August acute patient days were 2.6% (24 days) less than budgeted and 8.4% (83 days) less than the prior year. The acute average length of stay in August was 4.13 compared to a budget of 4.00.



Sub-Acute patient days were 1.6% less than budget and 18.5% greater than the prior year. The following graph shows the Sub-Acute programs average daily census.

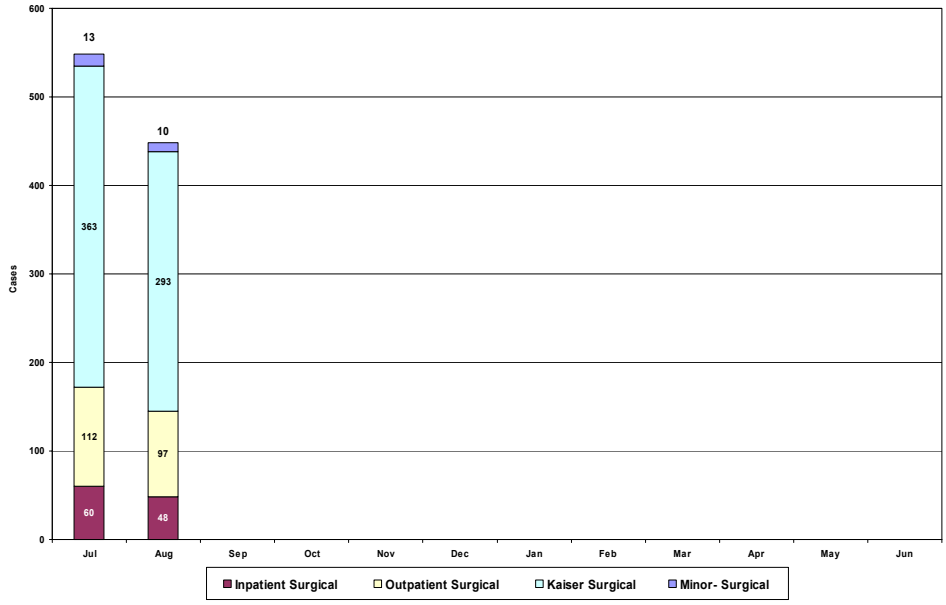


August ER visits were 7.0% less than budgeted and 9.2% less than the prior year.



August 2008 surgery cases were 448 versus the 437 budgeted and 467 in the prior year. However, out of the total surgical cases in August, 293, or 65% were Kaiser surgical cases, which is a decrease of 70 cases or 19.3% to the prior month's proportion of Kaiser cases to total cases. Additionally, as mentioned early the total charges related to Kaiser cases decreased by $621,463 from July dropping the estimated break-even point to 271 cases. As a result of this decline in charges our reimbursement for Kaiser Outpatient cases in August increased to 21.6% as compared to 18.3% of gross charges in July.

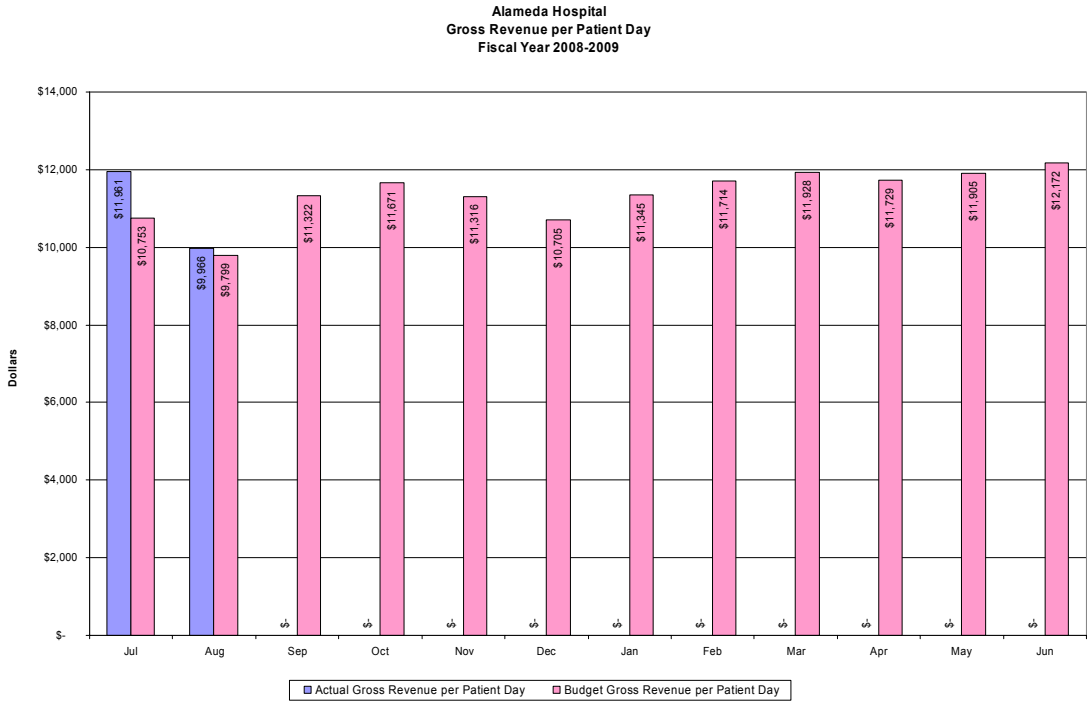
Surgical Cases



Income Statement – Hospital Only

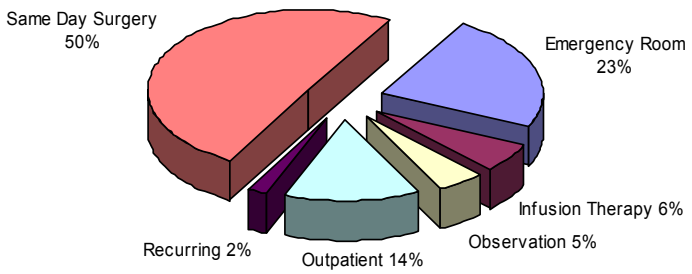
Gross Patient Charges

Gross charges in August were greater than budgeted by $89,438, and was comprised of an unfavorable variance in inpatient gross revenues of $219,811 while outpatient gross revenues were again favorable to budget by $309,249. On an adjusted patient day basis total patient revenue was $6,388 versus the budgeted $6,369 or a 0.3% favorable variance from budget.



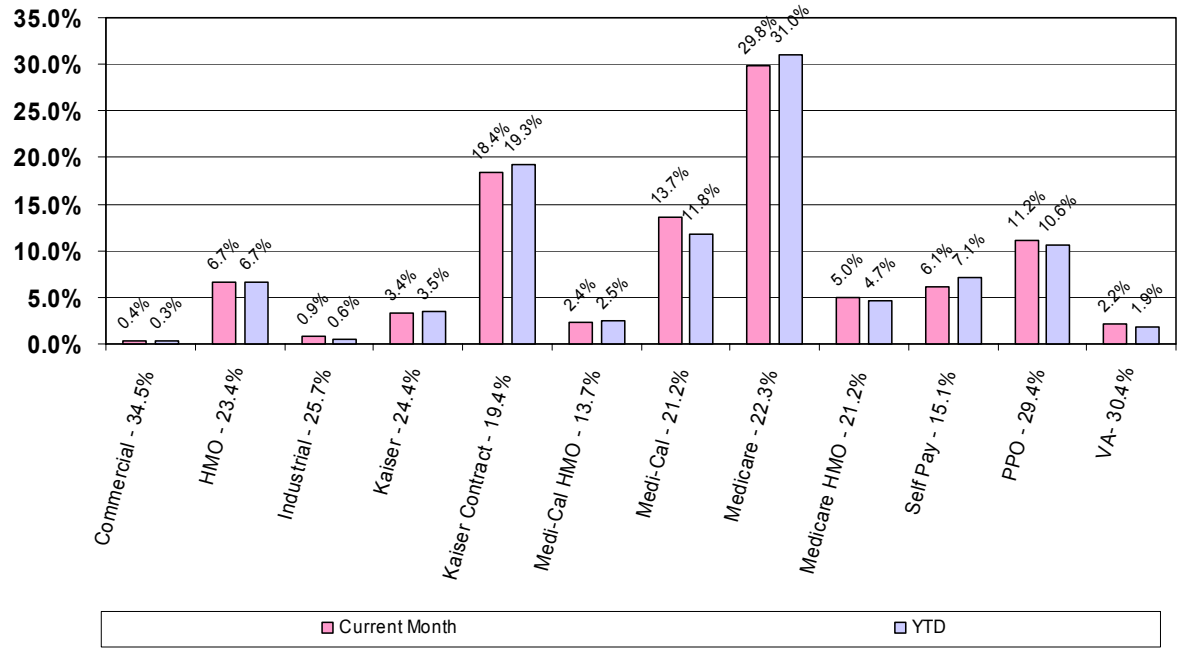
In looking at the composition of the outpatient revenues, same day surgeries makes up the majority of the outpatient revenue book of business at $4.5 million or 48.7% followed by emergency services at $2.2 million or 23.7%. The remaining 25.5% is made up of outpatient ancillary services such as radiology, laboratory, the IVT program and other outpatient services as shown in the pie chart below:

Composition of Year-to-Date Outpatient Gross Charges



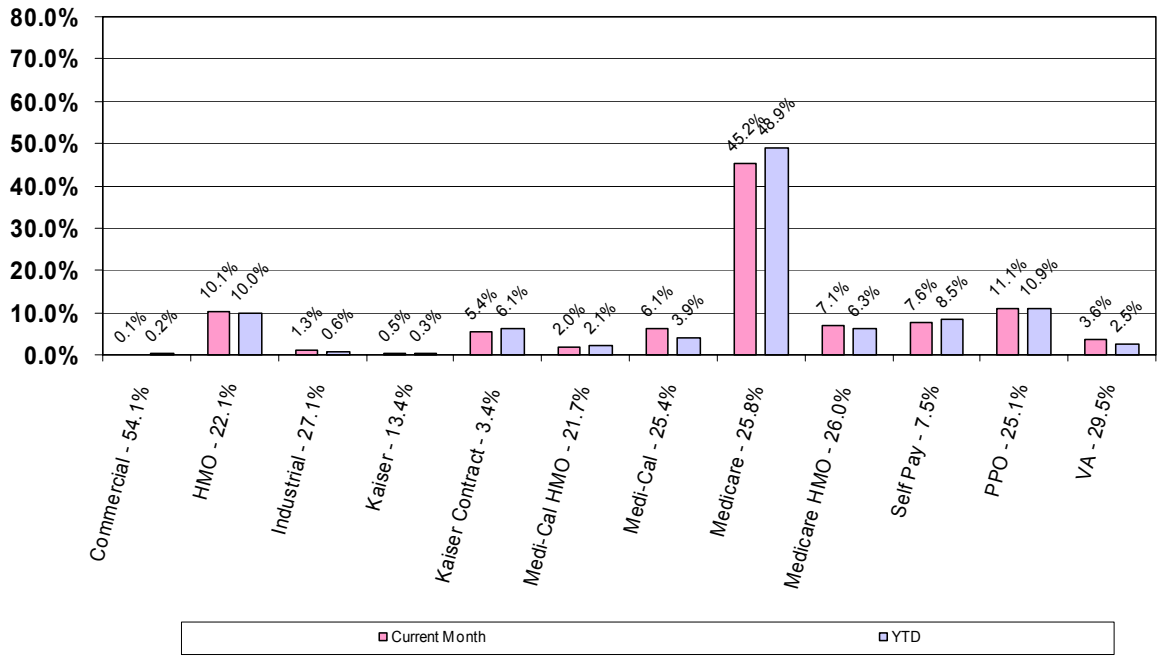
When looking at the combined payor mix for the hospital, Medicare continues to hold the top payor position with total gross revenue representing 29.8% and 31.0% for the current month and year to date, respectively of our total gross patient charges with Kaiser as the second largest source of gross patient revenues at 21.7% and 22.8% for the current month and year to date, respectively. The graph below shows the percentage of revenues generated by each of the major payors as well as the current months expected reimbursement for each.

Combined Payor Mix



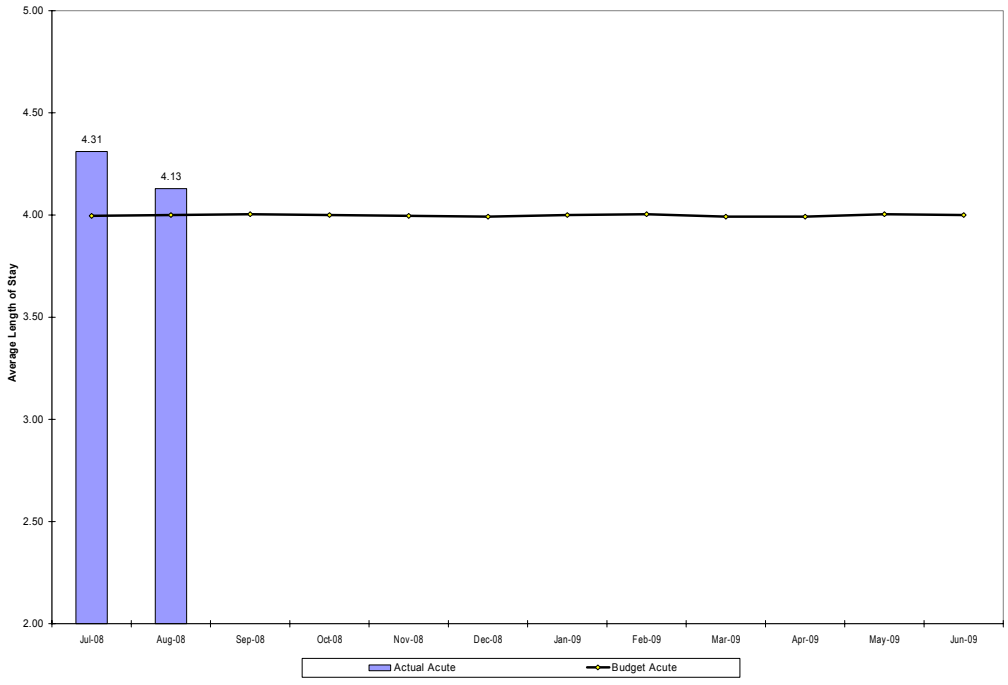
On the Hospital's inpatient acute side, 45.2% and 48.9% for the current month and year to date, respectively of the total gross revenue was generated by Medicare patients. Expected reimbursement for inpatient Medicare cases has been estimated to be 25.8% based upon August discharges, which is slightly better than the reimbursement level experienced in July. This improvement in expected reimbursement in August is primarily the result of four (4) cases qualifying for outlier reimbursement as opposed to the month of July which had no cases hitting outlier threshold levels.

Inpatient Acute Care Payor Mix



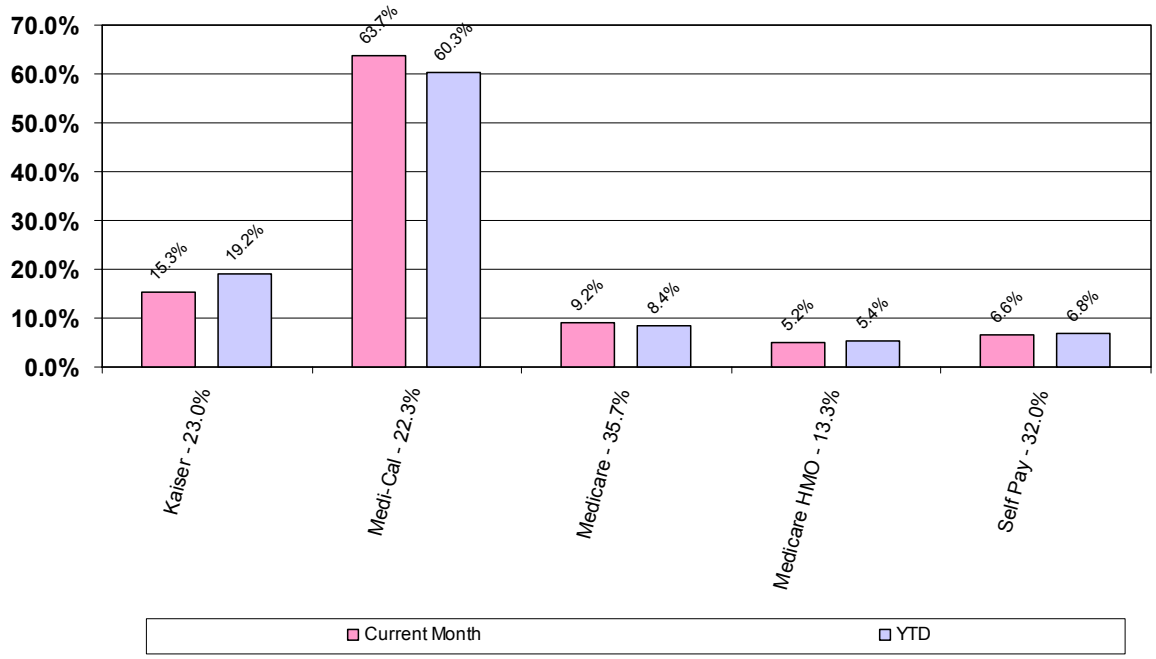
Average length of stay for the inpatient acute care units decreased to 4.13 days which is 3.2% greater than the 4.00 average length of stay that was budgeted for fiscal year 2009.

Average Length of Stay



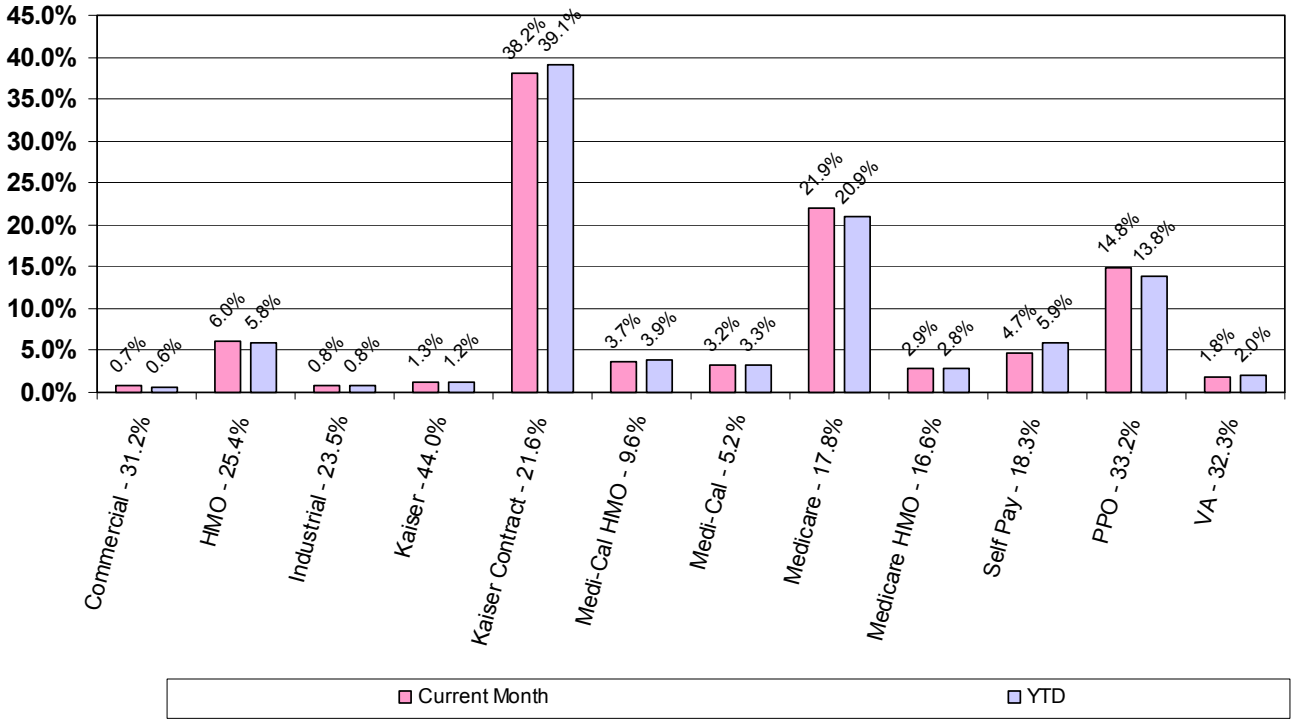
In August, 63.7% of the Sub-Acute programs gross revenue was from Medi-Cal beneficiaries followed by 15.3% from Kaiser and 9.2% from Medicare as is seen on the graph on the following page.

Inpatient Sub-Acute Care Payor Mix



The outpatient gross revenue payor mix for August was comprised of 39.5% Kaiser, 21.9% Medicare, 14.8% PPO and 6.0% HMO and is shown on the following graph.

Outpatient Services Payor Mix



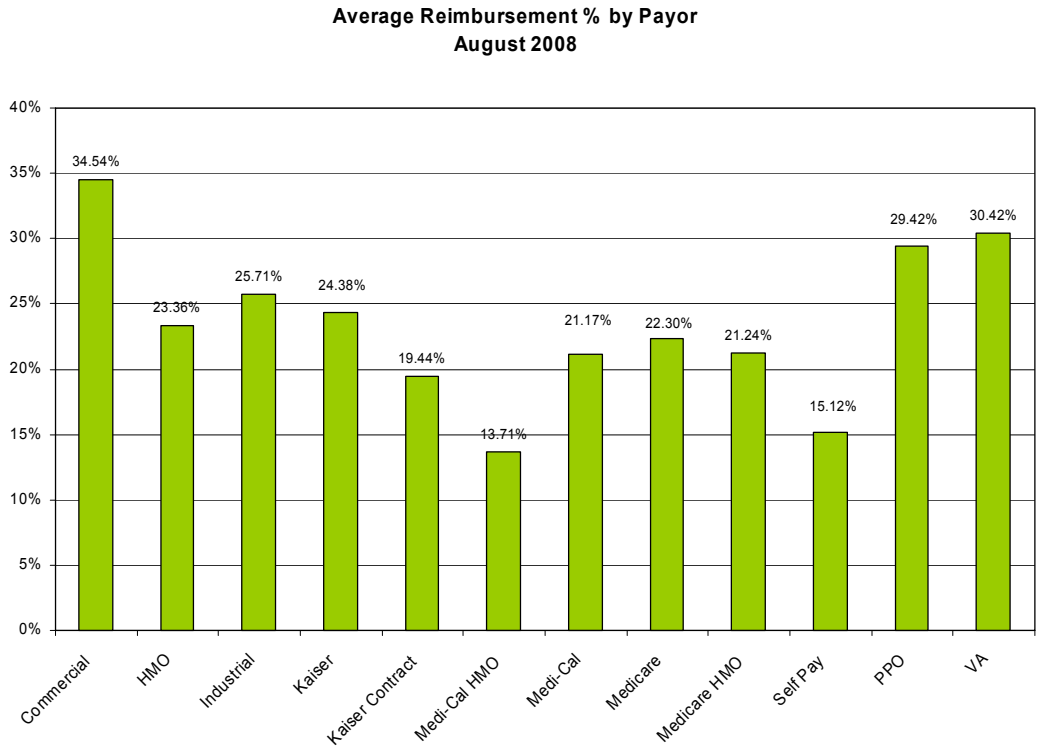
Deductions From Revenue

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

In the month of August contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 77.47% versus the budgeted 77.14%. In August there were again no DRG "take backs" associated with the RAC project.

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 actual anticipated cash payments the Hospital is to receive for the services provided. The graph on the following page shows the level of reimbursement that the Hospital has experienced during the current month of fiscal year 2009 by major payor category.

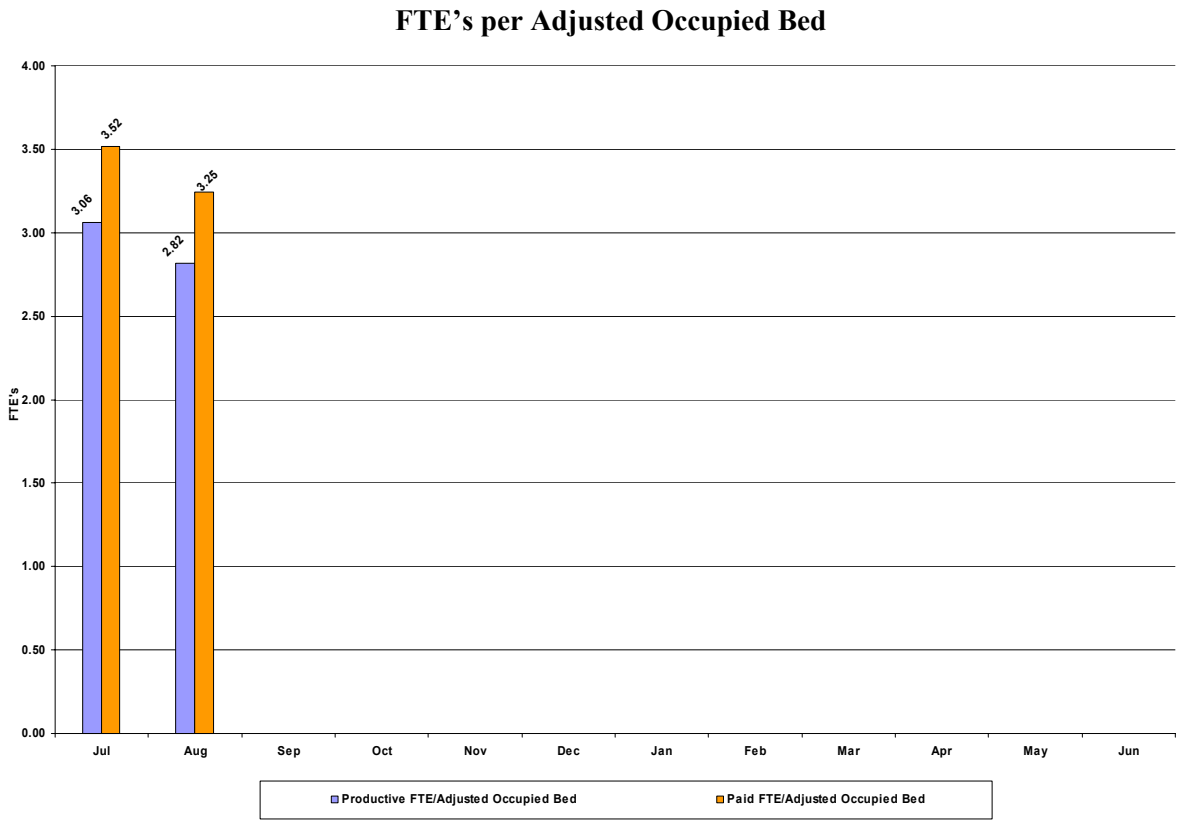


Total Operating Expenses

Total operating expenses were less than the fixed budget by $56,700 or 1.0%. This favorable variance resulted in expenses per adjusted patient day of $1,583 compared to a budget of $1,601 or 1.1% favorable to the volume adjusted budget. The following discusses the significant areas that make up the variance from the fixed operating budget.

Salary and Registry Expenses

Salary and registry costs combined were less than budgeted by $50,481, with the majority of the favorable variance ($108,921) in the salary category while registry costs exceeded budget by $58,440. The salary and registry costs per adjusted patient day were $838 versus the budgeted $854 resulting in a favorable variance of $16 per adjusted patient day. Combined productive FTE's per adjusted occupied bed was 2.82 in August versus the budgeted 2.85. The following graph shows the combined productive and paid FTE's per adjusted occupied bed for FY 2009.



Benefits

For the month of August benefits exceeded budget by $7,747 and was the result of higher than budgeted amounts for vacation accruals, $75,049 which was offset by lower than anticipated group health insurance costs of $64,248. This favorable variance was the result of a $24,177 decrease to required IBNR reserves and the receipt of $32,594 in stop loss recoveries.

Professional Fees

Professional medical and non-medical fees were over budget by $30,920 with the negative variance occurring in the non-medical category. Non-medical professional fees were over budget as a result of higher than expected legal fees totaling $24,777 and costs associated with the Strategic Plan development of $21,250.

Supplies
Overall supplies were $26,551 under budget in August. This favorable variance from the fixed operating budget was the result of lower than budgeted costs for medical supplies of $12,842, office supplies of $8,010 and the reclassification of minor equipment costs expensed in July that should have been treated as prepaid expenses in the amount of $5,495.

Balance Sheet

Patient Accounts Receivable
Gross patient accounts receivable increased by $6,248,589 from the prior month and the gross days in receivables increased to 61 compared to 51 in the prior month. Both increases are primarily attributable to the Medi-Cal scheduled non-payment of claims in August and the State of California's budget crisis.

Liabilities
Total Current and Long Term Liabilities at August31, 2008 were $19,689,362 versus $20,301,225 in the prior month, a decrease of $611,863 or 3.0%. This decrease was the result of the amortization of one month of fiscal year 2009's parcel tax proceeds in the amount of $477,000 and the decrease in accounts payable and accrued expenses of $554,392 offset by an increase of $323,986 of payroll related accruals.

ALAMEDA HOSPITAL
Balance Sheet
August 31, 2008

	August 31, 2008	July 31, 2008	June 30, 2007
Assets			
Current assets:			
Cash and cash equivalents	$ 1,947,482	$ 3,810,306	4,363,875.00
Net Accounts Receivable	9,509,713	7,813,948	7,300,864.00
Net Accounts Receivable %	20.57%	19.54%	19.70%
Inventories	1,055,919	1,041,296	949,780
Other assets	7,037,083	7,388,225	7,371,617
Total Current Assets	19,550,198	20,053,775	19,986,136
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate	623,159	613,283	467,958
Fixed Assets:			
Total fixed assets, net of accumulated depreciation	7,232,996	7,338,348	8,614,986
Total Assets	$ 27,406,352	$ 28,005,406	$ 29,069,080
Liabilities and Net Assets			
Current Liabilities:			
Line of credit - Bank of Alameda	$ -	$ -	$ 1,000,000
Accounts payable and accrued expenses	4,856,131	5,410,524	4,819,845
Loans Payable	2,378,152	2,380,000	-
Payroll and benefit related accruals	3,636,938	3,221,746	3,009,861
Est.Third-party payer settlement payable	811,519	742,750	450,000
Other liabilities	7,412,532	7,903,557	8,581,368
Total Current Liabilities	19,095,272	19,658,577	17,861,074
Long-Term Liabilities:			
Long-term pension liabilities	(23,911)	(37,964)	$ (31,318.00)
Long-term IBNR reserves	330,000	330,000	360,000
Capitalized Lease payable	288,001	350,612	1,022,616
Total Long-Term Liabilities	594,089	642,648	1,351,298
Total Liabilities	19,689,362	20,301,225	19,212,372
Net Assets			
Net Assets - Beginning	9,856,708	9,856,708	13,135,808
Fund Transfer C W & S		-	610,984
Current year changes	(2,276,168)	(2,297,852)	(3,890,084)
Investment income - Jaber Trust	136,450	145,324	-
Net Assets - Ending	7,716,990	7,704,180	9,856,708
Total Liabilities and Net Assets	$ 27,406,352	$ 28,005,406	$ 29,069,080

ALAMEDA HOSPITAL - COMBINED
Summary Statement of Revenues, Expenses
For the Two Months Ended August 31, 2008

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	Budget	Variance	Var %	Jul 07	YTD Actual	YTD Budget	Variance	Var %	FY07 Actual
Operating revenues:										
IP Revenue	$ 12,477,991	$ 12,648,658	$ (170,667)	-1.3%	$ 12,591,381	$ 26,197,208	$ 25,443,562	$ 753,646	3.0%	$ 23,291,372
OP Revenue	9,786,724	9,486,966	299,758	3.2%	8,762,095	20,205,560	18,155,717	2,049,843	11.3%	17,573,962
Total revenue	$ 22,264,715	$ 22,135,624	$ 129,091	0.6%	$ 21,353,476	$ 46,402,768	$ 43,599,279	$ 2,803,489	6.4%	$ 40,865,335
Less: Deductions from Revenue	(16,500,723)	(16,364,772)	(135,951)	0.8%	(16,503,196)	(34,399,424)	(32,059,577)	(2,339,847)	7.3%	(31,262,137)
Bad Debt	(677,801)	(610,021)	(67,780)	11.1%	(294,534)	(1,499,347)	(1,349,412)	(149,935)	11.1%	(556,202)
Charity	(59,289)	(53,360)	(5,929)	11.1%	(75,579)	(155,855)	(140,269)	(15,585)	11.1%	(93,077)
Net patient service revenue	$ 5,026,902	$ 5,107,471	$ (80,569)	-1.6%	$ 4,480,167	$ 10,348,143	$ 10,050,021	$ 298,122	3.0%	$ 8,953,918
	22.58%	23.07%			20.98%	22.30%	23.05%			21.91%
Other revenue	11,663	10,040	1,623	16.2%	16,854	22,392	20,080	2,312	11.5%	26,486
Total operating revenues	$ 5,038,565	$ 5,117,511	$ (78,946)	-1.5%	$ 4,497,021	$ 10,370,535	$ 10,070,101	$ 300,434	3.0%	$ 8,980,404
Operating expenses:										
Salaries	$ 2,752,319	$ 2,882,528	$ 130,209	4.5%	$ 2,652,801	$ 5,526,575	$ 5,775,939	$ 249,364	4.3%	$ 5,441,713
Registry	173,653	115,213	(58,440)	-50.7%	146,148	377,892	232,810	(145,082)	-62.3%	291,163
Benefits	853,337	860,400	7,063	0.8%	659,538	1,765,309	1,713,417	(51,892)	-3.0%	1,195,666
Professional Fees	314,251	281,937	(32,314)	-11.5%	352,236	666,297	550,943	(115,354)	-20.9%	658,601
Supplies	722,904	751,272	28,368	3.8%	789,669	1,532,120	1,477,751	(54,369)	-3.7%	1,490,540
Purchase Services	338,077	344,517	6,440	1.9%	310,848	681,698	688,336	6,638	1.0%	604,713
Rents and Leases	52,082	50,878	(1,204)	-2.4%	52,016	114,989	98,072	(16,917)	-17.3%	99,445
Utilities and Telephone	74,955	74,296	(659)	-0.9%	69,860	148,254	147,384	(870)	-0.6%	135,028
Insurance	48,912	60,409	11,497	19.0%	59,364	92,686	121,380	28,694	23.6%	118,728
Interest Expense	13,043	12,131	(912)	-7.5%	10,132	26,297	24,263	(2,034)	-8.4%	20,448
Depreciation and amortization	123,396	112,922	(10,474)	-9.3%	166,686	246,784	225,369	(21,415)	-9.5%	333,949
Other Operating Expenses	53,058	66,473	13,415	20.2%	38,261	117,481	132,418	14,937	11.3%	68,252
Total operating expenses	$ 5,519,987	$ 5,612,976	$ 92,989	1.7%	$ 5,307,559	$ 11,296,382	$ 11,188,082	$ (108,300)	-1.0%	$ 10,458,247
Operating gain (loss)	$ (481,422)	$ (495,465)	$ 14,043	-2.8%	$ (810,538)	$ (925,847)	$ (1,117,981)	$ 192,134	-17.2%	$ (1,477,843)
Non-operating revenues (expenses):	$ 503,108	$ 510,213	$ (7,105)	-1.4%	$ 520,656	$ 1,004,808	$ 1,020,426	$ (15,618)	-1.5%	$ 1,045,867
Excess of revenues over expenses	21,686	14,748	6,938	47.0%	(289,882)	78,961	(97,555)	176,516	-180.9%	(431,976)

ALAMEDA HOSPITAL - HOSPITAL ONLY
Summary Statement of Revenues, Expenses
For the Two Months Ended August 31, 2008

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	Budget	Variance	Var %	Jul 07	YTD Actual	YTD Budget	Variance	Var %	FY07 Actual
Operating revenues:										
IP Revenue	$ 12,257,201	$ 12,477,012	$ (219,811)	-1.8%	$ 12,591,381	$ 25,976,418	$ 25,271,916	$ 704,502	2.8%	$ 23,291,372
OP Revenue	9,786,724	9,477,475	309,249	3.3%	8,762,095	20,205,560	18,146,226	2,059,334	11.3%	17,573,962
Total revenue	$ 22,043,925	$ 21,954,487	$ 89,438	0.4%	$ 21,353,476	$ 46,181,978	$ 43,418,142	$ 2,763,836	6.4%	$ 40,865,335
Less: Deductions from Revenue	(16,339,546)	(16,272,925)	(66,621)	0.4%	(16,503,196)	(34,238,247)	(31,967,730)	(2,270,517)	7.1%	(31,262,137)
Bad Debt	(677,801)	(610,021)	(67,780)	11.1%	(294,534)	(1,499,347)	(1,349,412)	(149,935)	11.1%	(556,202)
Charity	(59,289)	(53,360)	(5,929)	11.1%	(75,579)	(155,855)	(140,269)	(15,585)	11.1%	(93,077)
Net patient service revenue	$ 4,967,289	$ 5,018,181	$ (50,892)	-1.0%	$ 4,480,167	$ 10,288,530	$ 9,960,731	$ 327,799	3.3%	$ 8,953,918
	22.53%	22.86%			20.98%	22.28%	22.94%			21.91%
Other revenue	11,663	10,040	1,623	16.2%	16,854	22,392	20,080	2,312	11.5%	26,486
Total operating revenues	$ 4,978,952	$ 5,028,221	$ (49,269)	-1.0%	$ 4,497,021	$ 10,310,922	$ 9,980,811	$ 330,111	3.3%	$ 8,980,404
Operating expenses:										
Salaries	$ 2,719,817	$ 2,828,738	$ 108,921	3.9%	$ 2,652,801	$ 5,494,074	$ 5,722,149	$ 228,075	4.0%	$ 5,441,713
Registry	173,653	115,213	(58,440)	-50.7%	146,148	377,892	232,810	(145,082)	-62.3%	291,163
Benefits	852,348	844,601	(7,747)	-0.9%	659,538	1,764,320	1,697,618	(66,702)	-3.9%	1,195,666
Professional Fees	299,927	269,007	(30,920)	-11.5%	352,236	636,972	525,513	(111,459)	-21.2%	658,601
Supplies	719,961	746,512	26,551	3.6%	789,669	1,529,177	1,472,991	(56,186)	-3.8%	1,490,540
Purchase Services	336,661	343,812	7,151	2.1%	310,848	680,283	687,631	7,348	1.1%	604,713
Rents and Leases	48,707	47,195	(1,512)	-3.2%	52,016	111,614	94,389	(17,225)	-18.2%	99,445
Utilities and Telephone	73,792	73,084	(708)	-1.0%	69,860	147,091	146,172	(919)	-0.6%	135,028
Insurance	48,540	60,002	11,462	19.1%	59,364	92,314	120,973	28,659	23.7%	118,728
Interest Expense	13,043	12,131	(912)	-7.5%	10,132	26,297	24,263	(2,034)	-8.4%	20,448
Depreciation and amortization	122,959	112,444	(10,515)	-9.4%	166,686	246,346	224,891	(21,455)	-9.5%	333,949
Other Operating Expenses	52,566	65,936	13,370	20.3%	38,261	116,989	131,881	14,892	11.3%	68,252
Total operating expenses	$ 5,461,975	$ 5,518,675	$ 56,700	1.0%	$ 5,307,559	$ 11,223,370	$ 11,081,281	$ (142,089)	-1.3%	$ 10,458,247
Operating gain (loss)	$ (483,023)	$ (490,454)	$ 7,431	-1.5%	$ (810,538)	$ (912,447)	$ (1,100,470)	$ 188,023	-17.1%	$ (1,477,843)
Non-operating revenues (expenses):	$ 503,108	$ 510,213	$ (7,105)	-1.4%	$ 520,656	$ 1,004,808	$ 1,020,426	$ (15,618)	-1.5%	$ 1,045,867
Excess of revenues over expenses	20,085	19,759	326	1.7%	(289,882)	92,360	(80,044)	172,404	-215.4%	(431,976)

ALAMEDA HOSPITAL - SOUTH SHORE ONLY
Summary Statement of Revenues, Expenses
For the Two Months Ended August 31, 2008

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	Budget	Variance	Var %	Jul 07	YTD Actual	YTD Budget	Variance	Var %	FY07 Actual
Operating revenues:										
IP Revenue	$ 220,790	$ 171,646	$ 49,144	28.6%	$ -	$ 220,790	$ 171,646	$ 49,144	28.6%	$ -
OP Revenue	-	9,491	(9,491)	-100.0%	-	-	9,491	(9,491)	-100.0%	-
Total revenue	$ 220,790	$ 181,137	$ 39,653	21.9%	$ -	$ 220,790	$ 181,137	$ 39,653	21.9%	$ -
Less: Deductions from Revenue	(161,177)	(91,847)	(69,330)	75.5%	-	(161,177)	(91,847)	(69,330)	75.5%	-
Bad Debt	-	-	-	#DIV/0!	-	-	-	-	#DIV/0!	-
Charity	-	-	-	#DIV/0!	-	-	-	-	#DIV/0!	-
Net patient service revenue	$ 59,613	$ 89,290	$ (29,677)	-33.2%	$ -	$ 59,613	$ 89,290	$ (29,677)	-33.2%	$ -
	27.00%	49.29%			#DIV/0!	27.00%	49.29%			#DIV/0!
Other revenue	-	-	-	#DIV/0!	-	-	-	-	#DIV/0!	-
Total operating revenues	$ 59,613	$ 89,290	$ (29,677)	-33.2%	$ -	$ 59,613	$ 89,290	$ (29,677)	-33.2%	$ -
Operating expenses:										
Salaries	$ 32,502	$ 53,790	$ 21,288	39.6%	$ -	$ 32,502	$ 53,790	$ 21,288	39.6%	$ -
Registry	-	-	-	#DIV/0!	-	-	-	-	#DIV/0!	-
Benefits	988	15,799	14,811	93.7%	-	988	15,799	14,811	93.7%	-
Professional Fees	14,324	12,930	(1,394)	-10.8%	-	29,324	25,430	(3,894)	-15.3%	-
Supplies	2,943	4,760	1,817	38.2%	-	2,943	4,760	1,817	38.2%	-
Purchase Services	1,416	705	(711)	-100.8%	-	1,416	705	(711)	-100.8%	-
Rents and Leases	3,375	3,683	308	8.4%	-	3,375	3,683	308	8.4%	-
Utilities and Telephone	1,162	1,212	50	4.1%	-	1,162	1,212	50	4.1%	-
Insurance	373	407	34	8.4%	-	373	407	34	8.4%	-
Interest Expense	-	-	-	#DIV/0!	-	-	-	-	#DIV/0!	-
Depreciation and amortization	438	478	41	8.5%	-	438	478	41	8.5%	-
Other Operating Expenses	492	537	45	8.4%	-	492	537	45	8.4%	-
Total operating expenses	$ 58,012	$ 94,301	$ 36,289	38.5%	$ -	$ 73,012	$ 106,801	$ 33,789	31.6%	$ -
Operating gain (loss)	$ 1,601	$ (5,011)	$ 6,612	-131.9%	$ -	$ (13,399)	$ (17,511)	$ 4,112	-23.5%	$ -
Non-operating revenues (expenses):	$ -	$ -	$ -	#DIV/0!	$ -	$ -	$ -	$ -	#DIV/0!	$ -
Excess of revenues over expenses	1,601	(5,011)	6,612	-131.9%	-	(13,399)	(17,511)	4,112	-23.5%	-

ALAMEDA HOSPITAL - HOSPITAL ONLY
Summary Statement of Revenues, Expenses
For the Two Months Ended August 31, 2008

	Current Month - Per Adjusted Patient Day					Year to Date - Per Adjusted Patient Day				
	Actual	Budget	Variance	Var %	July 07	YTD Actual	YTD Budget	Variance	Var %	FY07 Actual
Operating revenues:										
IP Revenue	$ 3,552	$ 3,620	$ (68)	-1.9%	$ 3,765	$ 3,711	$ 3,719	$ (8)	-0.2%	$ 3,572
OP Revenue	2,836	2,749	86	3.1%	2,620	2,887	2,671	216	8.1%	2,695
Total revenue	$ 6,388	$ 6,369	$ 19	0.3%	$ 6,386	$ 6,598	$ 6,390	$ 209	3.3%	$ 6,268
Less: Deductions from Revenue	(4,735)	(4,721)	(14)	0.3%	(4,935)	(4,892)	(4,705)	(187)	4.0%	(4,795)
Bad Debt	(196)	(177)	(19)	11.0%	(88)	(214)	(199)	(16)	7.9%	(85)
Charity	(17)	(15)	(2)	11.0%	(23)	(22)	(21)	(2)	7.9%	(14)
Net patient service revenue	$ 1,439	$ 1,456	$ (16)	-1.1%	$ 1,340	$ 1,470	$ 1,466	$ 4	0.3%	$ 1,373
	22.53%	22.86%			20.98%	22.28%	22.94%			21.91%
Other revenue	3	3	0	16.0%	5	3	3	0	8.3%	4
Total operating revenues	$ 1,443	$ 1,459	$ (16)	-1.1%	$ 1,345	$ 1,473	$ 1,469	$ 4	0.3%	$ 1,377
Operating expenses:										
Salaries	$ 788	$ 821	$ 33	4.0%	$ 793	$ 785	$ 842	$ 57	6.8%	$ 835
Registry	50	33	(17)	-50.5%	44	54	34	(20)	-57.6%	45
Benefits	247	245	(2)	-0.8%	197	252	250	(2)	-0.9%	183
Professional Fees	87	78	(9)	-11.4%	105	91	77	(14)	-17.7%	101
Supplies	209	217	8	3.7%	236	218	217	(2)	-0.8%	229
Purchase Services	98	100	2	2.2%	93	97	101	4	4.0%	93
Rents and Leases	14	14	(0)	-3.1%	16	16	14	(2)	-14.8%	15
Utilities and Telephone	21	21	(0)	-0.9%	21	21	22	0	2.3%	21
Insurance	14	17	3	19.2%	18	13	18	5	25.9%	18
Interest Expense	4	4	(0)	-7.4%	3	4	4	(0)	-5.2%	3
Depreciation and amortization	36	33	(3)	-9.2%	50	35	33	(2)	-6.3%	51
Other Operating Expenses	15	19	4	20.4%	11	17	19	3	13.9%	10
Total operating expenses	$ 1,583	$ 1,601	$ 18	1.1%	$ 1,587	$ 1,604	$ 1,631	$ 27	1.7%	$ 1,604
Operating gain (loss)	$ (140)	$ (142)	$ 2	-1.6%	$ (242)	$ (130)	$ (162)	$ 32	-19.5%	$ (227)
Non-operating revenues (expenses):	$ 146	$ 148	$ (2)	-1.5%	$ 156	$ 144	$ 150	$ (7)	-4.4%	$ 160
Excess of revenues over expenses	6	6	0	1.5%	(87)	13	(12)	25	-212.0%	(66)

ALAMEDA HOSPITAL
KEY STATISTICS
August , 2008

	ACTUAL AUGUST 2008	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	AUGUST 2007	YTD AUGUST 2008	YTD FIXED BUDGET	VARIANCE	%	YTD AUGUST 2007
Discharges:										
Total Acute	220	233	(13)	-5.6%	239	457	470	(13)	-2.8%	463
Total Sub-Acute	4	2	2	100.0%	1	6	4	2	50.0%	2
Total Skilled Nursing	4	4	-	0.0%	9	4	4	-	0.0%	19
	228	235	(11)	-4.7%	249	463	474	(11)	-2.3%	484
Patient Days:										
Total Acute	908	932	(24)	-2.6%	991	1,930	1,911	19	1.0%	1,812
Total Sub-Acute	1,011	1,027	(16)	-1.6%	853	2,007	2,044	(37)	-1.8%	1,686
Total Skilled Nursing	315	300	15	5.0%	128	315	300	15	5.0%	218
	2,234	2,259	(25)	-1.1%	1,972	4,252	4,255	(3)	-0.1%	3,716
Average Length of Stay										
Total Acute	4.13	4.00	0.13	3.2%	4.15	4.22	4.07	0.16	3.9%	3.91
Average Daily Census										
Total Acute	29.29	30.06	(0.77)	-2.6%	31.97	31.13	30.82	0.31	1.0%	29.23
Total Sub-Acute	32.61	33.13	(0.52)	-1.6%	27.52	32.37	32.97	(0.60)	-1.8%	27.19
Total Skilled Nursing	21.00	20.00	0.48	2.4%	4.13	21.00	20.00	1.00	5.0%	3.52
	82.90	83.19	(0.81)	-1.0%	63.61	84.50	83.79	(0.29)	-0.3%	59.94
Emergency Room Visits	1,336	1,436	(100)	-7.0%	1,471	2,714	2,960	(246)	-8.3%	2,885
Outpatient Registrations	2,441	2,626	(185)	-7.0%	2,616	4,995	4,994	1	0.0%	4,991
Surgery Cases:										
Inpatient	52	52	-	0.0%	64	127	110	17	15.5%	120
Outpatient	396	385	11	2.9%	403	869	709	160	22.6%	788
	448	437	11	2.5%	467	996	819	177	21.6%	908
Kaiser Inpatient Cases	4	-	4	-	10	19	-	19	-	15
Kaiser Eye Cases	140	133	7	5.3%	144	324	224	100	44.6%	259
Kaiser Outpatient Cases	149	133	16	12.0%	116	313	255	58	22.7%	268
Total Kaiser Cases	293	266	27	10.2%	270	656	479	177	37.0%	542
% Kaiser Cases	65.4%	60.9%			57.8%	65.9%	58.5%			59.7%
Adjusted Occupied Bed	128.59	127.47	1.12	0.9%	107.94	121.48	117.57	3.91	3.3%	105.19
Productive FTE	362.15	363.25	(1.10)	-0.3%	351.75	366.57	362.73	3.84	1.1%	352.44
Total FTE	413.79	416.38	(2.59)	-0.6%	411.52	417.87	420.66	(2.79)	-0.7%	414.73
Productive FTE/Adj. Occ. Bed	2.82	2.85	(0.03)	-1.2%	3.26	3.02	3.09	(0.07)	-2.2%	3.35
Total FTE/ Adj. Occ. Bed	3.22	3.27	(0.05)	-1.5%	3.81	3.44	3.58	(0.14)	-3.9%	3.94

ALAMEDA HOSPITAL
12 MONTH CASH PROJECTION
PERIOD COVERED:9/1/08 THRU 8/31/09

MONTH	COLLECTIONS NON-KAISER	COLLECTIONS KAISER -USE	PROPERTY TAX[1]	W/C REFUND NET	OTHER	FY 2008 AB 915	TRANSFERS	EST. DISBURSEMENTS	BALANCE[2]
Operating Cash Balance as of 8/31/08									85,701
SEP 08	5,145,000	760,000	495,000		50,000		(1,000,000)	4,929,218	606,483
OCT 08	4,485,000	760,000	495,000		50,000		300,000	6,393,875	302,608
NOV 08	3,705,000	760,000	495,000		50,000		150,000	5,152,204	310,404
DEC 08	4,400,000	760,000	495,000		50,000		(300,000)	5,347,696	367,708
JAN 09	4,200,000	760,000	495,000		50,000		(100,000)	5,422,710	349,998
FEB 09	3,800,000	760,000	495,000	200,000	50,000		100,000	5,434,686	320,312
MAR 09	4,400,000	760,000	495,000		50,000		(300,000)	5,434,734	290,578
APR 09	4,410,000	790,000	495,000		50,000		(300,000)	5,400,467	335,111
MAY 09	4,620,000	790,000	495,000		50,000		900,000	6,848,463	341,648
JUNE 09	4,620,000	790,000	495,000		50,000	180,000	(700,000)	5,432,425	344,223
JULY 09	4,620,000	790,000	495,000		50,000			5,985,918	313,305
AUG 09	4,620,000	790,000	495,000		50,000			5,985,967	282,338
TOTALS	53,025,000	9,270,000	5,940,000	200,000	600,000	180,000	(1,250,000) #	67,768,363	

Notes:

1. Property tax receipts will be held in an interest bearing investment account and transferred to the operating account as needed each month.
2. Reflects only cash held in concentration and disbursement accounts at month-end. An additional $783K and $1,079K is held on deposit in money market accounts at the Bank of Alameda and Merrill Lynch, respectively.

ALAMEDA HOSPITAL

12 Month Cash Projection - Disbursement Detail

PERIOD COVERED:9/1/08 THRU 8/31/09

	DISBURSEMENTS						TOTAL CASH
			13%				
MONTH	PAYROLL	PENSION	PAYROLL RELATED	Total Payroll	A/P	Debt Service	OUTLAYS
SEP 08	2,488,233	46,500	300,000	2,834,733	1,994,652	99,833	4,929,218
OCT 08	3,745,719 a	46,500	300,000	4,092,219	2,200,000	101,657	6,393,875
NOV 08	2,557,420	46,500	300,000	2,903,920	2,200,000	48,284	5,152,204
DEC 08	2,557,420	46,500	495,430	3,099,350	2,200,000	48,346	5,347,696
JAN 09	2,760,871	69,750	343,673	3,174,294	2,200,000	48,417	5,422,710
FEB 09	2,796,002	46,500	343,673	3,186,175	2,200,000	48,511	5,434,686
MAR 09	2,796,002	46,500	343,673	3,186,175	2,200,000	48,559	5,434,734
APR 09	2,796,002	46,500	343,673	3,186,175	2,200,000	14,293	5,400,467
MAY 09	4,248,278 a	46,500	343,673	4,638,451	2,200,000	10,013	6,848,463
JUNE 09	2,832,185	46,500	343,673	3,222,358	2,200,000	10,067	5,432,425
JULY 09	3,385,636	46,500	343,673	3,775,809	2,200,000	10,109	5,985,918
AUG 09	3,385,636	46,500	343,673	3,775,809	2,200,000	10,158	5,985,967
TOTALS	36,349,401	581,250	4,144,814	41,075,465	26,194,652	498,246	67,768,363

a) 3 pay periods in the month

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: October 2, 2008

To: City of Alameda Health Care District Board of Directors

From: David A. Neapolitan, Chief Financial Officer

Subject: FY 2008 Audited Financial Statements, Board Report and Management Responses to Hospital Specific Accounting Issues

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Enclosed are the final audited financial statements for the fiscal year ended June 30, 2008 as presented to the Finance Committee on Wednesday September 24, 2008 with some very minor grammatical and formatting corrections. In addition, enclosed is the Management Letter as prepared by TCA Partners. While the fiscal year 2008 audit went very smoothly we appreciate the recommendations and suggestions for further improvement in our financial operations that have been provided in the Board Report.

Management agrees with the importance of the general accounting issues identified in this report and will continue to evaluate the organizations requirements related to taxable fringe benefit reporting, pension plan audit requirements and potential IRS Form 990 reporting requirements. The following are management's responses to the Hospital Specific Accounting Issues section of the report:

SAS 112

Management agrees that a strong internal control structure is cornerstone to not only the safeguarding of the assets of the organization but also to ensuring that the organization's financial statements appropriately reflect the financial condition of the organization. In order to accomplish this management must ensure that controls exist that allow management or employees, in the ordinary course of performing their assigned functions, to prevent or detect misstatements on a timely basis. In order to ensure that this objective continues to be met, management will begin the process of documenting and enhancing the existing control environment in areas critical to the ability to assure that the organization's financial statements are not materially misstated. Areas of focus will include the valuation of net patient accounts receivable, the disbursement and related payable accrual process and cash management activities.

Use of the Meditech System for Received Inventory

Management will investigate the use of this reporting functionality to assist in the evaluation of period-end accruals for potential liabilities related to the receipt of supplies used in hospital operations that have not yet been invoiced during the second quarter of fiscal year 2009. If appropriate, we will implement its use immediately.

Capitalization Policy

Management recognizes the importance of maintaining an appropriate balance between the cost to maintain a fixed asset inventory of items with relatively small dollar balances and the benefits of making such a change. We will investigate the impact of increasing this threshold and consider implementation of such a change with the fiscal year 2010 operating budget or earlier if there are no significant impacts to the current year's projected operating performance.

Board Report

CITY OF ALAMEDA
HEALTH CARE DISTRICT

DBA ALAMEDA HOSPITAL

June 30, 2008

TCA Partners, LLP

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

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

We have audited the financial statements of the City of Alameda Health Care District (the Hospital) for the year ended June 30, 2008, and have issued our report thereon dated September 22, 2008. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility under Generally Accepted Auditing Standards - As stated in our engagement letter, our responsibility, as described by professional standards, is to plan and perform our audit to obtain reasonable, but not absolute, assurance about whether the financial statements are free of material misstatement. Because of the concept of reasonable assurance and because we did not perform a detailed examination of all transactions, there is a risk that errors, irregularities, or illegal acts, including fraud and defalcations, may exist and not be detected by us.

As part of our audit, we considered the internal control structure of the Hospital. Such considerations were solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control structure.

Significant Accounting Policies - Management has the responsibility for selection and use of appropriate accounting policies. In accordance with the terms of our engagement letter, we will advise management about the appropriateness of accounting policies and their application. The significant accounting policies used by the Hospital are described in Note A to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the fiscal year ended June 30, 2008. We noted no transactions entered into by the Hospital during the year that were both significant and unusual, and of which, under professional standards, we are required to inform you, or transactions for which there is a lack of authoritative guidance or consensus.

Accounting Estimates - Accounting estimates are an integral part of the financial statements prepared by management and are based on management's current judgments. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from management's current judgments. We believe that allowance for contractuals, settlements and bad debts represent a particularly sensitive accounting estimate. The amount of the allowance is based on management's evaluation of the collectibility of receivables and settlements based on current regulations. We have performed tests of the allowance and settlements to satisfy ourselves as to their reasonableness in relation to the financial statements taken as a whole.

Significant Audit Adjustments - For purposes of this letter, professional standards define a significant audit adjustment as a proposed correction of the financial statements that in our judgment, may not have been detected except through our auditing procedures. All significant audit adjustments have been addressed by the Hospital for the June 30, 2008 financial presentation. These adjustments have been provided to the management of the Hospital and have been recorded by the Hospital.

Disagreement with Management - For purposes of this letter, professional standards define a disagreement with management as a matter, whether or not resolved to our satisfaction, concerning a financial accounting, reporting, or auditing matter that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Consultations with Other Independent Accountants - To the best of our knowledge, management has not consulted with or obtained opinions from other independent accountants during the past year that are subject to the requirements of Statement on Auditing Standards No. 50, *Reports on the Application of Accounting Principles.*

Issues Discussed Prior to Retention of Independent Auditors - We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Hospital's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Difficulties Encountered in Performing the Audit - We encountered no significant difficulties in dealing with management in performing our audit.

This information is intended solely for the use of the Finance Committee, Board of Directors, and management of the Hospital and should not be used for any other purpose.

Sincerely,

TCA Partners, LLP

September 22, 2008

HOSPITAL SPECIFIC ACCOUNTING ISSUES

Accounting Department - We would like to thank the accounting staff for their assistance in this year's audit. The accounting staff's continued assistance helped us expedite the completion of the audit in a timely manner with little disruption to the daily operations of the Hospital.

SAS 112 - The American Institute of Certified Public Accountants (AICPA), the national professional organization for certified public accountants, issued its *Statement on Auditing Standards* (SAS) 112, *"Communicating Internal Control Related Matters Identified in an Audit"* in May, 2006. SAS 112 substantially incorporates the Public Company Accounting Oversight Board's (PCAOB) definitions of significant deficiency and material weakness, making the definitions used for audits of nonpublic entities consistent with those in place for audits of public companies. Similarly, it is possible that the auditor would have to issue an adverse opinion without reasonable assurance about effective internal controls.

Communicating internal control matters is an important component of SAS 112. When auditors identify internal control deficiencies, they must report them to the Board of Directors, generally through either a finance committee (which also serves as an audit committee), as well as granting agencies and other stakeholders (banks, lenders, etc.)

We have been auditing healthcare entities for close to 30 years. During that time, we have seen hospitals generally experience only minor problems in internal controls at their facilities. Some of the following areas have been: false expense reports, improper company credit card usage, cash receipts (generally clerks collecting co-pays and deductibles, not issuing pre-numbered receipts, and pocketing the money), improper vendors on a vendor list being paid, related party vendors being paid excessive dollar amounts, kickbacks with construction contractors, payroll clerks pading their own PTO time, improper patient accounts receivable write-offs, and a few other areas.

In small healthcare facilities, such as the District, the majority of the controls rest with the Department heads, the CFO and the CEO. In addition, the Board of Directors may become directly involved in reviewing activities on a consistent basis. We are please to report to you that we did not discover any improprieties during our audit of the Hospital for the year. We do suggest, however, on a go-forward basis, that the management team, coupled with members of the finance committee, try to schedule and conduct a "brainstorming" session at least on an annual basis. During this session, discussion should take place as to "what could go wrong" and "what controls do we have in place to catch it". We feel such a session on an annual basis will heighten awareness of the importance and need for solid internal controls.

Use of the Meditech System for Received Inventory - We audit several hospitals who use the Meditech system for their hospital general accounting system. Within the Meditech system is a report that most of them use to track items received at the hospital, but not yet invoiced. Once received at the hospital, the costs of these items become a liability to the hospital until paid. We suggest that Alameda investigate the use of this feature within the Meditech system to possibly assist in their accounting functions.

HOSPITAL SPECIFIC ACCOUNTING ISSUES (continued)

Capitalization Policy - Currently the capitalization policy of the Hospital for recording a purchase as a capital item is $1,000. We understand the Medicare limit is $5,000 which allows the Hospital to increase their policy up to the Medicare limit if they so desires.

GENERAL ACCOUNTING ISSUES

Taxable Fringe Benefits - It has been our experience that hospitals offer a wide variety of fringe benefits to their employees for various reasons. These fringe benefits may include educational assistance programs, recognition awards for quality service, awards based upon years of service, recruiting incentives including sign-on, retention and referral bonuses and employee discounts. These benefits may be in the form of cash, gift cards, meals provided on the premises, paid travel arrangements or other tangible benefits.

The facts remain that many of these types of benefits provided to employees and others are considered "taxable events" by both the Internal Revenue Service (IRS) and the California State Franchise Tax Board (FTB) and are subject to payroll withholding or 1099 reporting. Taxing agencies are looking at more and more non-profit organizations regarding compensation and fringe benefit issues. We suggest that you continue to review fringe benefits offered to your employees to determine if they are creating "taxable events" that should be reported to the IRS and the FTB.

New 990 Reporting Requirements - Sweeping changes have been made to the form 990. Effective for years beginning January 1, 2008, the new 990 will be approximately 50 pages long. Previously it was only 9 pages. Examples are required registrations with the attorney general for each fundraising event, more emphasis on "non-cash" contribution accounting and valuation, and other requirements. Board of Directors are personally responsible for fines imposed for late filings. Although most district hospitals are exempt from 990 filings, certain related entities such as foundations and joint ventures are not and these filings can become the responsibility of a district hospital.

Pension Plan Audit Requirements - In the past, the Department of Labor had exempted not-for-profit organizations from its reporting and audit requirements for employee plans. Starting in 2009, non-for-profit organizations that offer employees ERISA-covered 403(b) plans will be required to file a form 5500 with the Department of Labor just as for-profit companies have done for years. Additionally, large 403(b) plans (100 or more participants) will be required to have an independent audit performed on the plan and submitted with the 5500. Again district hospitals are generally exempt from these filings except in the cases where elections are made by the district to have their retirement plans operate under ERISA requirements, which then requires them to file the same reports and forms.

OPERATIONS ANALYSIS

Operational Analysis - The following is a comparison of key Hospital operational trends for the past five years:

	2004	2005	2006	2007	2008
Financial Ratios:					
Deductible percentage	81.72%	79.89%	79.28%	78.61%	77.52%
Operating margin	-15.49%	0.00%	0.27%	-6.18%	-3.75%
Current ratio	0.93	1.20	1.25	1.06	0.98
Days in accounts receivable, net	50.29	51.41	46.90	47.02	51.70
Days cash on hand (with restricted)	62.86	42.03	31.96	28.68	30.61
Average pay period	56.19	56.86	50.56	55.23	58.93
Debt service coverage	-3.98	1.02	1.13	-0.87	-0.14
Long-term debt to fund balance	.19	.18	.15	.17	.26
Return on fund balance	-51.55%	0.00%	1.13%	-37.44%	-29.59%
Debt to number of beds	$24,252	$22,559	$18,575	$15,409	$20,932
Patient Care Information:					
Bed capacity	135	135	135	135	135
Patient days (all services)	21,215	22,422	22,715	23,102	22,687
Discharges (acute only)	2,936	2,990	3,189	3,209	2,885
Average length of stays (acute only)	4.16	4.17	4.12	4.07	3.91
Average daily patients (all sources)	57.96	61.43	62.23	63.29	61.99
Occupancy rate (all sources)	42.94%	45.50%	46.10%	46.68%	45.92%
Emergency visits per day	47.40	46.44	49.33	49.83	48.97
Staffing and Personnel:					
Productive FTE's	337	325	368	388	348
Total FTE's	396	385	420	448	400
Total FTE's per adjusted patient day	4.02	3.56	3.65	3.70	3.19
Ave. hourly salary (inc. benefits)	$43.01	$43.01	$46.55	$45.59	$50.55
Salaries and benefits as a % of expenses	66.39%	67.96%	69.19%	64.12%	64.69%
Salaries and benefits per FTE	$89,469	$89,456	$96,830	$94,819	$105,134

OPERATIONS ANALYSIS (continued)

Financial Ratios:

Deductible Percentage: A measure of contractual allowances. It is the percentage of contractual allowances to gross patient service revenues for a hospital.

Operating margin: The operating margin is a measure of a hospital's profitability in patient care services and operations. It measures whether the hospital makes or loses money from their patient care system.

Current ratio: The current ratio is an indicator of a hospital's liquidity and its ability to meet short-term (up to one year) obligations.

Days in accounts receivable, net: Both a gross and net method can be used. We have selected the net method. We believe that the more meaningful ratio is the net method as this is a measure of the number of days that operating revenue has due from its patient billings after deductions for contractual allowances, discounts, bad debts, charity care, and similar uncollectibles.

Days Cash on Hand: If the hospital were to receive no more cash from any source, how many days could they support payments for the expenses necessary to operate the hospital.

Average Pay Period: How many days does it take to pay payroll and operating expenses.

Debt Service Coverage: A standard measure of how much "coverage" from operations was there to support the payments required for interest and principal on debt borrowings.

Long-Term Debt to equity (fund balance): This is a measure of the ratio of creditor claims versus hospital equity. A lower number indicates better equity.

Debt to number of beds: The debt to number of beds is a measure of long-term debt of a hospital total licensed beds.

Patient Care Information:

Average length of stay: It is a key indicator of utilization, and is predictive of average resources used by a hospital on each patient who stays in the hospital as an in-patient. The ratio is generally only meaningful for acute services and not long-term care services. We have only shown the acute length of stay.

Occupancy rate: The occupancy rate is a measure of the capacity and "idle capacity" of the use of the hospital's beds. If a hospital were to have a patient in each of its beds for every day of the year, the occupancy rate would be 100%. Both the acute and the long-term care services are shown.

OPERATIONS ANALYSIS (continued)

Staffing and Personnel:

Full-time equivalents: Full-time equivalents is a measure of the total employee force at a hospital. If a hospital had only 100 employees who worked full-time for 2,080 (52 weeks at 40 hours a week) hours a year, they would have 100 FTE's.

FTE's per Adjusted Patient Day: Patient days are logged for patients inside the hospital and measures inpatient volume. As a hospital also performs services on an outpatient basis, the patient days are "adjusted" to account for the outpatient volume also in an effort to arrive at an adjusted volume figure for all services (inpatient and outpatient) at a hospital. Once an adjusted patient day figure is arrived at, this figure is divided by the number of total FTE's in order to measure how many employees it takes to service all the patients at a hospital.

Average Hourly Salary: This is a measure of the average hourly rate that employees earn at the hospital.

Salaries and Benefits as a % of operating expenses: This ratio measures the proportion of a hospital's operating expense that is attributable to employee labor expense.

Salaries and Benefits per FTE: This measures the average labor expense per employee.

Audited Financial Statements

CITY OF ALAMEDA
HEALTH CARE DISTRICT

Dba ALAMEDA HOSPITAL

June 30, 2008

Audited Financial Statements

CITY OF ALAMEDA HEALTH CARE DISTRICT

June 30, 2008

Management's Discussion and Analysis

CITY OF ALAMEDA HEALTH CARE DISTRICT

June 30, 2008

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, 2008 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, 2008 and accompanying notes to the financial statements to enhance one's understanding of the Hospital's financial performance.

Financial Highlights

- Total assets decreased slightly by $220,000 over the prior fiscal year. Total operating cash and cash equivalents increased by $123,000 over the prior year (see the *Statements of Cash Flows* for changes). In addition, net patient accounts receivable increased by $748,000. Net days in patient accounts receivable were 51.70 at June 30, 2008 as compared to 47.02 at June 30, 2007.

- Current assets increased by $868,000 and current liabilities increased by $2,407,000 over the prior fiscal year. The current ratio at June 30, 2008 was 0.98 as compared to 1.06 for the prior year.

- The decrease in net assets for fiscal year 2008 was $2,350,000 as compared to the decrease in the prior year of $3,853,000.

- Operating loss was $8,537,000 for fiscal year 2008 as compared to $10,071,000 for fiscal year 2007.

- Total operating expenses decreased significantly by $1,144,000 over the prior fiscal year during times of increasing expenses for hospitals, generally.

Cash and Investments

For the fiscal year ended June 30, 2008, the Hospital's total unrestricted and restricted cash and investments totaled $5.3 million as compared to $5.0 million in the prior fiscal year. At June 30, 2008, days cash on hand was 30.61 as compared to 28.68 for the prior year. The Hospital's goal is to maintain sufficient cash and cash equivalent balances to pay all short-term liabilities.

Current Liabilities

As previously noted, current liabilities of the Hospital increased by $2.4 million. This was due mainly to increases in bank loans by $1,400,000, trade payables by $513,000, deferred revenues by $1,008,000, and health insurance claims payable by $389,000 with offsetting decreases in third-party payor settlements of $509,000.

Capital Assets

During the year, the Hospital added $612,000 in capital assets mainly through the purchase of various items of medical equipment with the main purchase of $223,000 in telemetry units.

Volumes

- Acute care patient days were 11,276 for fiscal year 2008 as compared to 13,070 for the prior year. Discharges were 2,885 for the current year versus 3,209 for the prior year resulting in lengths of stay of 3.91 for 2008 as compared to 4.07 for 2007.
- Subacute and skilled nursing days were 11,411 for fiscal year 2008 as compared to 10,032 for fiscal year 2007, equaling an average daily census of 31.18 for 2008 versus 27.48 for 2007. Effective February, 2008, the Hospital converted all of its 5 skilled nursing level beds to subacute beds.
- Overall combined occupancy for the Hospital, including acute, subacute and skilled nursing days was 45.92% for the year ended June 30, 2008 versus 46.88% for the year ended June 30, 2007.
- Surgery cases for the fiscal year 2008 were slightly lower than the prior year. There were 5,410 cases (706 inpatient and 4,704 outpatient) as compared to 5,413 cases for the prior fiscal year (988 inpatient and 4,425 outpatient). Kaiser cases were 3,382 in 2008 versus 3,398 in 2007.
- Outpatient registrations decreased slightly by 1,242 registrations over the prior year (30,943 for 2008 versus 32,185 for 2007).
- Emergency room visits were 17,922 in the fiscal year 2008 as compared to 18,187 for the prior year.
- FTE's per adjusted occupied bed were 3.69 for 2008 versus 4.27 for the prior year.

Gross Patient Charges

The Hospital charges all its patients equally based on its established pricing structure for the services rendered. The Hospital raised rates on April 1, 2008.

Acute inpatient gross charges decreased by $18 million or 12.7% mainly due the volume decreases as previously stated. Subacute/SNF charges increased by $3 million or 20% due to a combination of room rate increases and a patient day increase of 1,379.

Outpatient gross charges increased by $4.2 million or 4%. due primarily to the price increases as volumes generally decreased as previously mentioned.

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 and Kaiser.

The provision for bad debts for fiscal year 2008 and fiscal year 2007 were $6.1 million and $4.7 million, respectively. As a percentage of gross patient charges, the allowance has increased from 1.9% in fiscal year 2007 to 2.4% in fiscal year 2008.

Contractual allowances and the provision for bad debts (as a percentage of gross patient charges) were 77.5% for fiscal year 2008 as compared to 78.6% for fiscal year 2007. The decrease in contractual allowances was due primarily to slight increases in reimbursement from government-based programs and other third party contracts.

Net Patient Service Revenues

Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. Net patient service revenues increased slightly by $380,000 or 0.6% as a result of better reimbursement and price increases even though volumes were generally slightly lower overall.

Operating Expenses

Total operating expenses were $64.92 million for fiscal year 2008 compared to $66.07 million for fiscal year 2007. The 1.7% decrease is due primarily to:

- A $2.2 million or 6.1% decrease in salaries, wages and registry. Total full time equivalents (FTE's) were 400.47 in 2008 versus 447.61 in 2007, a 10.5% decrease over the prior year.

- There was a $1.2 million increase in employee benefits due in part to increases in employee health benefits during the year.

- Other variable expenses (generally volume driven) such as professional fees, supplies and purchased services decreased slightly during the year by approximately $85,000 while other somewhat fixed expenses increased slightly due mainly to inflationary factors. Depreciation expense decreased by $324,000 due to certain assets becoming fully depreciated during the year.

Economic Factors and Next Fiscal Year's Budget

The Hospital's board approved the budget for fiscal year ending June 30, 2009 at a recent meeting. For fiscal year 2009, the Hospital is budgeted to increase its net assets by $101,000. The increase is due to several assumptions:

- A conservative increase in volumes for fiscal year 2009 were budgeted, with consideration given to the increased expectations within inpatient services while outpatient services remain constant at the Hospital.

- Gross revenues and net revenues are budgeted to increase due to a combination of volume increases, a mid-year price increase, and continuing improvements in third party payor contracts.

- Operating expenses are expected to increase by 5.4% or $3.4 million over 2008. The cost for labor (salaries and registry) and other medically trained staff is projected to increase by $2.6 million. Consumer price index (CPI) increases of 3% were applied to the cost of supplies and purchased services.

Management believes that the 2009 budget is obtainable despite the many challenges that will confront the Hospital in the upcoming year. Management's goals are to continue to build community support and enthusiasm for the services provided by the Hospital to help to provide quality health care to the residents of the City of Alameda Health Care District.

TCA Partners, LLP

A Certified Public Accountancy Limited Liability Partnership

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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 sheet of the City of Alameda Health Care District (the Hospital) as of June 30, 2008, and the related statements of revenues, expenses, and changes in net assets, and cash flows for the year 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 audit. The financial statements for the City of Alameda Health Care District as of June 30, 2007 were audited by another certified public accountant whose report dated October 17, 2007, expressed an unqualified opinion.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides 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, 2008, and the changes in its net assets and its cash flows for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note B to the financial statements, effective July 1, 2002, the Hospital adopted the provisions of Governmental Accounting Standards Board (GASB) Statement 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments*, GASB Statement 37, *Basic Financial Statements - Management's Discussion and Analysis - for State and Local Governments: Omnibus*, and GASB Statement 38, *Certain Financial Statement Note Disclosures*.

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 22, 2008

Balance Sheets

CITY OF ALAMEDA HEALTH CARE DISTRICT

	June 30	
	2008	2007
Assets		
Current assets:		
Cash and cash equivalents	$ 4,690,518	$ 4,567,669
Patient accounts receivable, net of allowances	7,944,522	7,196,386
Other receivables	6,682,339	6,235,337
Estimated third party payor settlements	245,115	161,000
Inventories	1,048,503	949,780
Prepaid expenses and deposits	587,777	1,221,098
Total current assets	21,198,774	20,331,270
Assets limited as to use	602,817	467,958
Capital assets, net of accumulated depreciation	7,789,004	8,961,434
Other assets		49,505
Total assets	$ 29,590,595	$ 29,810,168
Liabilities and Net Assets		
Current liabilities:		
Current maturities of debt borrowings	$ 2,744,870	$ 1,723,145
Accounts payable and accrued expenses	7,057,073	6,544,476
Accrued payroll and related liabilities	3,133,574	3,152,133
Deferred revenues	7,351,860	6,343,528
Estimated third party payor settlements	441,409	947,243
Health insurance claims payable (IBNR)	838,670	450,000
Total current liabilities	21,567,456	19,160,525
Debt borrowings, net of current maturities	80,992	357,048
Total liabilities	21,648,448	19,517,573
Net assets:		
Invested in capital assets, net of related debt	7,468,754	7,938,819
Restricted, by contributors	602,817	467,958
Unrestricted	(129,424)	1,885,818
Total net assets	7,942,147	10,292,595
Total liabilities and net assets	$ 29,590,595	$ 29,810,168

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	
	2008	2007
Operating revenues		
Net patient service revenue	$ 56,241,823	$ 55,861,941
Other operating revenue	144,451	134,847
Total operating revenues	56,386,274	55,996,788
Operating expenses		
Salaries and wages	32,022,845	33,597,560
Registry	1,864,163	2,499,350
Employee benefits	10,079,998	8,844,275
Professional fees	4,030,212	3,676,014
Supplies	8,483,048	8,506,019
Purchased services	3,651,663	4,067,455
Building and equipment rent	581,198	502,206
Utilities and phone	865,943	836,811
Insurance	720,305	643,002
Depreciation and amortization	1,787,352	2,111,508
Other operating expenses	836,768	783,511
Total operating expenses	64,923,495	66,067,711
Operating income (loss)	(8,537,221)	(10,070,923)
Nonoperating revenues (expenses)		
District tax revenues	5,745,308	5,703,967
Investment income	122,247	231,121
Interest expense	(156,562)	(126,074)
Rent and other income	340,921	313,547
Grants and contributions	134,859	95,000
Total nonoperating revenues (expenses)	6,186,773	6,217,561
Increase (decrease) in net assets	(2,350,448)	(3,853,362)
Net assets at beginning of the year	10,292,595	14,145,957
Net assets at end of the year	$ 7,942,147	$ 10,292,595

See accompanying notes and auditor's report

Statements of Cash Flows

CITY OF ALAMEDA HEALTH CARE DISTRICT

	Year Ended June 30	
	2008	2007
Cash flows from operating activities:		
Cash received from patients and third-parties on behalf of patients	$ 54,903,738	$ 56,015,898
Cash received from operations, other than patient services	705,781	197,438
Cash payments to suppliers and contractors	(19,597,435)	(18,924,975)
Cash payments to employees and benefit programs	(42,121,402)	(42,357,597)
Net cash provided by operating activities	(6,109,318)	(5,069,236)
Cash flows from noncapital financing activities:		
District tax revenues	5,745,308	5,703,967
Grants and contributions	134,859	95,000
Net cash provided by noncapital financing activities	5,880,167	5,798,967
Cash flows from capital financing activities:		
Purchase and donations of capital assets, net of loss on disposals	(224,495)	(418,302)
Proceeds from debt borrowings	1,524,741	
Principal payments on debt borrowings	(779,072)	(427,407)
Interest payments on debt borrowings	(156,562)	(126,074)
Net cash provided by (used in) capital financing activities	364,612	(971,783)
Cash flows from investing activities:		
Net change in assets limited as to use and other assets	(134,859)	(31,900)
Investment income	122,247	231,121
Net cash provided by (used in) investing activities	(12,612)	199,221
Net increase (decrease) in cash and cash equivalents	122,849	(42,831)
Cash and cash equivalents at beginning of year	4,567,669	4,610,500
Cash and cash equivalents at end of year	$ 4,690,518	$ 4,567,669

See accompanying notes and auditor's report

Statements of Cash Flows (continued)

CITY OF ALAMEDA HEALTH CARE DISTRICT

	Year Ended June 30	
	2008	2007
Reconciliation of operating income to net cash provided by operating activities:		
Operating income (loss)	$ (8,537,221)	$(10,070,923)
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	1,787,352	2,111,508
Provision for bad debts	6,080,303	4,863,040
Changes in operating assets and liabilities:		
Patient accounts receivables	(6,828,439)	(5,289,526)
Other receivables	(447,002)	142,063
Inventories	(98,723)	96,920
Prepaid expenses and deposits	633,321	338,802
Accounts payable and accrued expenses	512,597	2,153,671
Accrued payroll and related liabilities	(18,559)	84,238
Estimated third party payor settlements	(589,949)	580,443
Deferred revenues	1,008,332	(79,472)
Health insurance claims payable (IBNR)	388,670	
Net cash provided by operating activities	$ (6,109,318)	$ (5,069,236)

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 and a 35-bed sub acute unit within the Hospital. 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.

Changes in Financial Statement Presentation: 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. The impact of this change was related to the format of the financial statements; the inclusion of management's discussion and analysis; and the preparation of the statement of cash flows on the direct method. The application of these accounting standards had no impact on the total net assets.

Management's Discussion and Analysis: Statement 34 requires that financial statements be accompanied by a narrative introduction and analytical overview of the Hospital's financial activities in the form of "management's discussion and analysis" (MD&A). This analysis is similar to the analysis provided in the annual reports of organizations in the private sector.

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, 2008 and 2007, 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, 2008 and 2007 are $2,168,214 and $1,854,322, 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. Amounts are levied on the basis of the most current property values on record with the County. 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, 2008 and 2007, the Hospital had deposits invested in various financial institutions in the form of cash and cash equivalents in the amounts of $5,291,885 and $5,083,682 respectively. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code (CGC), except for $100,000 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 to the Hospital 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, 2008, cost reports through June 30, 2006 have been final settled.

Medi-Cal: For traditional Medi-Cal (non-HMO) services, payments for inpatient services rendered to patients are made based on reasonable costs while outpatient payments are based on pre-determined charge screens. The Hospital is paid for cost reimbursement services at an interim rate with final settlement determined after submission of annual cost reports and audits thereof by Medi-Cal. At June 30, 2008, cost reports through June 30, 2006, have been final settled. Medi-Cal HMO services are paid on a pre-determined rate and are not subject to cost reimbursement

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.

NOTE C - NET PATIENT SERVICE REVENUES (continued)

Net patient service revenues summarized by payor are as follows:

	2008	2007
Inpatient acute and inpatient ancillary services	$124,647,003	$142,824,974
Long-term care routine services	17,855,653	14,852,107
Outpatient acute services	107,724,923	103,530,473
Gross patient service revenues	250,227,579	261,207,554
Less deductions from revenue and related allowances	(193,985,756)	(205,345,613)
Net patient service revenues	$ 56,241,823	$ 55,861,941

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, 2008 and 2007 were as follows:

	2008	2007
Medicare	$ 13,571,657	$ 9,869,400
Medi-Cal	9,542,914	7,810,987
Other third party payors	11,623,307	14,267,315
Self pay and other	4,653,744	5,008,684
Gross patient accounts receivable	39,391,622	36,956,386
Less allowances for contractual adjustments and bad debts	(31,446,100)	(29,760,000)
Net patient accounts receivable	$ 7,944,522	$ 7,196,386

NOTE E - OTHER RECEIVABLES

Other receivables as of June 30, 2008 and 2007 were comprised of the following:

	2008	2007
Alameda County property taxes	$ 6,121,501	$ 6,011,764
Kaiser contract receivable	274,187	
Insurance recoveries related to self-funded programs	160,000	203,217
Due from Alameda Foundation	65,285	
Rents receivable	26,293	10,855
Other various receivables	35,073	1,916
	$ 6,682,339	$ 6,235,337

NOTE F - ASSETS LIMITED AS TO USE

Assets limited as to use as of June 30, 2008 and 2007 were comprised of the following:

	2008	2007
Cash and cash equivalents restricted by contributors	$ 602,817	$ 467,958

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 $1,247,261 and $1,329,500 at June 30, 2008 and 2007, respectively.

NOTE G - CAPITAL ASSETS (continued)

Capital assets as of June 30, 2008 and 2007 were comprised of the following:

	Balance at June 30, 2007	Transfers & Additions	Reclasses & Retirements	Balance at June 30, 2008
Land and land improvements	$ 1,369,164			$ 1,369,164
Buildings and improvements	23,437,357	209,543		23,646,900
Equipment	17,554,692	545,658		18,100,350
Construction-in-progress	181,569	(143,043)		38,526
Totals at historical cost	42,542,782	612,158		43,154,940
Accumulated depreciation for:				
Land and land improvements	(251,063)	(3,272)		(254,335)
Buildings and improvements	(19,443,070)	(681,723)		(20,124,793)
Equipment	(13,887,215)	(1,099,593)		(14,986,808)
Total accumulated depreciation	(33,581,348)	(1,784,588)		(35,365,936)
Capital assets, net	$ 8,961,434	$ (1,172,430)	$	$ 7,789,004

	Balance at June 30, 2006	Transfers & Additions	Reclasses & Retirements	Balance at June 30, 2007
Land and land improvements	$ 1,369,164			$ 1,369,164
Buildings and improvements	23,505,531	$ 4,304	$ (72,478)	23,437,357
Equipment	16,870,981	683,711		17,554,692
Construction-in-progress	145,088	36,481		181,569
Totals at historical cost	41,890,764	724,496	(72,478)	42,542,782
Accumulated depreciation for:				
Land and land improvements	(247,040)	(4,023)		(251,063)
Buildings and improvements	(18,533,657)	(909,413)		(19,443,070)
Equipment	(12,768,994)	(1,118,221)		(13,887,215)
Total accumulated depreciation	(31,549,691)	(2,031,657)		(33,581,348)
Capital assets, net	$ 10,341,073	$ (1,307,161)	$ (72,478)	$ 8,961,434

NOTE H - DEBT BORROWINGS

As of June 30, 2008 and 2007, debt borrowings were as follows:

	2008	2007
Note payable to a bank; interest at 5.58% due monthly with the principal due February 15, 2009; collateralized by Hospital receivables:	$ 2,400,000	
Bank line of credit; interest at prime, due monthly with the principal due January 15, 2008; collateralized by Hospital receivables:		$ 1,000,000
Capital lease due to a bank; principal and interest at 2.75% due in monthly installments of $53,573 each 23rd of the month through October 23, 2008; collateralized by Hospital property:	213,072	840,705
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:	84,378	129,574
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:	61,602	
Note payable to a bank; principal and interest at 6.88% due in monthly installments of $4,346 the 2nd of each month through April 2, 2009; collateralized by Hospital property:	44,010	
Other various debt borrowings	22,800	109,914
	2,825,862	2,080,193
Less current maturities of debt borrowings	(2,744,870)	(1,723,145)
	$ 80,992	$ 357,048

Future principal maturities for debt borrowings for the next succeeding years are: $2,744,870 in 2009; $66,264 in 2010; and $14,729 in 2011.

Line of Credit: The Hospital has a $1,500,000 bank line of credit available at year end with an interest rate at the bank's prime lending 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, 2008.

NOTE I - RETIREMENT PLANS

Contributions to Retirement Plans: Total contributions to all of the retirement plans for the years ended June 30, 2008 and 2007 were $1,713,500 and $1,520,300, 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, 2008 and 2007 are as follows:

	2008	2007
Annual required contribution	$ 51,789	$ 42,376
Interest on net pension asset	(10,281)	(9,693)
Adjustment to net pension obligation	10,570	9,966
Annual pension cost	52,078	42,649
Contributions made	(45,000)	(50,000)
Increase (decrease) in net pension obligation	7,078	(7,351)
Net pension asset at the beginning of the year	(128,518)	(121,167)
Net pension asset at the end of the year	$ (121,440)	$ (128,518)

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 I - 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 2008 and 2007 do not apply as the Plan has been frozen and has no covered payroll.

The required contribution for the year ended June 30, 2008, was determined as part of the July 1, 2007 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 an open amortization period of 30 years. The remaining amortization period at July 1, 2007 was 29 years. The table below presents 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 $
2006	$ 46,257	324.3%	$ (121,167)
2007	$ 42,649	117.2%	$ (128,518)
2008	$ 52,078	86.4%	$ (121,440)

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
7/1/05	$ 2,352,708	$ 1,832,404	$ 520,304	77.9%	N/A	N/A
7/1/06	$ 2,377,744	$ 1,900,687	$ 477,057	79.9%	N/A	N/A
7/1/07	$ 2,379,072	$ 1,796,040	$ 583,032	75.5%	N/A	N/A

NOTE J - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of June 30, 2008 and 2007, the Hospital had recorded $38,526 and $181,569, 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, 2008 and 2007. Estimated cost to complete these projects as of June 30, 2008 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, 2008 and 2007, were $581,198 and $502,206, respectively. Future minimum lease payments for the succeeding years under operating leases as of June 30, 2008, 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, 2008 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 and self insures workers' compensation losses up to $200,000 per claim with supplemental coverage for losses on individual claims in excess of $200,000. 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, workers' compensation 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, 2008 and 2007.

NOTE J - 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.

Management Services Agreement: On May 1, 2004, the Hospital entered into an agreement for management of the Hospital and its component units with Delta One Partners, Inc. (Delta). Under the agreement, Delta was to provide management and other services to the Hospital and was to have authority and responsibility to conduct, supervise and administer the day-to-day operations of the Hospital and its component units. Effective May 1, 2006, the agreement was extended for three years to April 30, 2009. Compensation to Delta was to consist of a base fee of $60,000 per month through April 30, 2006 and $62,000 per month through April 30, 2007, $64,000 per month through April 30, 2008 and $66,000 per month through April 30, 2009. In addition to the monthly base fee, Delta was to be reimbursed for its expenses directly related to the management of the Hospital and its component units. During the year ended June 30, 2007, the Hospital, under this agreement, incurred fees and expenses totaling $827,400. On June 4, 2007, Delta terminated its management contract with the Hospital, effective December 31, 2007.

Self-Reported Billing Practices: In September, 2003, the Hospital, on its own initiative, notified the federal Medicare program that an internal review of its one-day hospital stay billing practices during the period January 1, 2000 to December 31, 2002 indicated the Hospital had been overpaid by approximately $427,000. In December, 2005, management began meeting with Medicare representatives in an attempt to settle the matter. In early 2006, the Hospital presented Medicare with results of its internal review. The Medicare intermediary reviewed the results and a settlement was reached. Effective January 9, 2007, the Hospital refunded the Medicare program $427,500 in a final settlement of this matter.

NOTE J - COMMITMENTS AND CONTINGENCIES (continued)

RAC Audits: Most Hospitals in California have recently been subject to specific Medicare claim audits by Recovery Audit Contractors (RAC's). In March, 2007, RAC auditors notified the Hospital that it would be reviewing 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, even though each given discrepancy in the claim had not been fully adjudicated. The Hospital is pursuing its appeal rights where it disagrees with RAC conclusions. Total RAC audit recoveries to date have been $352,280 and it is anticipated that additional recoveries of approximately $100,000 may be collected which the Hospital has recorded as a liability as of June 30, 2008. The Hospital anticipates either partial or full recoupment, on a claim-by-claim basis, through appeal.

Medicare Disproportionate Share: As a part of the Medicare reimbursement for inpatient services, the Hospital receives an "add-on" to their DRG entitlement through the Medicare Disproportionate Share program, a program designed to assist Hospitals who "disproportionately" serve welfare patients. The disproportionate share payment is larger if a hospital operates 100 beds or more, and the program allows for additional capital payments. Former settled cost reports for June 30, 2005 and 2006 have been reopened by the Medicare intermediary as it has been proposed by them that the Hospital operated under 100 beds for those two years. As a result, the Hospital will be required to refund the Medicare program approximately $94,000 for these two years under the disproportionate share capital payment program. The Hospital has recorded this as a liability as of June 30, 2008.

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 K - FAIR VALUE OF FINANCIAL INSTRUMENTS

The Hospital uses certain methods and assumptions in estimating its fair value disclosures for financial instruments. For cash and cash equivalents, the Hospital uses the carrying amounts which approximate fair value due to the short maturity of any financial instrument considered as a cash equivalent. For debt borrowings (including capital lease obligations), the fair values are estimated using discounted cash flow analysis, based on the Hospital's current incremental borrowing rates for similar types of borrowing arrangements. As of June 30, 2008 and 2007, the fair values of debt borrowings were not considered to be materially different from the carrying values.

NOTE L - 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 $181,058 and $95,000 for the years ended June 30, 2008 and 2007, respectively. At December 31, 2007 and 2006, the Foundation's audited financial statements reported total assets of $2,387,445 and $1,975,000, 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 M - 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, 2008 and 2007, in terms of services to the poor and benefits to the broader community:

	2008	2007
Benefits for the poor:		
Traditional charity care	$ 1,187,169	$ 1,279,000
Unpaid Medi-Cal and other public aid programs	33,315,010	33,570,500
Total quantifiable benefits for the poor	34,502,179	34,849,500
Benefits for the broader community:		
Unpaid Medicare program charges	41,287,550	40,600,400
Total quantifiable benefits for the broader community	41,287,550	40,600,400
Total quantifiable community benefits	$ 75,789,729	$ 75,449,900

NOTE N - 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. AHCC has no operating activities. The financial results for the years ended June 30, 2008 and 2007 of these component units are included within the financial statements of the Hospital. Net assets of these units were $509,122 for 2008 and $435,884 for 2007. Net increase in assets for these units were $73,238 for 2008 and $66,300 for 2007. 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 O - SUBSEQUENT EVENTS

On August 17, 2008, the Hospital became the operator of a 26-bed skilled nursing facility formerly known as South Shore Convalescent Hospital. This building, owned by the CW&S corporation, will be leased to the Hospital who will now operate the facility under the Hospital's license.

TITLE:	EFFECTIVE DATE:
ARTICLE 1: ADMISSION OF PATIENTS	12/09/97 03/10/03
	PAGE: 1 of 2

A. **Priority of Admission**

Patients requiring emergency surgery or intensive care monitoring and treatment shall have admission priority regardless of the physician's Medical Staff category. Accommodations shall be available in the order in which applications for such accommodations are made. For all other admissions Active Medical Staff members shall, as far as feasible, have priority over other staff members in seeking accommodations and appointments for their patients, and Associate Staff members shall, as far as feasible, have priority over Courtesy Staff members in seeking accommodations for their patients.

B. **Admission Exceptions**

The Medical Staff shall admit patients except the following:

1. Admissions primarily for psychiatric treatment.

2. Patients who are dangerous to themselves or to others, who are destructive to property or who are offensive to other patients for psychiatric reasons unless underlying medical condition necessitates admission for stabilization and/or monitoring.

3. Patients requiring facilities not available in the Hospital.

4. ~~All~~ **M**~~m~~edical patients under the age of fourteen (14) years.

5. ~~All E~~**lective** surgical patients under the age of ~~two (2)~~ **five (5**) years.

6. Emergency surgeries under the age of eight (8) years deemed stable for transfer.

~~6.~~**7.** Surgical patients between the ages of ~~two (2)~~ **five (5)** years and fourteen (14) years whose length of stay is expected to be greater than forty-eight (48) hours.

~~7.~~**8.** Surgical patients between the ages of ~~two (2)~~ **five (5)** years and fourteen (14) years with medical co-morbidities **(ASA Class II or greater)** or who may require cardiac/respiratory monitoring post-operatively.

~~8.~~**9.** Admission of outpatient **surgeries** ~~<2 years~~ **< five (5) years** of age will be at the discretion of the anesthesiologist.

C. **Provisional Diagnosis**

No patient shall be electively admitted to the Hospital until after a provisional diagnosis has been stated and the consent of the Admitting Office is secured.

D. **Admission of Patients with Contagious Infections**

Medical Staff members admitting patients with contagious infections shall be held responsible for providing the Infection Control Nurse, the Director of Nursing or the supervisor in charge at the time such information as may be necessary to assure the protection of other patients.

E. **Admission of Patients - Safety Considerations**

Physicians admitting patients shall be held responsible for giving such information as may be necessary to secure the protection of other patients from those who are a potential danger of any sort whatsoever.

F. **Admission of Suicidal Patients**

For the protection of patients, the Medical and Nursing Staffs, and the Hospital, precautions to be taken in the care of the potentially suicidal patient include:

1. Any such patient shall be admitted to a secure room. If there are no accommodations available, the patient shall be referred, as soon as possible, to another institution where suitable facilities are available.

2. When transfer is not possible, the patient may be admitted to a general area of the Hospital with continuous supervision.

G. **Attending Responsibilities**

All patients must be personally seen and examined by their staff physician or the covering staff physician within 24 hours of admission and at least once per day while admitted.

H. **Dental and Podiatric Admissions**

Dental and podiatry admissions require a history and physical examination written by a qualified physician with admitting privileges on the Medical Staff who will be responsible for the care of the patient's medical problems. The complete medical history and physical shall be recorded within one week prior to admission. Dentists and Podiatrists shall be responsible for recording the dental or podiatry medical history.

I. **Laboratory Examinations**

Laboratory examinations shall be made according to Rules and Regulations found in subsequent sections. Any abnormalities must be addressed before discharge.

J. **On-Call Hired Physicians**

Physicians hired for on-call duty by members of the Alameda Hospital Medical Staff are intended to serve as a temporary but complete replacement for staff members insofar as the credentialing of on-call physicians allows. On-call physicians must be at least second year residents (PG2) with at least a rotating or medical internship. There must be a back-up staff physician available when an on-call physician is on duty.

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Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: October 2, 2008

To: City of Alameda Health Care District Board of Directors

From: Deborah E. Stebbins, CEO

Subject: Key State Issues Summary

For your reference, attached is the California Hospital Association's (CHA) 2008 Key State Issues Summary. With the Governor having acted on all bills, there will be no further updates from CHA until 2009 when the California State legislature goes back in session.

California Hospital Association
Key State Issues
Final Legislative Wrap-Up
October 1, 2008

Legislatively, 2008 was a challenging year for hospitals. Our thanks to all who contributed to winning passage of legislation important to hospitals and securing defeat of or significant amendment to high-priority CHA-opposed bills.

Progress				CHA Key State Issues
Objectives Achieved	Work in Progress	CHA Position	Advocacy Focus	
SB 840 vetoed	**X**	**Support: Health care reform consistent with CHA Board principles** **Oppose: SB 840** **Oppose : Piecemeal reform bills as noted in this report.**		**Health Coverage Expansion/Health Care Reform.** The Governor unveiled during 2008 a phased two-year approach to achieving comprehensive reform. Links specific elements of Phase I were posted at http://opr.ca.gov/temp/. Subjects of Phase I included: a 24-Hour coverage pilot project; a prohibition on balance billing; E-prescribing; a healthy action rewards program; Medi-Cal managed care surveys; limits on medical loss ratios; nurse practitioner scope of practice changes; hospital patient safety plans; personal health records and e-transmission; limitations on rescission of coverage by plans and insurers; non payment for adverse events; tiering of individual market products and transparency. Dozens of bills in 2008 addressed a range of issues which had been elements of comprehensive reform proposals. This report lists key bills by subject matter on a variety of those subjects including insurance reforms, balance billing, price and quality transparency, patient safety and other issues. As described below, CHA opposed some of those bills, several of which were defeated and several of which were mitigated by negotiated amendments. **SB 840** (Kuehl) would have replaced California's current public and private health coverage with a tax-financed single payer system *(Vetoed by Governor).*
	X	**Advocate CHA budget priorities.** **Protect: Medi-Cal funding and payments and the health care safety net**	**FY 2008-09 proposed state budget and related bills** **Pending Medi-Cal cuts enacted in February 2008** **Litigation**	**State Budget.** Governor Schwarzenegger signed the FY 2008-09 state budget on September 23, 85 days into the new fiscal year. The Governor's signature cleared the way for back Medi-Cal payments to be paid. Budget advocacy began very early in 2008 and was conducted on multiple fronts including legislative and grassroots advocacy, litigation, media relations, and public advocacy. CHA conducted an aggressive statewide public advocacy campaign. This call-to-action campaign featured television commercials, supporting print ads and a website. CHA and other health care provider organizations continue to pursue litigation seeking to block the 10 percent cuts in Medi-Cal payments enacted and signed in February that took effect July 1 and which, under the budget as enacted this week, would continue until March 1, 2009, at which time smaller reductions would take effect. The budget contained some elements of budget reform demanded by the Governor but did not address the structural imbalance between revenues and spending. The structural imbalance, compounded in the short term by a weak economy and weakening tax collections assure that this year's problems will recur next year.

Progress				CHA Key State Issues
Objectives Achieved	Work in Progress	CHA Position	Advocacy Focus	
HAZUS adopted as permanent building code standard **AB 2216 signed** **AB 2966 amended, then held** **AB 3028 signed** **SB 1272 signed**	**X**	**Support:** **AB 2216** **AB 3028** **SB 1272** **Oppose, then neutral as amended:** **AB 2966**	**Legislation** **OSHPD**	**Seismic Mandate and Facility Issues.** CHA continued working during 2008 to secure modification of the unfunded seismic mandate on hospitals. CHA supports changes that address the deadlines, building evaluation methodology, funding, and plan review process and criteria and is working with the Office of Statewide Health Planning and Development (OSHPD) on implementation and application of HAZUS, the state's new building evaluation methodology. On May 21, the California Building Standards Commission (CBSC) adopted the OSHPD proposal for use of HAZUS as a permanent building code standard. CHA-sponsored **AB 2216** (Gaines) will extend the sunset date for monthly rather than weekly testing of diesel backup generators to Jan. 1, 2011 *(Signed by Governor)*. **AB 2966** (Lieber) would have shifted responsibility for acquiring and managing inspectors of record from individual hospitals to OSHPD *(Senate Inactive File)*.The bill was amended June 25 to become a study bill. Among other things, **AB 3028** (Salas) will permit electronic plan review and approval by OSHPD and will enhance OSHPD's over-the-counter option to expedite the plan review process *(Signed by Governor)*. **SB 1272** (Cox) will increase the Cal-Mortgage Loan Insurance program small project loan amount from $5 to $10 million, thereby increasing the number of loans eligible for insurance of 95% of the construction cost for *(Signed by Governor)*.
AB 2298 held by author **SB 894 held by author** **AB 2942 held** **SB 1221 amended, then vetoed** **AB 371 vetoed**	**X**	**Oppose:** **AB 371** **AB 2942** **AB 2298** **Oppose, until amended or dropped:** **AB 894** **Oppose, then Neutral as amended:** **SB 1221**	**Listed bills** **CHFFA**	**Community Benefits/Not-for-Profit Hospital Issues.** CHA continued during 2008 to work with the Legislature, OSHPD, the Board of Equalization (BOE) and the California Health Facilities Financing Authority (CHFFA) on issues of concern to not-for-profit hospitals. **SB 894** (Ducheny) would have prohibited the Attorney General from consenting to a health facility or transaction in which the seller had not allowed for a public offering and exposure in the open market and considered any competing offers to the sale and would have authorized the Attorney General to not consent if all or a large part of the net proceeds were not kept in the affected community *(This bill was placed back on the Assembly Inactive File on August 28. This bill will remain on the Inactive File)*. **AB 2942** (Ma) would have required all hospitals, including for-profit hospitals that choose to provide community benefits, to develop and implement community benefit plans in a standardized format using a uniform calculation methodology to quantify community benefits information. The bill also would have required community involvement and oversight in plan development and implementation *(Held in Senate Appropriations)*. **AB 2298** (Hayashi) would have required each hospital to allocate at least 50% of money that it uses to implement its community benefits plan to fund specified programs to eliminate racial, ethnic and gender health disparities *(Held by author in Assembly Health)*. As amended, **SB 1221** (Kuehl) would have required hospitals that apply to CHFFA and any joint powers authority for financing, to demonstrate that the facility performs community service *(Vetoed by Governor)*. CHA provided amendments to limit the scope of the bill and eliminate ambiguity. See also CHA-opposed **AB 371** (Huffman) discussed below under **Workforce Issues.**

Progress				CHA Key State Issues
Objectives Achieved	Work in Progress	CHA Position	Advocacy Focus	
AB 1894 amended to delete testing mandate on hospitals signed **AB 2207 held**	**X**	**Follow as Amended: AB 1894** **Oppose/ Amend: AB 2207** **Oppose: AB 2702** **Follow: SB 1738**	**Legislation**	**Emergency Services.** CHA continued in 2008 to seek and advocate solutions to the emergency services crisis, including the growing crisis of call-panel physician availability for hospital emergency departments. As introduced, **AB 1894** (Krekorian) would have required hospitals that provide emergency medical care to offer patients testing for HIV and for AIDS regardless of whether the testing is related to a primary diagnosis. The bill was amended to delete the requirement on hospitals and instead will require plans and insurers to provide testing for HIV and AIDS regardless of whether the testing is related to a primary diagnosis *(Signed by Governor)*. **AB 2207** (Lieu) would have required each hospital to assess the condition of its emergency department every 3 hours and calculate and record a NEDOCS (overcrowding) score It also would have required hospitals to adopt "full capacity" protocols for each category of the NEDOCS overcrowding scale *(Held in Assembly Appropriations)*. **AB 2702** (Núñez) will dilute the Maddy EMS funds available to Los Angeles County physicians by requiring reimbursement to physicians who provide emergency services in qualifying urban standby emergency departments *(Signed by Governor)*. **SB 1738** (Steinberg) would have created the Frequent Users of Health Care Pilot Program, designed to reduce participants' use of hospital emergency departments when more effective care can be provided in less costly settings, to be implemented only if federal financial participation and necessary federal approvals are obtained (*Vetoed by Governor)*.
Mitigated: AB 2400 amended signed **SB 1688 dropped by author** **AB 2741 held** **SB 1351 vetoed** **SB 1734 held by author**	**X**	**Oppose: AB 2741 SB 1688 SB 1351 SB 1734** **Oppose, then Neutral as amended: AB 2400**	**Listed Bills**	**Hospital Closures, Changes in Services and Transfers of Assets.** Closures, reductions in service, and transfers of assets continued to provoke legislation in 2008. As amended, **AB 2400** (Price) will impose new notice requirements before a hospital closes a service or relocates a supplemental service to a different campus *(Signed by Governor)*. **SB 1688** (Ridley-Thomas) would have required for-profit owners or operators of hospitals in specified circumstances to maintain or increase levels of care and services of individual hospitals on a year-to-year basis *(Held by author in Assembly Appropriations)*. **AB 2741** (Torrico) would have required DPH, in evaluating an application for licensure, to obtain a health impact analysis to determine whether the transaction may create a significant effect on the availability or accessibility of health care services and whether the transaction is in the public interest if the applicant did not meet certain existing statutory requirements relating to the sale or transfer of the assets of a nonprofit corporation that operates or controls a facility that provides health care *(Held in Senate Appropriations)*. **SB 1351** (Corbett) would have imposed multiple new restrictions and requirements relating to the transfer of assets from a health care district to a not-for-profit or for-profit entity (*Vetoed by Governor)*. **SB 1734** (Kuehl) would have prohibited a REIT that owns property on which a hospital is situated from taking specified actions that would result in a reduction of care. DPH would have been required to establish a mediation process to resolve any dispute between the REIT and the operator of the hospital, if the dispute could result in hospital closure *(Held in Assembly Appropriations).*

Progress				CHA Key State Issues
Objectives Achieved	Work in Progress	CHA Position	Advocacy Focus	
AB 2653 held by author **AB 1554 held** **AB 2910 gutted and amended by author** **AB 2220 vetoed** **AB 1390 held by author** **SB 1300 defeated** **Mitigated: AB 1203 amended** **SB 1553 signed**	**X**	**Oppose: AB 2653 AB 1554** **Oppose/ Amend: SB 1300** **Oppose/ Amend, then Neutral as amended: AB 1203** **Letter of Concern, then follow as amended: AB 2220** **Support: SB 1553** **Follow: AB 1150 AB 1155 AB 1945 SB 1553 SB 1440 AB 2549 AB 1525** **Approve: SB 1522** **Follow as Amended: AB 2910** **Follow as Amended: AB 1390**	**Legislation, regulatory advocacy, and litigation**	**Health Care Coverage Practices and Plan-Provider Relationships.** Many bills were introduced on health care coverage issues. **AB 1155** (Huffman) would have imposed new requirements on DMHC regarding underpayments by plans to providers and unfair payment patterns *(Vetoed by Governor)*. **AB 1203** (Salas) will prohibit a noncontracting hospital from billing a covered patient for post-stabilization care if the hospital fails to contact the patient's plan *(Signed by Governor)*. **AB 2653** (Garcia) would have authorized a plan participating in Healthy Families or the Medi-Cal program to request a "hospital access pass" if the plan is unable to reach an agreement with a hospital and would require hospital services to be provided thereafter at rates set by CMAC *(Held in Assembly Health)*. **AB 1554** (Jones) would, with some exceptions, have required advance approval of increases in premiums, copayments, deductibles, and other charges by a plan or insurer *(Senate Health—not heard)*. **AB 1390** (Huffman) would have expanded current law limiting a hospital's ability to determine or condition medical staff privileges, but the bill was gutted and amended to deal with a new subject matter of integrated waste. *(Referred back to Senate Rules)*. **AB 2220** (Jones) would have enacted significant new regulation of contractual rights and obligations among physicians, physician groups, health plans and hospitals; it was amended to provide for arbitration of contract disputes between plans and emergency physicians *(Vetoed by Governor)*. **SB 1553** (Lowenthal) will prohibit plans from denying authorization for mental health services based upon whether the admission was voluntary or involuntary or based upon the method of transportation to the health facility *(Signed by Governor)*. **AB 2910** (Huffman) would have prohibited construing existing law to relieve health plans of liability for the medical decisions made by delegated medical groups. The bill had unintended effects on MICRA which were discussed with the author. It was gutted and amended by the author to use for a different purpose. **SB 1300** (Corbett) would have nullified confidentiality provisions in contracts between health plans and providers *(Failed passage on Senate Floor)*. **SB 1522** (Steinberg) would have required plans and insurers offering individual coverage to offer coverage in each of five coverage categories *(Failed passage on Assembly Floor)*. **AB 1150** (Lieu) will prohibit specified incentives and practices regarding rescission or cancellation of coverage *(Signed by Governor)*. As amended, **AB 1945** (De La Torre) would have required DMHC and DOI to establish a pool of approved application questions for individual health plan contracts and individual health insurance policies and would restrict plans and insurers to use of those questions in application forms. The bill also would have required prior approval before rescinding a contract or policy *(Vetoed by Governor)*. **SB 1440** (Kuehl) would have required at least 85 percent of health plans' and health insurers' aggregate dues, fees, premiums and other periodic payments to be spent on health services (*Vetoed by Governor)*. **SB 1525** (Kuehl) would have added a review of the procedures for making determinations of medical necessity to existing requirements regarding periodic onsite surveys of health plans' medical delivery systems, *(Held in Assembly Appropriations)*. **AB 2549** (Hayashi) would prohibit plans and insurers from rescinding coverage for any reason after 18 months following its issuance *(Held in Senate Appropriations)*.

Progress				CHA Key State Issues
Objectives Achieved	Work in Progress	CHA Position	Advocacy Focus	
AB 2644 held by author **SB 1169 signed** **AB 2474 signed** **AB 2146 held**		**Support:** **SB 1169** **AB 2474** **Oppose:** **AB 2644** **AB 2146**		**Billing/Reimbursement Issues. AB 2440** (Laird) would have required DHCS to update and publish in the Medi-Cal provider bulletin, diagnostic and reimbursement codes by October 1 of the year for which the codes are published by CMS *(Vetoed by Governor)*. **AB 2644** (Huff) would have required hospital bills to provide in plain English a description of the medical procedure or services for which a patient is billed *(Held by author in Assembly Health)*. **SB 1169** (Runner) will extend the Jan. 1, 2009 sunset date on current law relating to payment for services rendered to patients who are in the custody of local law enforcement agencies *(Signed by Governor)*. (Current law is a compromise between hospitals and law enforcement agencies initially enacted in 2005. It allows sheriffs and police chiefs to negotiate contracts for emergency and non-emergency care for people in their custody and requires that hospitals not under contract be paid at a rate equal to 110 percent of the hospital's actual costs.) **AB 2474** (Galgiani) will clarify the Legislature's intent with regard to several provisions of the budget trailer bill *(Signed by Governor)*. (See also **AB 2146** (Feuer), immediately below, which would have prohibited billing a patient or insurer for care related to an adverse event.)
Mitigated: SB 158 amended signed **Mitigated: SB 1058 amended signed** **AB 2967 held** **AB 2146 held** **AB 2038 held**		**Oppose:** **AB 2967** **AB 2038** **Oppose/ Amend:** **AB 2146** **Oppose, then Neutral as amended:** **SB 158** **SB 1058**	**Listed bills** **OSHPD**	**Patient Safety/Quality/Reporting/Disclosure.** CHA supports universal rational and valid patient-safety and quality indicators and reporting mechanisms, and is participating in development and promotion of meaningful metrics and processes, specifically, through the California Hospitals Assessment and Reporting Task Force (CHART). (Online at: CalHospitalCompare.org). CHA supports adoption of CHART as the single standard tool by which plans and insurers would measure hospital quality. CHA supports appropriate and meaningful transparency for prices, processes and outcomes for hospitals, physicians, pharmacists, insurers, health plans and other health care stakeholders. On May 2, 2008, the CHA Board approved the development of a statewide central-line infection reduction program by CHA/California Hospital Patient Safety Organization (CHPSO); and endorsed in concept a statewide patient safety education program. CHA/CHPSO works in cooperation with the Regional Associations and other stakeholders. CHA opposes prescriptive, redundant or excessively burdensome requirements. As amended, **SB 158** (Florez) will require CDPH to establish additional oversight of hospital-acquired infections (HAIs), as well as enacting training, education and other requirements including an HAI advisory committee *(Signed by Governor)*. As amended, **SB 1058** (Alquist) will implement HAI reporting, limited MRSA testing and very limited retesting before discharge, public reporting, and fees, among other provisions *(Signed by Governor)*. CHA worked with the author, the administration and stakeholders to craft acceptable language. **AB 2967** (Lieber), independently of comprehensive health care reform, would have established a Health Care Cost and Quality Transparency Committee to develop and implemented a new hospital data reporting system paid for by an additional fee on hospitals *(To Senate Inactive File)*. **AB 2146 (**Feuer) would have prohibited a health care provider from billing a patient or a patient's insurer for an adverse event that occurs while the patient is in the care of the provider, or for the care provided by the health care provider to treat or correct the consequences of the adverse event *(Held in Senate Appropriations)*. **AB 2038** (Lieber) would have rewritten the law regarding reporting and prosecution of crimes against dependent adults and adults with disabilities. It would have made significant changes to abuse-reporting requirements applicable to long-term-facilities and other changes to abuse-reporting law for all health facilities *(Held in Senate Appropriations—Suspense File)*

Progress				CHA Key State Issues
Objectives Achieved	Work in Progress	CHA Position	Advocacy Focus	
AB 55 signed **AB 2120 signed** **AB 2661 held by author**	**X**	**Support: AB 55 AB 2120** **Oppose: AB 2661**	**Legislation** **OSHPD** **Cal-RHIO** **PSAB** **CalOHII**	**Health Information Technology.** Fostering the development and implementation of health information technology is the subject of public/private efforts including the California Regional Health Information Organization (CalRHIO) in which CHA is participating. Assuring privacy and security is essential to the electronic exchange of health information. CHA participates as a member of the Privacy and Security Advisory Board (CalPSAB), a private and public collaboration to address and coordinate health information exchange privacy and security efforts in California and works with the California Office of Health Information Integrity (CalOHII). CHA-sponsored **AB 55** (Laird) will broaden allowed technology sharing among hospitals and physicians (previously limited to e-prescribing only) and would bring California law into compliance with the revised federal law, creating a safe harbor for those engaging in IT sharing *(Signed by Governor)*. **AB 2120** (Galgiani) will extend the Jan. 1, 2009 sunset date to Jan. 1, 2013 on a statute that authorizes the Medi-Cal program to reimburse for teleopthalmology and teledermatology by store and forward *(Signed by Governor)*. **AB 2661** (Dymally) would have made several problematic changes to the Telemedicine Practice Act *(Held by author in Assembly Health)*.
Mitigated: AB 211 signed **Mitigated: SB 541 signed**		**Oppose/ Amend, then Support: AB 211** **Oppose/ Amend, then Neutral: SB 541** **Follow: SB 1415**		**Patient Privacy/Medical Records.** As amended, **AB 211 (**Jones) will establish the state Office of Health Information Integrity (OHII) and would authorize the OHII to levy substantial administrative fines on persons or non-hospital entities, licensed or unlicensed, for violations of medical privacy laws *(Signed by Governor)*. As amended, **SB 541** (Alquist) will require health facilities to prevent unlawful access, use, or disclosure of a patient's medical information and would authorize CDPH to assess, against health facilities, substantial monetary penalties for each improper access, use, or disclosure. The bill will also substantially increase monetary penalties for "immediate jeopardy" deficiencies *(Signed by Governor).* **SB 1415** (Kuehl) would have required non-hospital health care providers to provide patients, when an initial patient record is created, a notice to be signed by the patient explaining the provider's records retention policy and would require notice before records could be destroyed *(Vetoed by Governor)*
AB 2516 held by author	**X**	**Support: SB 1270** **Follow: SB 1307** **Oppose: AB 2516**	**Listed bills**	**Pharmacy/Pharmaceuticals.** Earlier in 2008, the state Pharmacy Board voted to delay an existing drug pedigree tracking requirement to Jan. 1, 2011. **SB 1270** (Cedillo) would have required the Board to establish a task force to advise the Board on pedigree tracking *(Held in Assembly Appropriations).* **SB 1307** (Ridley-Thomas) will define "pedigree" and phase in the pedigree requirement starting in 2011 *(Signed by Governor)*. **AB 2516** (Mendoza), commencing Jan. 1, 2010, would have required all prescribers to ensure that prescriptions be electronically transmitted to the patient's pharmacy of choice *(Held in Assembly B&P).*
AB 1468 held **AB 364 amended, then held**	**X**	**Oppose, then Support as amended: AB 364** **Oppose: AB 1468**	**Listed bills**	**Patient Transport/Patient Discharge Policies.** As introduced, **AB 364** (Berg) would have required that hospital discharge policy inform patients of home and community-based options prior to discharge, and would have required preadmission screening before an older adult is transferred to any skilled nursing facility. The bill was amended to replace the preadmission screening mandate with a pilot program, at which time CHA changed its position to support. *(Held in Assembly Appropriations)*. CHA-opposed **AB 1468** (Garrick) would have added citizenship status to the discharge abstract data hospitals are required to record on each patient *(Held in Assembly Health)*.

Progress				CHA Key State Issues
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SB 1393 signed **SB 1621 signed** **AB 2128 signed**		**Support:** **AB 2375** **SB 1393** **SB 1620** **SB 1621** **AB 2128**	**Listed bills**	**Health Care Workforce Shortages.** CHA continued during 2008 to address health care workforce shortages through legislation, and public advocacy. **AB 2375** (Hernandez) would have required OSHPD to establish a health care workforce task force to assist in the development of a health care workforce master plan for California *(Held in Senate Appropriations)*. **SB 1393** (Scott) will clarify existing law to prohibit CSUS and community colleges from requiring registered nursing students with baccalaureate degrees to take courses not unique and exclusively required to earn a nursing degree *(Signed by Governor)*. **SB 1620** (Ashburn) would have bolstered the number of nursing instructors in California's community colleges by allowing more part-time instructors, attracting nurses who prefer to teach and practice *(Assembly Appropriations)*. **SB 1621** (Ashburn) will extend student loan forgiveness to registered nurses who are willing teach as well as practice *(Signed by Governor)*. CHA-cosponsored **AB 2128** (Emmerson) will expand the mechanisms by which dietary services supervisors employed in skilled nursing facilities could meet educational and qualification requirements *(Signed by Governor)*.
AB 13 vetoed **AB 371 vetoed** **AB 437 vetoed** **AB 2244 vetoed** **AB 2279 vetoed** **SB 1151 vetoed** **SB 1721 held** **AB 1711 held** **SB 529 held** **AB 2716 held**	**X**	**Oppose:** **AB 13** **AB 371** **AB 1711** **SB 529** **AB 437** **SB 1721** **AB 2716** **AB 2279** **Oppose/ Amend:** **SB 1151** **Oppose, then neutral as amended:** **AB 2244** **Follow:** **SB 1526**	**Listed bills** **Regulatory agencies**	**Staffing Requirements and other Workforce Issues.** CHA opposes expansion of ratios beyond nurses. CHA advocates hospitals' interests on labor and workforce legislation and regulation of particular interest to hospitals, and works with the California Chamber of Commerce, the California Employers Coalition and other organizations on other legislation and regulation of concern to California employers. CHA-opposed **AB 13** (Brownley) would have imposed new requirements on hospitals to adopt and comply with staffing plans for professional and technical staff other than nurses *(Vetoed by Governor)*. **AB 2244** (Price) would have required CDPH to collect and review non-nursing staffing plans from UC hospitals *(Vetoed by Governor)*. **SB 1526** (Perata) would have enacted the Polysomnographic Technologist Act to provide for licensing and regulation of sleep lab technicians by the Respiratory Care Board *(Vetoed by Governor)*. **SB 1721** (Yee) would have required each direct care nurse to complete an orientation to the hospital and the unit in which he or she will be working and would have precluded a nurse who has not completed the orientation and been observed for 5 days from being assigned direct patient care or being counted toward state-required nurse to patient ratios *(Held in Assembly Appropriations)*. **AB 1711** (Levine) would have problematically amended Labor Code Section 512 regarding meal periods *(Held in Senate Labor)*. **SB 529** (Cedillo) would have allowed select unionized industries to negotiate meal period rules and authorized non-union security guards to enter into on-duty meal period agreements *(Moved to Assembly Inactive File)*. **SB 1151** (Perata) would have required each hospital to adopt a safe patient handling policy and would require hospitals to purchase lift equipment and use it except in an emergency *(Vetoed by Governor)*. **AB 371** (Huffman) would have required every hospital that applies for tax-exempt financing through the Calif. Health Facilities Financing Authority (CHFFA) or any other public entity to submit its injury prevention program, which would be required to include a safe patient handling policy *(Vetoed by Governor)*. **AB 437** (Jones) would have effectively eliminated the statute of limitations for California employers' compensation decisions *(Vetoed by Governor)*. **AB 2716** (Ma) would have required all employers to provide sick leave for all employees at a rate of one hour for every 30 hours worked *(Held in Senate Appropriations)*. **AB 2279** (Leno) would have prohibited employers from refusing to hire, discharging or discriminating against an individual because they use medical marijuana *(Vetoed by Governor)*.

Progress				CHA Key State Issues
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SB 940 signed **SB 1103 held** **SB 1717 veto**	**X**	**Oppose: SB 1717 SB 1103** **Oppose until amended, then neutral: SB 940**	**Listed bills**	**Workers' Compensation. SB 1717** (Perata) would double, by Jan. 1, 2011, permanent disability benefits by revising the formula for computing benefits for injuries that occur after Jan.1, 2009 and would repeal the 15 percent bump up/down for return-to-work-offers *(Vetoed by Governor)*. **SB 1103** (Cedillo) was amended August 15 to provide for a supplemental job displacement benefit in the form of a voucher for up to $6,000 for reeducation and skill enhancement services *(Assembly Rules)*. **SB 940** (Yee) will allow employees of temporary staffing agencies to sue both the temp agency and the hospital where they had temporary assignments for personal injury if neither the hospital nor the temp agency had workers' compensation coverage for the employee; the bill was amended to delete those provisions. As enacted, the bill establishes a definition of temporary services employer which excludes a bona fide nonprofit organization and provides the time frames for payment of wages for their employees *(Signed by Governor)*.
AB 2910 gutted and amended by author **MICRA preserved**	**X**	**Concern until amended then follow: AB 2910**	**MICRA litigation/ legislation.** **Civil justice legislation**	**MICRA/Civil Justice Issues.** CHA continues to work through Californians Allied for Patient Protection (CAPP) with other interested parties to protect the Medical Injury Compensation Reform Act (MICRA) legislatively and in court. CAPP advocacy deterred introduction of bills to amend MICRA during 2008. CHA also continues to support broader civil justice reform legislation and oppose problematic legislation through participation in the Civil Justice Association of California (CJAC). CAPP and CJAC raised health care providers' concerns with **AB 2910** (Huffman) (discussed above under **Health Care Coverage Practices and Plan-Provider Relationships** regarding the potential impact of the bill on MICRA and other civil justice issues.)
	X		**EMSA** **CDPH** **OHS** **OES**	**Disaster Preparedness.** CHA continues to work to strengthen hospital preparedness. During the past few years, the emphasis has been on building surge capacity and capability. Specific focus areas are: developing evacuation and shelter-in-place planning guides; hospital guidance for fatality management; assisting in the development of memoranda of understanding for the sharing of personnel, equipment and supplies. The CHA Hospital Preparedness Program (CHA HPP) regional coordinators provide direct assistance to hospital disaster planners. They collaborate with the Regional Associations and their regional vice presidents where applicable. Specific assistance is directed toward meeting the Joint Commission emergency management standards and meeting the federal Hospital Preparedness grant requirements. Program activity includes but is not limited to developing planning tools and resources, identifying best practices, providing HICS training, tools and guidance to improve hospital emergency operations plans. CHA coordinates with state and federal agencies including the Emergency Medical Services Authority (EMSA) the California Department of Public Health (CDPH), the Governor's Office of Homeland Security (OHS) and the Office of Emergency Services (OES). CHA participates on various state and national committees and work groups representing the interests of California Hospitals.
	X		**Federal: RAC claims review and recovery**	**Medical Rehabilitation Services.** CHA's Center for Medical Rehabilitation Services provides focused state and federal legislative and regulatory advocacy for member hospitals that provide inpatient and outpatient rehabilitation services. High-priority issues include addressing inappropriate Recovery Audit Contract program (RAC) claims review and reimbursement recovery.

Progress				CHA Key State Issues
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SB 1553 signed	**X**	**Support: AB 2861 AB 1887 SB 1553**	**Legislation**	**Behavioral Health.** CHA/CBH–sponsored **AB 2861** (Hayashi) would have defined the term "psychiatric emergency medical condition" for purposes of the existing requirement that hospitals with emergency departments provide, and that health plans pay for, emergency services provided under specified circumstances *(Vetoed by Governor)*. Other high priority issues include monitoring county mental health funding, Mental Health Services Act implementation, the integration of mental health and physical health and improving services for individuals with co-occurring disorders. **AB 1887** (Beall) would have broaden parity diagnoses to include any mental disorder defined in the DSM IV *(Vetoed by Governor)*. **SB 1553** (Lowenthal) will prohibit plans from denying authorization for mental health services based upon whether the admission was voluntary or involuntary or based upon the method of transportation to the health facility *(Signed by Governor)*. (See also **SB 1738** (Steinberg) to establish a frequent users of health care pilot project discussed above under **Emergency Services**.)
	X	**Support: AB 661**	**State budget DP/NF rate**	**Rural Hospitals.** Top priorities include protecting payments to rural hospitals and clinics for services provided to Medi-Cal and medically indigent patients and protecting Critical Access Hospitals (CAHs) and the rural hospital safety net, including expansion of Medi-Cal managed care. CHA-sponsored **AB 661** (Berg) would have required that CAHs be paid Medi-Cal allowable costs for outpatient services *(Held in Assembly Appropriations)*.
AB 2128 signed AB 2038 held	**X**	**Support: AB 2128 Oppose: AB 2038**	**Budget DP/NF rate**	**Post-Acute /Skilled Nursing.** CHA's Hospital Services for Continuing Care (HSCC) represents the interests of hospital-sponsored distinct-part skilled nursing facilities, including subacute facilities, and advocates for them on legislative and regulatory issues. Key issues include implementation of nurse staff ratios, training of dietary services supervisors and advocating Medicare and Medi-Cal reimbursement. Unless reversed, special session budget legislation signed by the Governor earlier this year cut Medi-Cal rates by 10 percent for distinct-part skilled nursing facilities, subacute facilities and adult day health care. CHA and others are challenging that reduction in court. On Jan. 30 CHA HSCC testified before DPH on emergency regulations filed by CDPH regarding skilled nursing facility staffing ratios and followed up with written comments. CHA-cosponsored **AB 2128** (Emmerson) will expand the mechanisms by which dietary services supervisors employed in skilled nursing facilities can meet educational and qualification requirements *(Signed by Governor)*. (See also **AB 2038** (Lieber) on dependent adult abuse reporting, discussed above under **Patient Safety/Quality/Reporting/Disclosure**).
	X		**Legislation**	**Women's and Children's Issues.** CHA continued to monitor issues and legislation impacting women's and children's services provided in hospitals.
SB 1260 signed	**X**	**Support: SB 1260**	**Listed bills**	**Hospital-Based Outpatient Clinics. SB 1260** (Runner) will require DPH to identify hospital-based outpatient clinics on a hospital's license *(Signed by Governor)*.
SB 891 signed AB 2565 signed	**X**	**Support: SB 891 AB 214 Oppose/ Amend, then Support: AB 2565**	**Listed bills**	**Other. SB 891** (Correa) will establish the Elective percutaneous Coronary Intervention (PCI) Pilot Program to authorize up to 6 eligible acute-care hospitals to perform elective and scheduled primary percutaneous coronary interventions *(Signed by Governor)*. **AB 2565** (Eng) will require hospitals to provide a reasonable period of accommodation for family or next of kin in the event that a patient is declared dead by neurological criteria *(Signed by Governor)*. The author accepted CHA's amendments to the bill. **AB 214** (Fuentes) would have facilitated the early recognition, treatment and monitoring of impaired physicians by the Medical Board *(Vetoed by Governor)*.