Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

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

Monday, October 12, 2009

Location:

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

Office of the Clerk: (510) 814-4001

Regular Meeting

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

I.	**Call to Order** (6:00 p.m. – 2 East Board Room)	Jordan Battani
	Roll Call	Kristen Thorson
III.	**Adjourn into Executive Closed Session**	
IV.	**Special Auxiliary Appreciation Presentation**	Jordan Battani
V.	**Closed Session Agenda**	
A.	Closed Session Minutes –September 12, 2009	
B.	Medical Executive Committee Report and Approval of Credentialing Recommendations	H & S Code Sec. 32155
C.	Discussion of Pooled Insurance Claims	Gov't Code Sec. 54956.95
D.	Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions	Gov't Code Sec. 54957.6
E.	Consideration of Performance Evaluation of District Employees – Chief Executive Officer	Gov't Code Sec. 54957
F.	Discussion of Report Involving Trade Secrets	H & S Code Sec. 32106
G.	Board Quality Committee Report (BQC)	H & S Code Sec. 32155

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

A. Announcements from Closed Session — Jordan Battani

VI. **Consent Agenda**

A. September 12, 2009 Minutes [enclosure]

B. Acceptance of August 2009 Financial Statements **ACTION ITEM** [enclosure]

C. Approval of Executive Incentive Compensation for FY 2009 **ACTION ITEM** [enclosure]

D. Approval of Amendment to Medical Staff Rules and Regulations Article 1-A: Allied Health Professional Status **ACTION ITEM** [enclosure]

VII. **Regular Agenda**

A. President's Report — Jordan Battani

1. Appointment of Executive Compensation Subcommittee

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

1. Administrative Policies and Procedures Update

C. Strategic Planning and Community Relations Report — Robert Bonta

1. September 13, 2009 Meeting

2. Approval of Capital Expenditure Authority for Seismic Planning **ACTION ITEM** [enclosure]

D. Finance and Management Committee Report

1. Committee Report – September 30, 2009 — Steve Wasson

2. Acceptance of FY 2009 Audited Financials **ACTION ITEM** [enclosure] — David Neapolitan & Rick Jackson, TCA Partners

E. Medical Staff President Report — Alka Sharma, MD

VIII. **General Public Comments**

IX. **Board Comments**

Adjournment

The next regularly scheduled board meeting is scheduled for November 2, 2009

Closed Session will begin at 6:00 p.m.
Open Session will follow at approximately 7:30 p.m.

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: October 12, 2009

TO: Board of Directors
City of Alameda Health Care District

FROM: Deborah E. Stebbins
Chief Executive Officer

Subject: Minutes for Closed and Open Board Meeting of September 14, 2009

The minutes for the September 14, 2009 Closed and Open Sessions of the Board of Directors have not been completed due to the death of Kristen Thorson's grandfather last Saturday and her travel back to South Dakota to be with her family at this sad time.

The minutes will be completed and distributed to you under separate cover before the November 2, 2009 Board meeting, when they will be presented for your review and approval.

Thank you for your understanding.

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING AUGUST 31, 2009

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
August 31, 2009

Table of Contents **Page**

Financial Management Discussion	1 – 12
Balance Sheet	13
Statement of Revenue and Expenses	14
Statement of Revenue and Expenses – Per Adjusted Patient Day	15
Key Statistics for Current Month and Year-to-Date	16

ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
AUGUST 31, 2009

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

Financial Overview as of August 31, 2009

- Gross patient revenue was greater than budget by $1,888,000 or 8.0%. Inpatient revenue was greater than budgeted by 7.4% and outpatient revenue was greater than budgeted by 8.7%. On an adjusted patient day basis gross patient revenue was $5,531 compared to a budgeted amount of $5,106 or a 8.3% favorable variance.

- Total patient days were 2,604 compared to the prior month's total patient days of 2,731 and the prior year's 2,234 total patient days. The average daily acute care census was 30.7 compared to a budget of 30.1 and an actual average daily census of 35.1 in the prior month; the average daily Sub-Acute census was 33.6 versus a budget of 33.1 and 31.3 in the prior month and the South Shore unit had an average daily census of 19.7 versus a budget of 21.5 and prior month census of 21.7, respectively.

- ER visits were 1,550 or 13.8% greater than the budgeted 1,362 visits and were greater than the prior year's visits of 1,336.

- Total surgery cases were 7.6% greater than budget, with Kaiser surgical cases making up 67.7% of the 493 total cases. Alameda physician surgical cases were 159 cases as compared to 158 cases in July.

- Combined excess revenues over expense (profit) for August was $42,000 versus a budgeted excess of revenues over expense (profit) of $16,000.

- Total assets increased by $449,142 from the prior month as a result of an increase in current assets of $480142 and an increase in restricted contributions of $9,633 offset by a decrease in net fixed assets of $40,633. The following items make up the increase in current assets:

  - Total unrestricted cash and cash equivalents for August decreased by $16,883 which resulted in our unrestricted day's cash on hand remaining at 9.0 at August 31, 2009. This was the result of the use of one twelfth of our parcel tax funds as planned offset by a second consecutive month of strong patient account collections that totaled $5,948,677, including the monthly payment from Kaiser ($800,800) in accordance with our current contract.

  - Net patient accounts receivable decreased in August by $76,537 compared to a decrease of $589,572 in July. Day's in outstanding receivables decreased to 49.1 as compared to 55.1 in July.

  - Other assets increased by $549,735 in August. This increase was the result of $728,702 in stop loss receivables that were accrued for employee health plan insurance payments that were paid in August.

- Total liabilities increased by $365,209 compared to a decrease of $464,428 in the prior month. This increase was the result of the following:

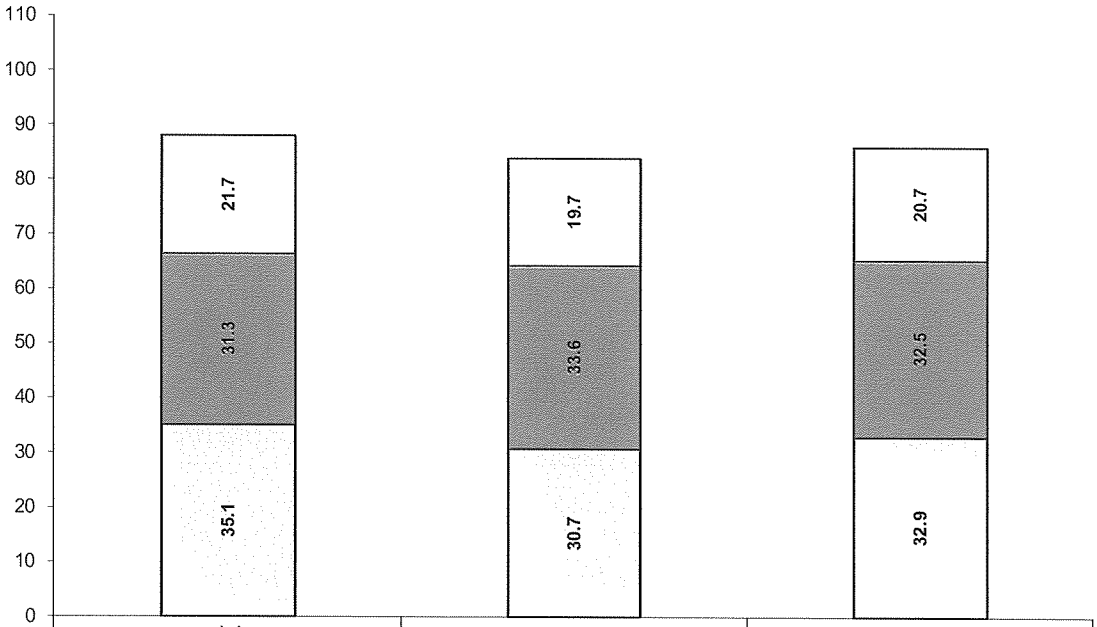
- Accounts payable increased by $407,613 from the prior month. As a result of this increase the average accounts payable payment period increased in August to 53.4 from 49.5 as of July 31, 2009.

- Payroll and benefit related accruals increased by $335,832 from the prior month. This increase was primarily the result of increased accrued payroll of $398,530 resulting from the timing of the actual paid payroll.

- Other liabilities decreased by $336,674 as a result of the amortization of one month's deferred revenue related to the 2009/2010 parcel tax revenues.

Volumes

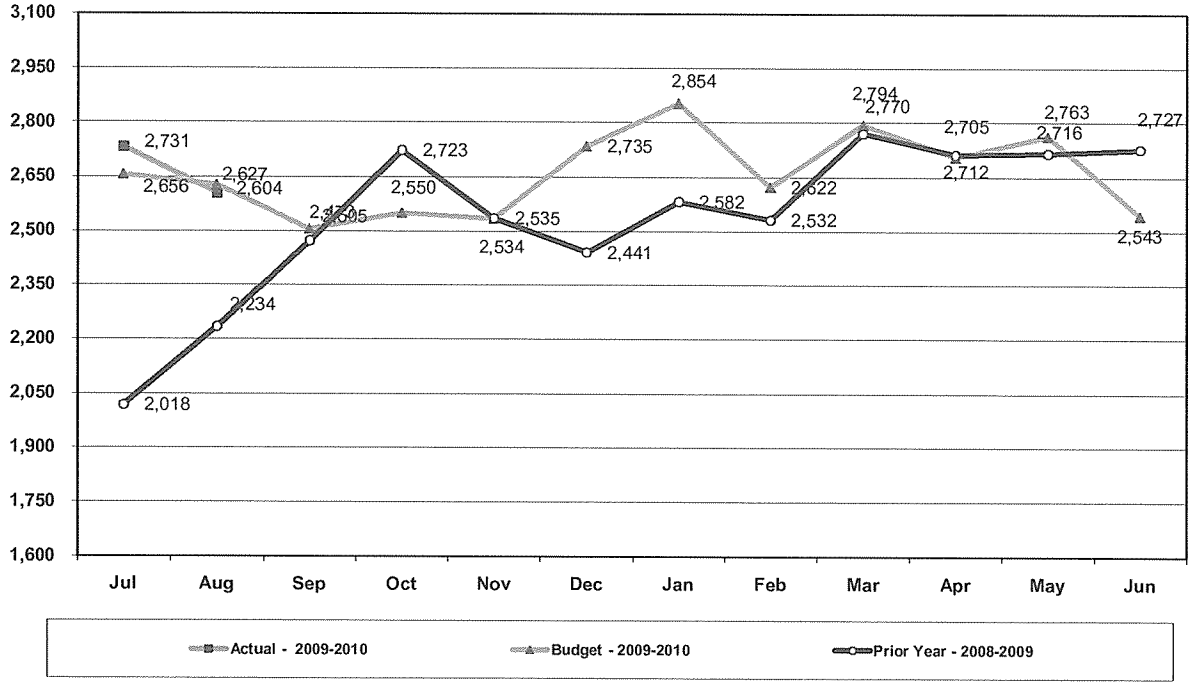
The combined actual daily census was 84.0 versus a budget of 84.7. This slightly unfavorable variance was primarily the result of the Skilled Nursing program average daily census that was 19.7 versus a budget of 21.5. Both the Acute and Sub-Acute programs had slightly favorably variances of 0.6 and 0.5, respectively.



	Jul	Aug	YTD
Actual SNF	21.7	19.7	20.7
Actual Sub-Acute	31.3	33.6	32.5
Actual Acute	35.1	30.7	32.9

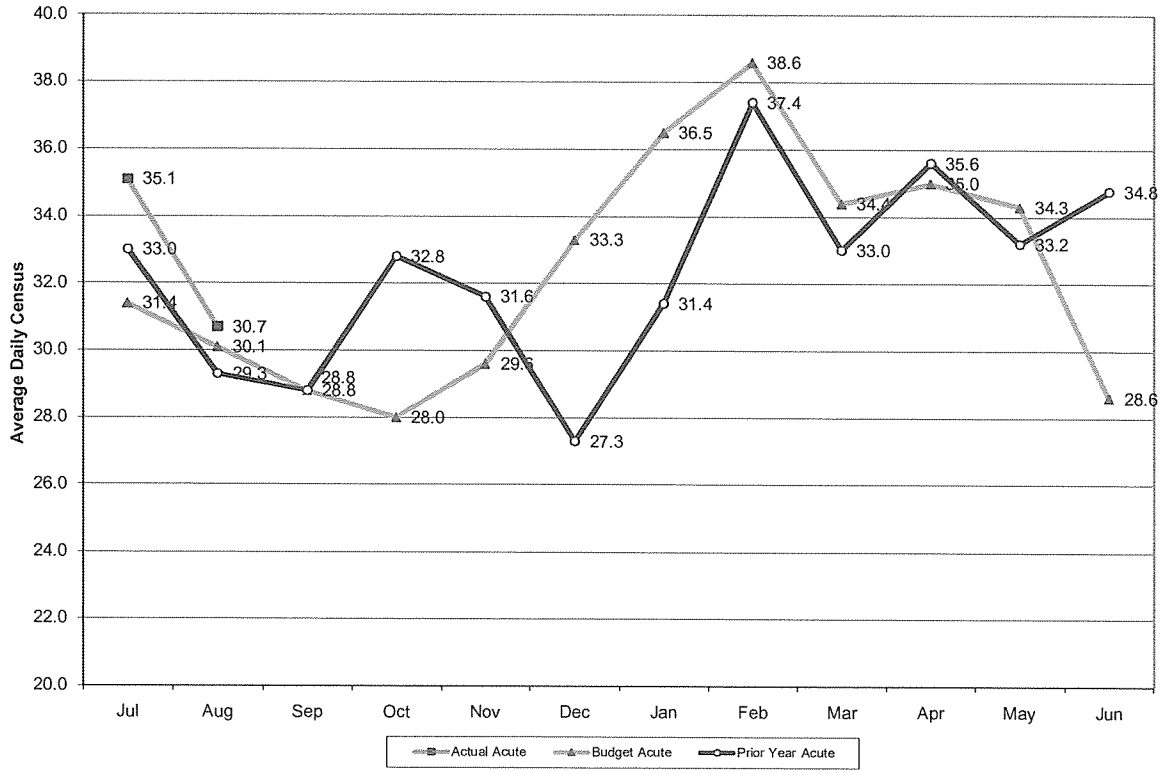
Total patient days in August were 0.9% less than budgeted but were 3.9% greater than the prior year after removing the South Shore patient days (program began operations August 16, 2008) from the current year total patient day count. The graphs on the following pages show the total patient days by month for fiscal year 2010 including South Shore:

Total Patient Days



Separating the inpatient components of our volumes for the month of August we see that the acute care patient days were 1.9% (18 days) greater than budgeted and were 4.7% greater than the prior year's average daily census. This was driven by higher than budgeted average daily census in the CCU (ADC = 5.0) and DOU (ADC = 11.0).

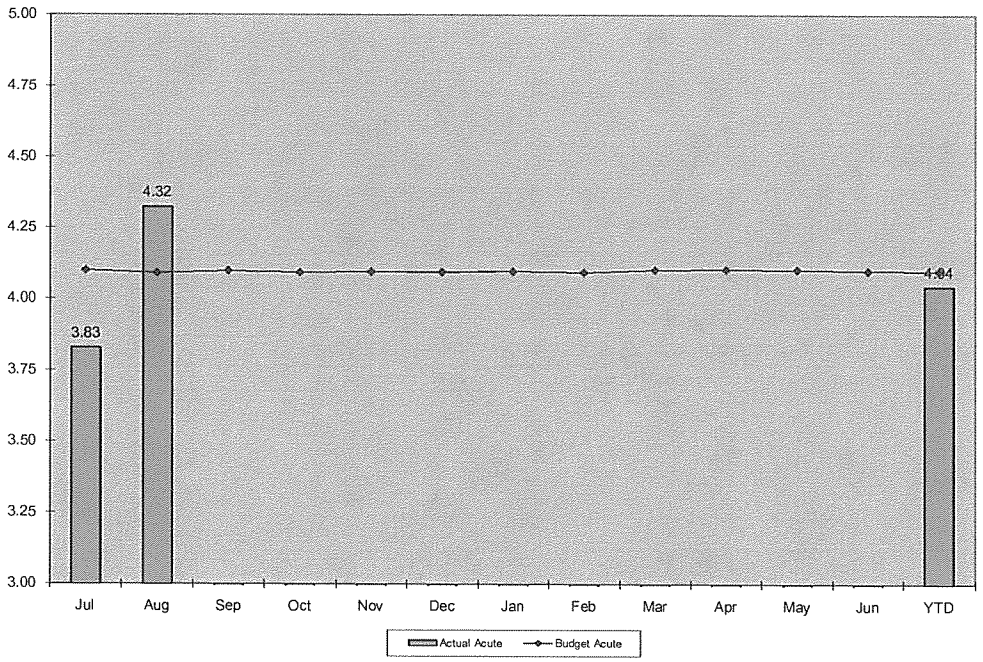
Inpatient Acute Care Average Daily Census



The average length of stay (ALOS) increased to 4.32 days for the month of August and is being driven by a

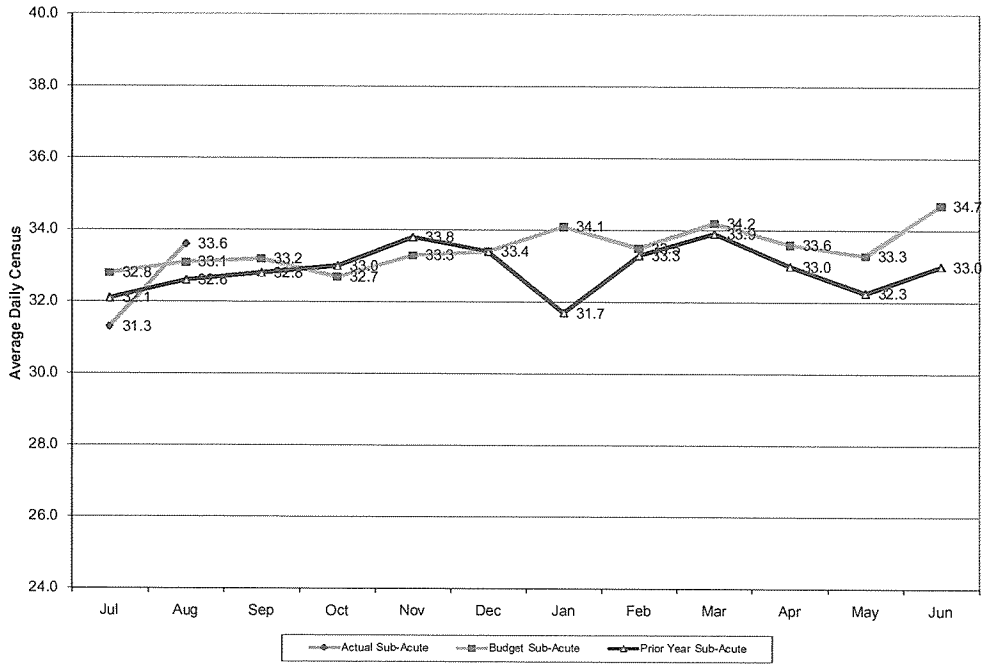
higher acuity level (CMI = 1.3675) of patients treated during the month. Our projected year to date ALOS of 4.10 remains slightly greater than the actual year to date average of 4.04 for the two months ended August 31, 2009, and is shown in the graph below.

Average Length of Stay



The Sub-Acute programs patient days were 1.5% greater than budget or 15 days and finished the last two weeks 100% occupied at an average daily census of 35.0 patients. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

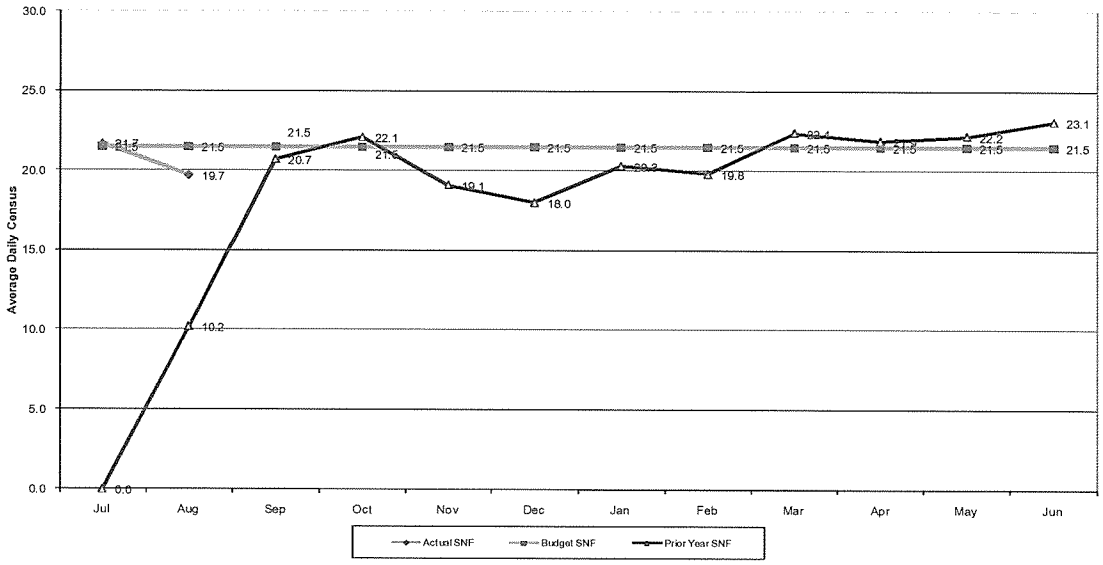
Sub-Acute Care Average Daily Census



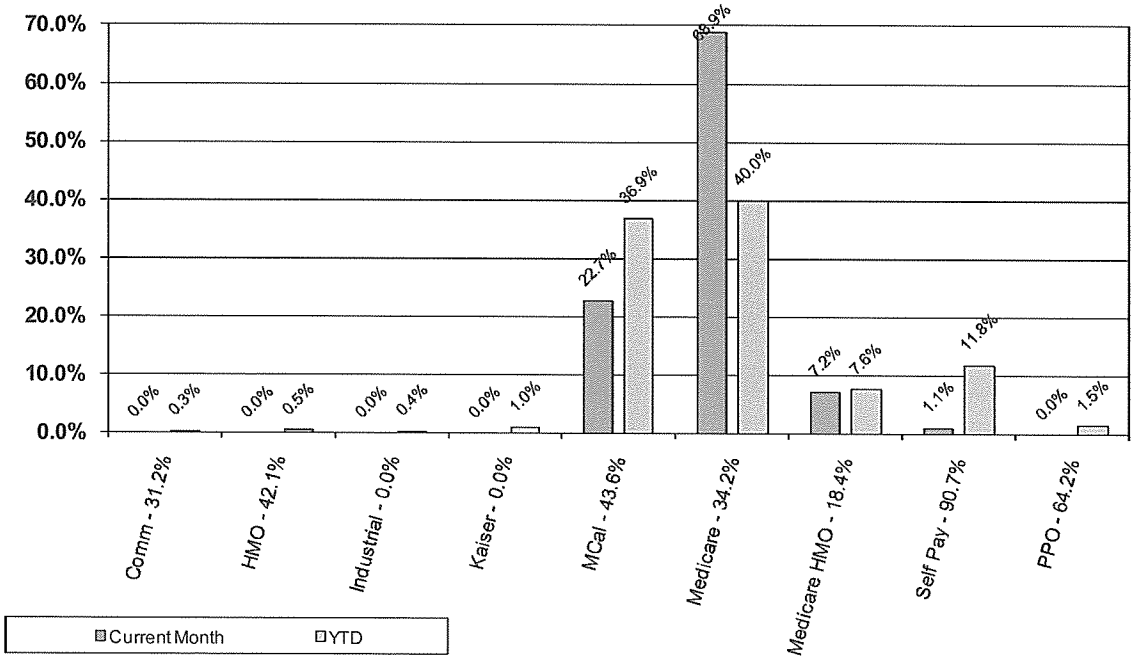
The Skilled Nursing Unit (South Shore) patient days were 8.4% less than budgeted for the month of August. The

following graphs show the Skilled Nursing Unit average daily census as compared to budget by month and the payor mix experienced during the current month.

Skilled Nursing Unit Average Daily Census

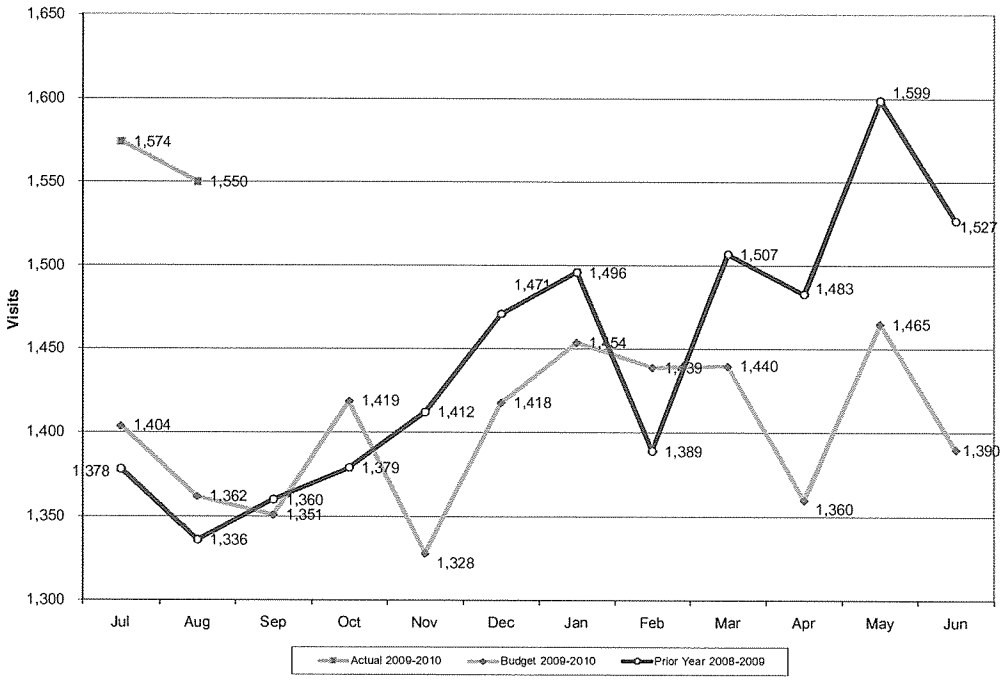


Skilled Nursing Unit Payor Mix



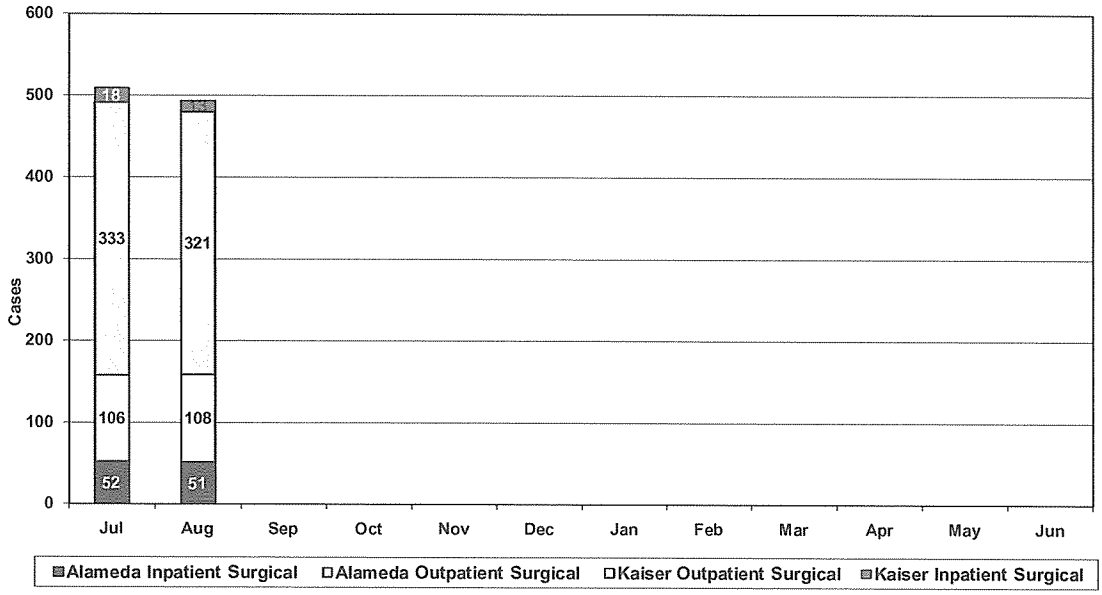
August ER visits were 13.8% greater than budgeted for the month.

Emergency Care Center Visits



Surgery cases were 493 versus the 458 budgeted and 448 in the prior year. In August, Alameda physician cases were consistent with the prior month at 159 cases versus 158 in July. Kaiser related cases in August decreased to 334 as compared to the 351 cases performed in July. However, despite this decrease in cases Kaiser Same Day Surgery revenue increased by $330.507 from the prior month. As a result of this month's activity, our reimbursement for Kaiser Outpatient cases in August decreased to 19.2% as compared to 21.0% of gross charges in July.

Surgical Cases

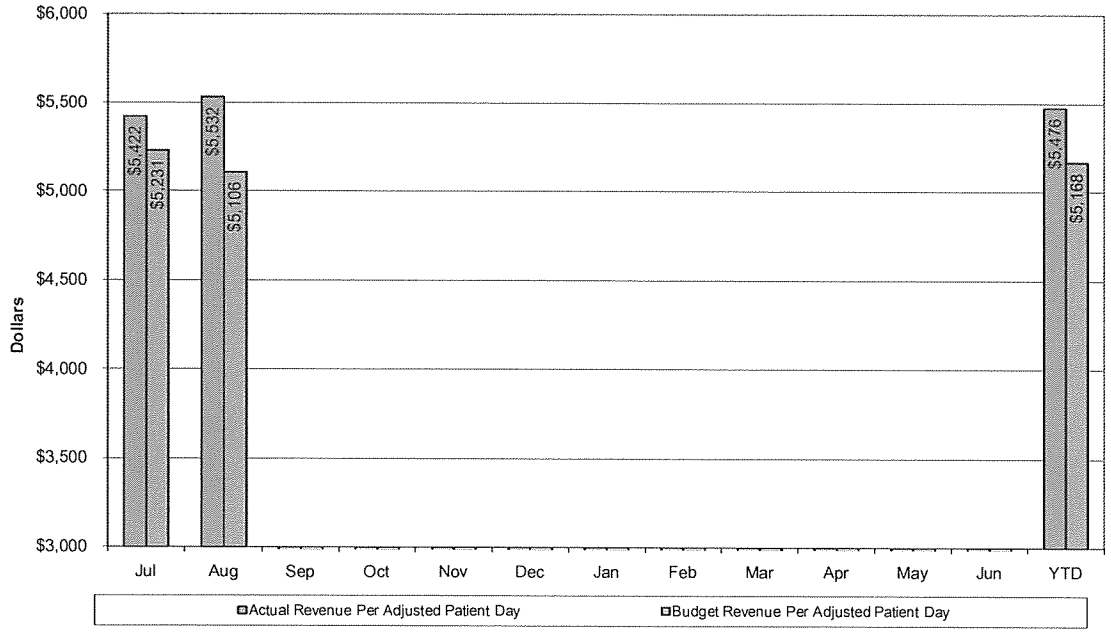


Income Statement – Hospital Only

Gross Patient Charges

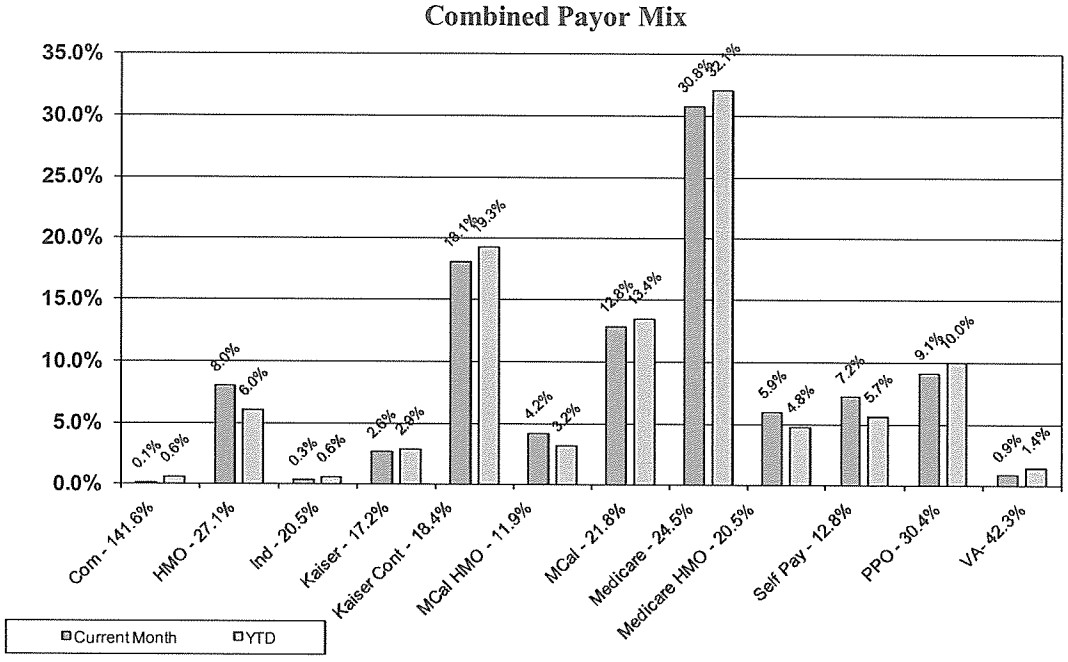
Gross patient charges in August were greater than budgeted by $1,888,000. This favorable variance was comprised of favorable variances of $988,000 and $899,000 in inpatient and outpatient revenues respectively. On an adjusted patient day basis total patient revenue was $5,531 versus the budgeted $5,106 or an 8.3% favorable variance from budget for the month of August.

Gross Charges per Adjusted Patient Day

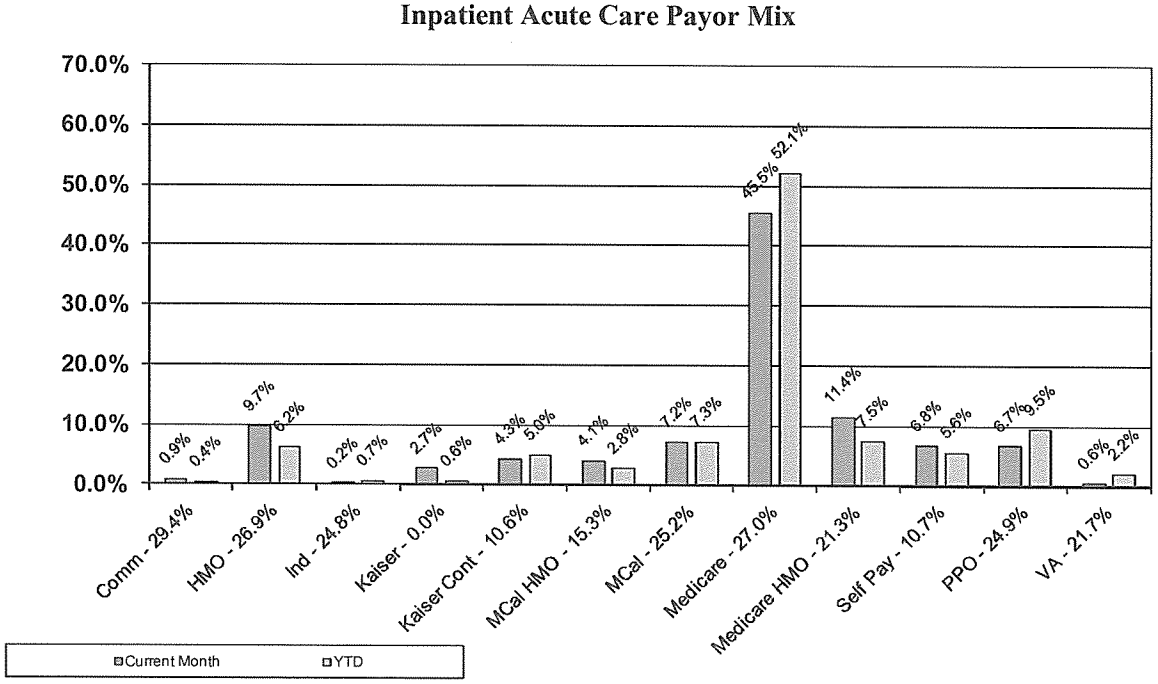


Payor Mix

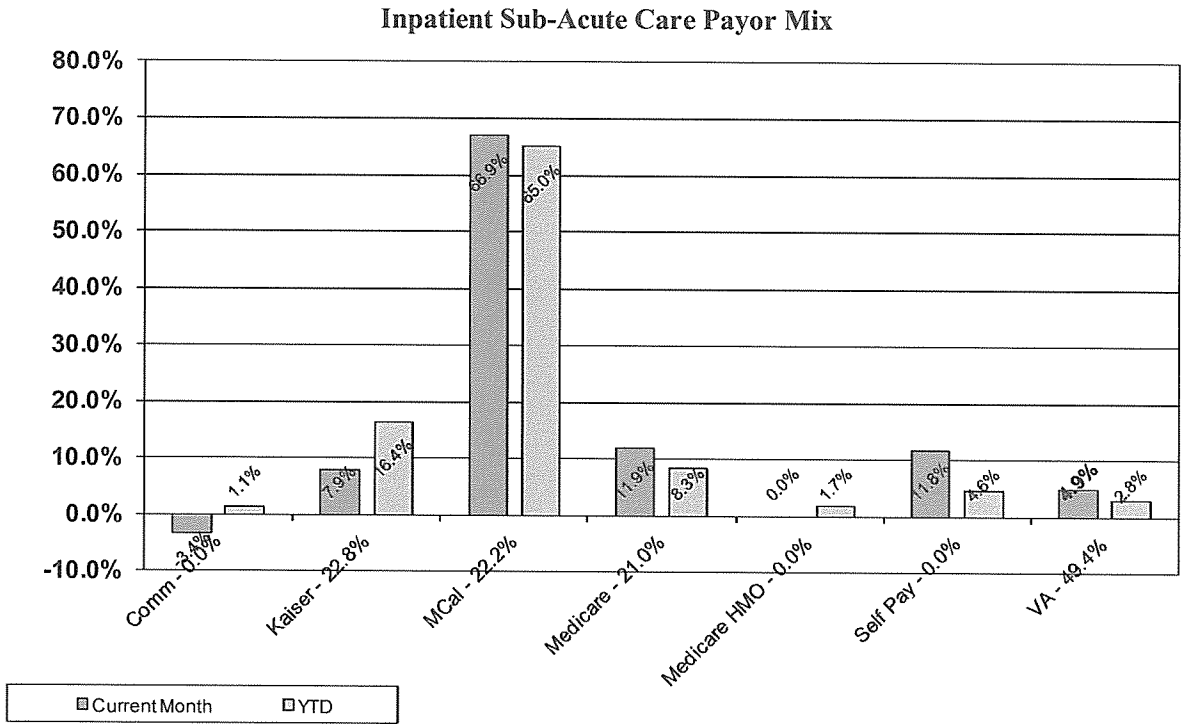
Medicare total gross revenue in August made up 30.8% our total gross patient charges down from 32.7% in the prior month. Kaiser was again the second largest source of gross patient revenues at 20.7%. Also, helping the bottom line performance in August was a combined HMO / PPO volume of 17.1%. The graph on the following page shows the percentage of revenues generated by each of the major payors for the current month as well as the current months expected reimbursement for each payor.



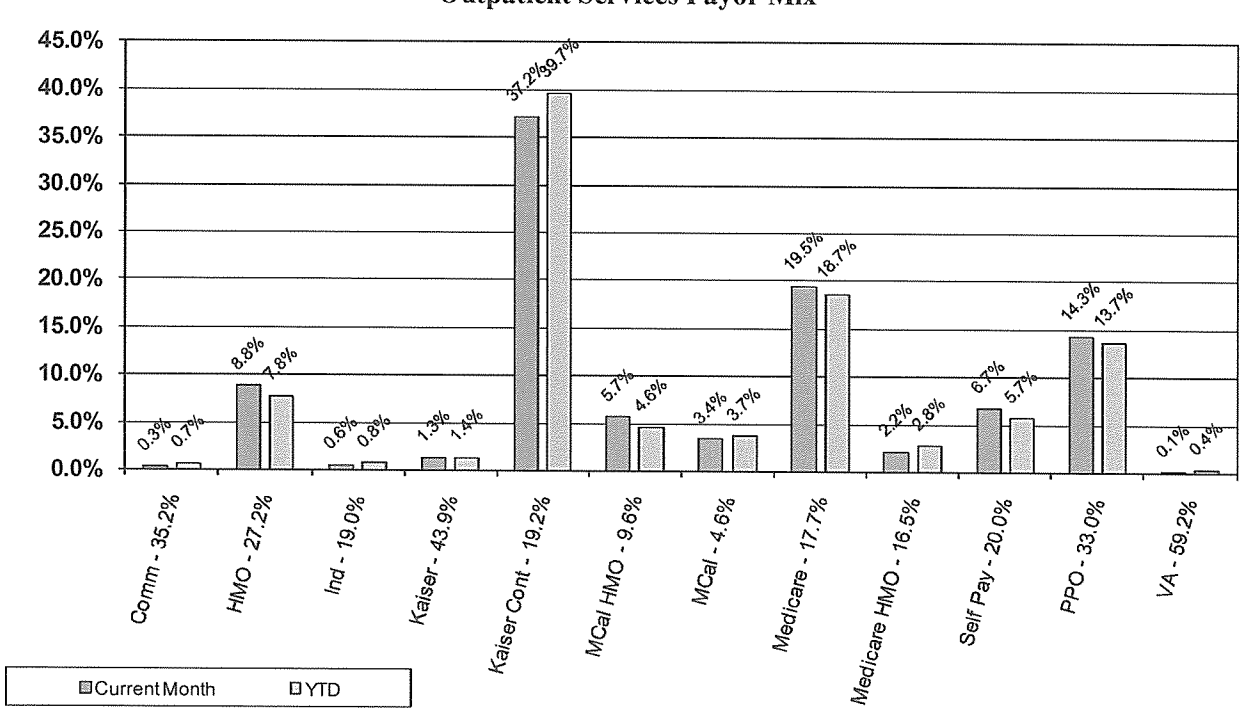
On the Hospital's inpatient acute care business, current month gross Medicare charges were 45.5% of our total inpatient acute care gross revenues. In August there was one case that hit outlier thresholds which favorably impacted net patient revenues in August. Additionally, the Medicare Case Mix Index (CMI) increased to 1.4064 from 1.3749 in July. These changes to the acuity level of Medicare patients treated during the month of August and the number of outlier cases resulted in our expected reimbursement for Medicare inpatient cases to increase slightly from July's estimate of 26.7% to 27.0% in August.



In August the Sub-Acute care program again was dominated by Medi-Cal utilization of 66.9%. The following graph shows the payor mix for August and the expected reimbursement rate for each payor.



The outpatient gross revenue payor mix for August was comprised of 38.5% Kaiser, 19.5% Medicare, 14.3% PPO and 8.8% HMO. The graph below shows the current month outpatient payor mix and expected level of reimbursement for each payor.

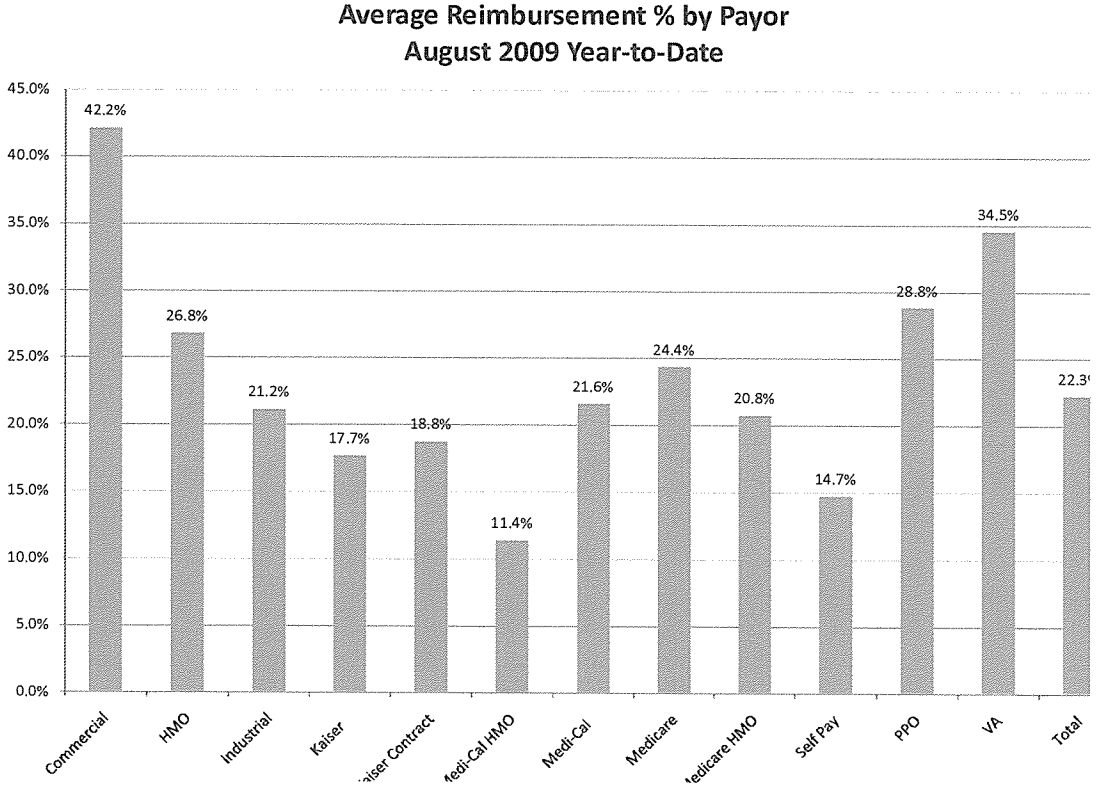


Deductions from Revenue

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 77.1% versus the budgeted 76.5%.

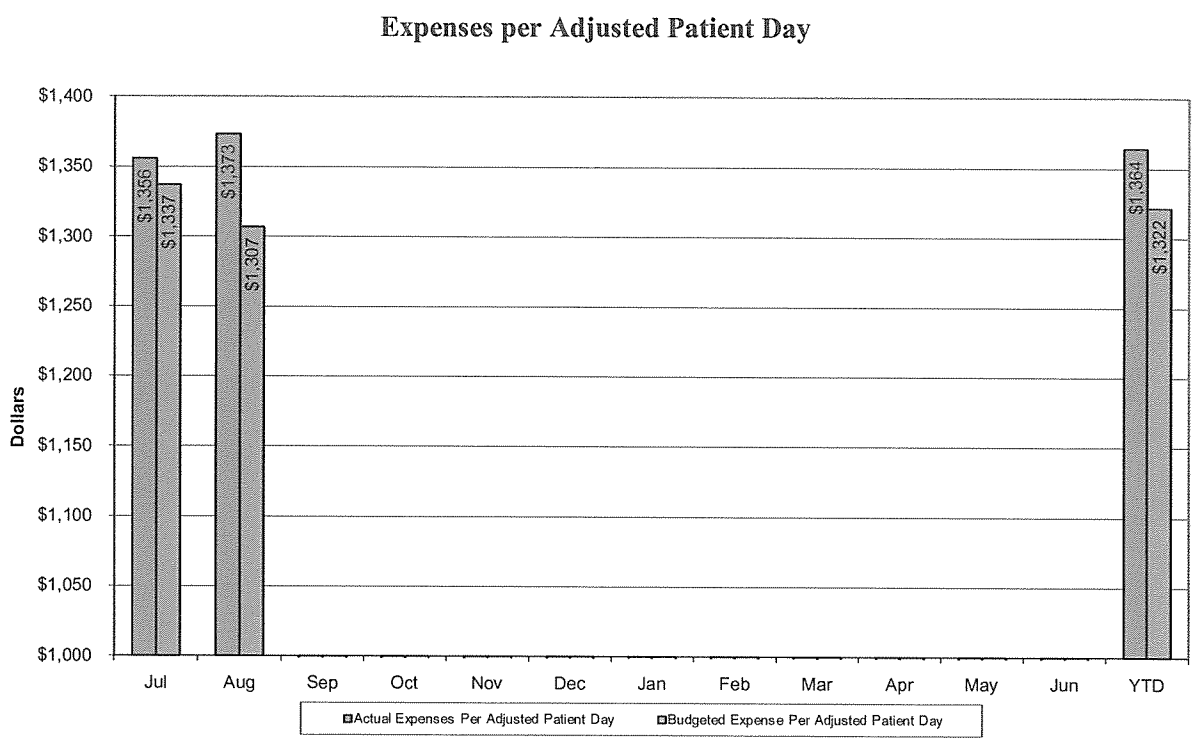
Net Patient Service Revenue

Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. The graph on the following page shows the level of reimbursement that the Hospital has estimated for fiscal year 2010 by major payor category.



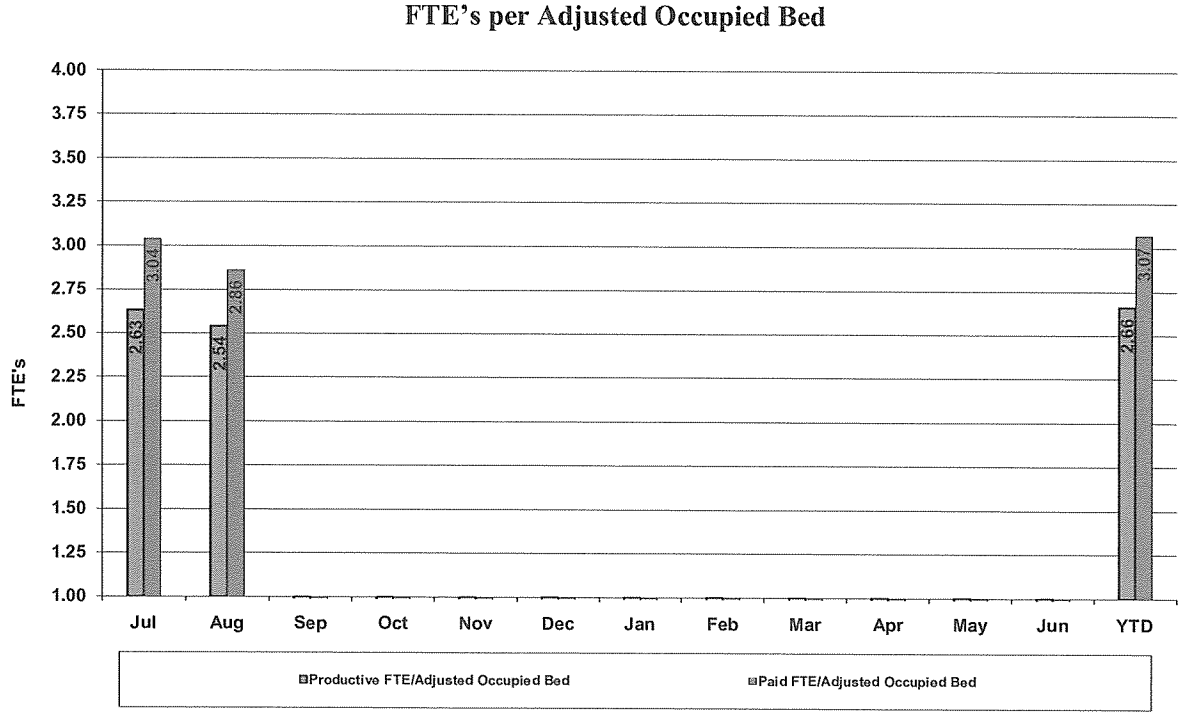
Total Operating Expenses

Total operating expenses were greater than the fixed budget by $287,000 or 4.7%. On an adjusted patient day basis, our cost per adjusted patient day was $1,373 which is $66 per adjusted patient day or approximately $306,000 unfavorable to budget. This variance was the result of unfavorable variances in three expense categories that included: salaries; benefits and supplies. The graph on the following page shows the hospital operating expenses on an adjusted patient day basis for the 2010 fiscal year by month and is followed by explanations of the significant areas of variance that were experienced in the current month.



Salary and Registry Expenses

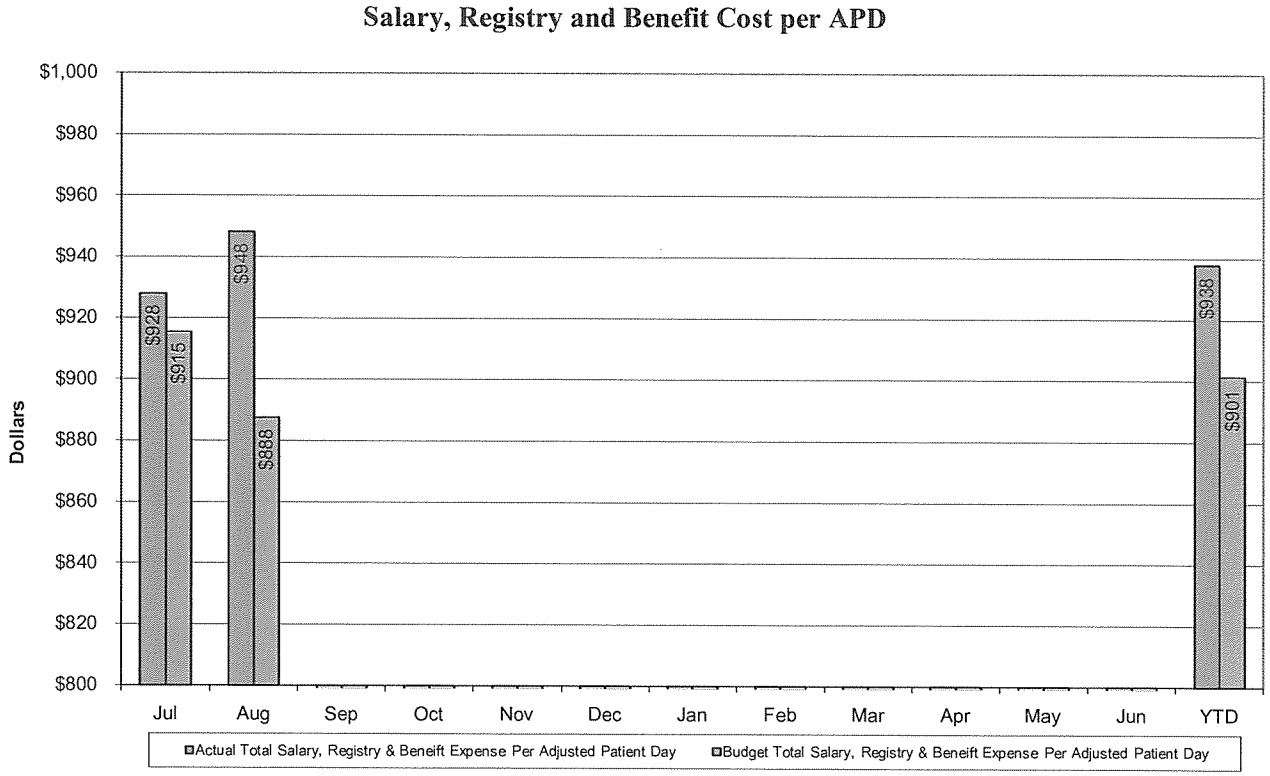
Salary and registry costs combined were unfavorable to the fixed budget by $190,000 and were $43 per adjusted patient day unfavorable to budget in August. On an adjusted occupied bed basis, productive FTE's were 2.54 in August versus the budgeted 2.56. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2010 by month and year to date.



Benefits

Benefit costs were $99,000 unfavorable to the fixed budget and $22 unfavorable to budget on an adjusted patient day basis in August. This unfavorable variance was the result of $139,000 adjustment of the health benefits incurred but not reported (IBNR) liability. This increase in IBNR was the result of a single claim that increased one of the twelve months used to calculate the average payment per claim from approximately $400 to over $1,200 per claim.

The following graph shows the combined salary, registry and benefit costs on an adjusted patient basis for FY 2010 by month.



Supplies

The supplies expense category was unfavorable to budget by $129,000. This unfavorable variance from the fixed budget was primarily the result of increased prosthetic, surgical supplies and pharmacy costs in August that were the result of the current months activities.

Depreciation and Amortization

Depreciation and amortization expense was $32,000 less than budgeted in August as a result of various pieces of equipment that were purchased in 2004 which became fully depreciated in June 2009.

The following pages include the detailed financial statements for the two month of fiscal year 2010 ended August 31, 2009.

ALAMEDA HOSPITAL
Balance Sheet
August 31, 2009

	August 31, 2009	July 31, 2009	Audited June 30, 2008
Assets			
Current assets:			
Cash and cash equivalents	$ 1,799,327	$ 1,816,210	$ 4,520,157
Net Accounts Receivable	9,741,842	9,818,379	7,944,523
Net Accounts Receivable %	33.07%	21.11%	20.17%
Inventories	1,033,125	1,019,383	1,048,503
Est.Third-party payer settlement receivable	225,510	215,425	245,115
Other assets	8,128,359	7,578,624	7,270,116
Total Current Assets	20,928,163	20,448,021	21,028,414
Restricted by contributors and grantors for capital acquisitions and research-Jabor Estate	487,818	478,185	602,817
Total Non-Current Assets	487,818	478,185	602,817
Fixed Assets:			
Land	877,945	877,945	877,945
Depreciable capital assets, net of accumulated depreciation	5,920,543	5,961,176	6,572,299
Total fixed assets, net of accumulated depreciation	6,798,488	6,839,121	7,450,244
Total Assets	$ 28,214,469	$ 27,765,327	$ 29,081,475
Liabilities and Net Assets			
Current Liabilities:			
Current portion of long term debt	$ 425,757	$ 433,400	$ 2,744,870
Accounts payable and accrued expenses	6,218,371	5,810,758	7,057,075
Payroll and benefit related accruals	4,634,325	4,298,493	3,133,574
Est.Third-party payer settlement payable	502,229	502,229	441,409
Other liabilities	6,535,555	6,872,229	8,190,529
Total Current Liabilities	18,316,237	17,917,109	21,567,457
Long-Term Liabilities:			
Debt borrowings net of current maturities	1,665,929	1,699,848	80,992
Total Long-Term Liabilities	1,665,929	1,699,848	80,992
Total Liabilities	19,982,166	19,616,957	21,648,449
Net Assets			
Unrestricted Funds	7,534,072	7,489,771	6,830,209
Restricted Funds	698,232	658,599	602,817
Net Assets	8,232,304	8,148,370	7,433,026
Total Liabilities and Net Assets	$ 28,214,469	$ 27,765,327	$ 29,081,475

City of Alameda Health Care District

Statements of Operations

August 31, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 14,403	$ 13,415	$ 988	7.4%	$ 12,478	$ 29,210	$ 27,306	$ 1,904	7.0%	$ 26,197
Gross Outpatient Revenues	11,224	10,325	899	8.7%	9,787	22,122	20,390	1,733	8.5%	20,206
Total Gross Revenues	25,628	23,740	1,888	8.0%	22,265	51,333	47,696	3,637	7.6%	46,403
Contractual Deductions	19,592	17,644	(1,948)	-11.0%	16,501	38,486	35,448	(3,038)	-8.6%	34,399
Bad Debts	114	442	328	74.2%	678	800	887	87	9.8%	1,499
Charity and Other Adjustments	43	85	42	49.6%	59	191	172	(20)	-11.4%	156
Net Patient Revenues	5,878	5,569	309	5.6%	5,027	11,855	11,189	667	6.0%	10,348
Net Patient Revenue %	22.9%	23.5%			22.6%	23.1%	23.5%			22.3%
Other Operating Revenue	35	15	20	133.5%	12	56	30	26	85.6%	22
Total Revenues	**5,914**	**5,584**	**330**	5.9%	**5,039**	**11,912**	**11,219**	**692**	6.2%	**10,371**
Expenses										
Salaries	3,248	3,059	(190)	-6.2%	2,752	6,466	6,172	(294)	-4.8%	5,527
Registry	146	168	23	13.4%	174	388	341	(48)	-14.0%	378
Benefits	998	899	(99)	-11.0%	853	1,937	1,806	(131)	-7.2%	1,765
Professional Fees	308	349	40	11.6%	314	661	697	36	5.2%	666
Supplies	911	782	(129)	-16.5%	723	1,820	1,553	(267)	-17.2%	1,532
Purchased Services	391	400	10	2.4%	338	777	795	17	2.2%	682
Rents and Leases	67	71	5	6.5%	52	132	143	11	7.5%	115
Utilities and Telephone	65	79	15	18.6%	75	141	159	18	11.3%	148
Insurance	47	46	(0)	-0.8%	49	92	92	0	0.1%	93
Depreciation and amortization	101	133	32	24.2%	123	201	266	64	24.3%	247
Other Operating Expenses	80	87	8	8.6%	53	172	175	3	1.6%	117
Total Expenses	**6,362**	**6,075**	**(287)**	-4.7%	**5,507**	**12,789**	**12,199**	**(590)**	-4.8%	**11,270**
Operating gain (loss)	**(448)**	**(490)**	**43**	8.7%	**(468)**	**(877)**	**(980)**	**103**	-10.5%	**(899)**
Net Non-Operating Income / (Expense)	**490**	**507**	**(17)**	-3.4%	**490**	**980**	**1,014**	**(34)**	-3.3%	**979**
Excess of Revenues Over Expenses	$ 42	$ 16	$ 25	155.0%	$ 22	$ 103	$ 34	$ 69	201.3%	$ 79

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

August 31, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,109	$ 2,886	$ 223	7.7%	$ 3,130	$ 3,116	$ 2,959	$ 157	5.3%	$ 3,478
Gross Outpatient Revenues	2,423	2,221	202	9.1%	2,455	2,360	2,210	150	6.8%	2,683
Total Gross Revenues	5,531	5,106	425	8.3%	5,585	5,475	5,169	307	5.9%	6,161
Contractual Deductions	4,229	3,795	(433)	-11.4%	4,139	4,105	3,841	(264)	-6.9%	4,567
Bad Debts	25	95	70	74.1%	170	85	96	11	11.3%	199
Charity and Other Adjustments	9	18	9	49.4%	15	20	19	(2)	-9.6%	21
Net Patient Revenues	1,269	1,198	71	5.9%	1,261	1,264	1,212	52	4.3%	1,374
Net Patient Revenue %	22.9%	23.5%			22.6%	23.1%	23.5%			22.3%
Other Operating Revenue	8	3	4	134.3%	3	6	3	3	82.7%	3
Total Revenues	1,277	1,201	75	6.3%	1,264	1,271	1,216	55	4.5%	1,377
Expenses										
Salaries	701	658	(43)	-6.6%	690	690	669	(21)	-3.1%	734
Registry	31	36	5	13.1%	44	41	37	(5)	-12.2%	50
Benefits	215	193	(22)	-11.4%	214	207	196	(11)	-5.6%	234
Professional Fees	67	75	8	11.3%	79	71	76	5	6.7%	88
Supplies	197	168	(28)	-16.9%	181	194	168	(26)	-15.3%	203
Purchased Services	84	86	2	2.1%	85	83	86	3	3.7%	91
Rents and Leases	14	15	1	6.2%	13	14	15	1	9.0%	15
Utilities and Telephone	14	17	3	18.3%	19	15	17	2	12.7%	20
Insurance	10	10	(0)	-1.2%	12	10	10	0	1.7%	12
Depreciation and Amortization	22	29	7	23.9%	31	21	29	7	25.5%	33
Other Operating Expenses	17	19	2	8.3%	13	18	19	1	3.2%	16
Total Expenses	1,373	1,307	(66)	-5.1%	1,382	1,364	1,322	(42)	-3.2%	1,496
Operating Gain / (Loss)	(96)	(105)	9	8.4%	(117)	(93)	(106)	13	-11.9%	(119)
Net Non-Operating Income / (Expense)	106	109	(3)	-3.1%	123	105	110	(5)	-4.9%	130
Excess of Revenues Over Expenses	$ 9	$ 4	$ 6	148.1%	$ 6	$ 11	$ 4	$ 7	186.0%	$ 11

ALAMEDA HOSPITAL
KEY STATISTICS
AUGUST 2009

	ACTUAL AUGUST 2009	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	AUGUST 2008	YTD AUGUST 2009	YTD FIXED BUDGET	VARIANCE	%	YTD AUGUST 2008
Discharges:										
Total Acute	220	228	(8)	-3.5%	220	504	465	39	8.4%	457
Total Sub-Acute	-	4	(4)	-100.0%	4	3	8	(5)	-62.5%	6
Total Skilled Nursing	11	13	(2)	-15.4%	4	21	26	(5)	-19.2%	4
	231	245	(14)	-5.7%	228	528	499	29	5.8%	467
Patient Days:										
Total Acute	951	933	18	1.9%	908	2,038	1,905	133	7.0%	1,930
Total Sub-Acute	1,042	1,027	15	1.5%	1,011	2,013	2,044	(31)	-1.5%	2,007
Total Skilled Nursing	611	667	(56)	-8.4%	315	1,284	1,334	(50)	-3.7%	315
	2,604	2,627	(23)	-0.9%	2,234	5,335	5,283	52	1.0%	4,252
Average Length of Stay										
Total Acute	4.32	4.09	0.23	5.6%	4.13	4.04	4.10	(0.05)	-1.3%	4.22
Average Daily Census										
Total Acute	30.68	30.10	0.60	2.0%	29.29	32.87	30.73	2.15	7.0%	31.13
Total Sub-Acute	33.61	33.13	0.50	1.5%	32.61	32.47	32.97	(0.50)	-1.5%	32.37
Total Skilled Nursing	19.71	21.52	(1.87)	-8.7%	10.16	20.71	21.52	(0.81)	-3.7%	5.08
	84.00	84.74	(0.77)	-0.9%	72.06	86.05	85.21	1.65	1.9%	68.58
Emergency Room Visits	1,550	1,362	188	13.8%	1,336	3,124	2,766	358	12.9%	2,714
Outpatient Registrations	2,607	2,836	(229)	-8.1%	2,441	5,068	4,913	155	3.2%	4,995
Surgery Cases:										
Inpatient	64	44	20	45.5%	52	134	106	28	26.4%	127
Outpatient	429	414	15	3.6%	396	868	811	57	7.0%	869
	493	458	35	7.6%	448	1,002	917	85	9.3%	996
Kaiser Inpatient Cases	13	9	4	-	4	31	19	12	-	19
Kaiser Eye Cases	168	160	8	5.0%	140	317	293	24	8.2%	324
Kaiser Outpatient Cases	153	142	11	7.7%	149	337	301	36	12.0%	313
Total Kaiser Cases	334	311	23	7.4%	293	685	613	72	11.7%	656
% Kaiser Cases	67.7%	67.9%			65.4%	68.4%	66.8%			65.9%
Adjusted Occupied Bed	149.46	149.91	0.45	0.3%	128.59	151.22	148.81	2.41	1.6%	121.48
Productive FTE	379.91	384.25	4.34	1.1%	362.15	391.10	383.60	(7.50)	-2.0%	366.57
Total FTE	427.61	433.79	6.18	1.4%	413.79	446.14	437.92	(8.22)	-1.9%	417.87
Productive FTE/Adj. Occ. Bed	2.54	2.56	0.02	0.8%	2.82	2.59	2.58	(0.01)	-0.3%	3.02
Total FTE/ Adj. Occ. Bed	2.86	2.89	0.03	1.1%	3.22	2.95	2.94	(0.01)	-0.3%	3.44

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: October 12, 2009

TO: Board of Directors
City of Alameda Health Care District

FROM: Deborah E. Stebbins
Chief Executive Officer

Subject: Formula for Calculating FY 2009 Executive Compensation Payment

---

Attached is a summary of the performance and accomplishments of the executive team who participate in the Executive Incentive compensation program.

To summarize how the formula for computing the percentage pay-out:

BASE INCENTIVE COMPONENTS	WEIGHT FACTOR	PROPOSED SCORE
FINANCIAL SUCCESS		
• Achievement of Breakeven (Threshold) • Net Margin	60%	60%
• Achievement of Budgeted Net Revenue	10%	10%
QUALITY/SATISFACTION	10%	10%
WORKFORCE SUCCESS	10%	9%
OPERATIONAL SUCCESS	10%	10%
SUBTOTAL	**100%**	**99%**
STRETCH INCENTIVE COMPONENTS		
Achievement of Target Net Margin of $275,000		**100%**
Achievement of Target Net Margin of $275,000		**0%**

Therefore the payment for the base incentive would be calculated for the CEO at:

25% x 99% performance x base annual salary.

In addition, because the first "stretch" financial objective for 2009 was met, the participants in the incentive program have earned an additional incentive. Payment for the stretch incentive would be calculated for the CEO at:

6.25% x base annual salary

A detailed report on management performance is attached as further documentation of the recommended scores.

Recommendation:

That the Board of Directors approve:

1. The detailed assessment of the performance against the FY 2009 metrics and the recommended scores, and

2. The payment of the incentive outlined above to the CEO, in accordance with the executive incentive plan approved by the Board on March 2, 2009 and

3. Authorize the CEO to approve similar incentive payments to the other participating executives.

Note that all proposed incentive compensation amounts are fully accrued and funded.

Alameda Hospital FY2009 Executive Incentive Compensation

INTRODUCTION

Payment of any incentive compensation to an executive is predicated upon a performance evaluation of "meets expectations" or above.The base percentage bonus (based on % base compensation) for the Chief Executive Officer is established by the Board. The Incentive compensation levels for other participating executives are estabiiished by the CEO. Metrics are approved each year by the Board, including any target or high stretch financial objectives.

The Chief Executive Officer (CEO) is responsible for recommending additional executive participants in an incentive Plan to the Board. The CEO is responsible for structuring the terms of their incentive in a manner consistent with the Executive incentive compensation system. In FY 2009, the full incentive compensation target for the CEO and other participating executives has been accrued at the "taget" financial level and at full achievement of the other three areas to ensure that the incentive payments are appropriately funded. In FY 2010, we will include a projected expense for incentive payments in the budget. The Excess Revenue over Expense will include the Hospital and South Shore only and exclude CWS and the 501(c)3 corporation. Based on the audited financials for FY 2009, the organization achieved a bottom line of $439,570 (excluding CWS and 501(c)3) and achieved the budgeted annual operating revenue of $63,252,000. This places the financil performance well above the "target" level of net income > expense of $275,000, but less that the "high" performance of $550,000.

The proportion of pay-out of the bonus is based on the achievement of the metrics outlined below in the following areas:

	Weighting
Financial Success	70%
Quality / Satisfaction	10%
Workforce Success	10%
Operational Success	10%
Total	100%

Metrics for FY 2009 are suggested; in some cases, metrics for FY 2010 are also suggested which build upon the 2009 metrics. In the report that follows, the status column provides an update on perfomrance against the FY 2009 metrics. At the bottom of each section, in red, is the recommended score on each of the metrics

Goals	Actions	Measures				Weighting Points
Financial Success						**70**
Achieve our FY10 Financial Targets & Goals	**Tripwire: Excess Revenues over Expenses. Must meet threshold or no incentive compensation paid**	Threshold	Target	High	Net Revenue > Expense = $439,570, excluding CWS and 501(c)3	**60**
		Breakeven	$275,000	$550,000 or >		
	Total Operating Revenues	Total Operating Revnue at Budget Levels (2009)			Actual Annual Operating Revenue of $63,252,000 vs Budget of $63,168,000 RECOMMENDED SCORE: 70	**10**

Note for Additional Bonus at "Target" or "High" Financial Performance:

There is a potential for an upside gain beyond an executive's base bonus in the event of extraordinary achievement in the actual net income for the year. These levels are highlighted in the yelow boxes above, for FY 2010.

Participant	Base Bonus (% base salary)	Threshold	Target (% base salary)	High (% base salary)	Total Potential Bonus (% base salary)
Stebbins	25%	25%	6.25%	6.25%	37.5%
Easthope	15%	15%	3.75%	3.75%	22.50%
Neapolitan	15%	15%	3.75%	3.75%	22.50%

Goals	Actions	Measures		Weighting Points
Quality / Satisfaction Success				**10**
Improve Customer Satisfaction, Engagement & Referenceability	Eastbalish and disseminate Code of Conduct (2009)	Maintain willingness to recommend at 80% (2009): Improve willingness by 2% (2010).	New code of conduct drafted and undergoing review at MEC and Board level. Willingness to recommend per HCAHPS standards = 93.7% compared to 80% target RECOMMENDED SCORE: 4	4
Overall Quality	Organize preparation for 2010 Joint Commission Survey	Joint Commission Accreditation to acceptable level (2010)	TJC Task Force established and meeting bi-weekly Staff and physician education initiated Began bi-weekly Tracer studies Update all of policies and procedures RECOMMENDED SCORE: 4	4
Specific Quality	Implement customer service excellence program	Improve HCAHPS score on noise levels by 2% (2010)	Implemented 12 behaviors CARE program with one behavior spotlighted bi-monthly Program administered through Service Excellence Committee RECOMMENDED SCORE: 2	2

Goals	Actions	Measures		Weighting Points
Workforce Success				**10**
Invest in employee training, development and engagement	Establish or select a commerciallly available employee satisfaction tool.	Measure baseline (2009)	• First employee attitude survey, using NRC Picker tool in 2009. Results became available in September 2009. 29% employee participation which compares well with NRC picker average returns.	**5**
		Target Improvement (2010)		
	Design employee reward /recognition program geared to code of conduct	Employee turnover rates < Bay Area average	Have instituted numerous informal recognition programs that have been well received: Birthday and sympathy cards, year end thank you letter, hospital week/nursing celebrations. Nurse of the year award instituted RECOMMENDED SCORE: 4	
Build the strength and depth of our leadership teams to support future growth	Implement middle manager training program (2009-2010)	75% middle managers complete training by 2010	12 month Crestcom middle management program initiated in February 2009. 27 managers participating with excellent reviews thus far of program effectiveness. Has also provided good vehicle for team building. RECOMMENDED SCORE: 5	**5**

Goals	Actions	Measures		Weighting Points
Operational Success				**10**
Develop Critical Capabilities in Planning, Product Development & Marketing Effectiveness		Complete at least 3 service line analyses (2009) and recommend action / improvement	Completed service line analysis for Kaiser contract, South Shore (feasibility study), 1206B community clinic. Results used to strategize Kaiser negotiation structure and advance two new programs	3
		Develop physician recruitment vehicle (2009)	Establish 1206B community clinic as recruitment vehicle for physicians seeking quasi employment structure. Hired OB/GYN RECOMMENDED SCORE: 3	
Simplify Core Business Processes and Build a Scalable, Cost-Efficient Infrastructure	Establish marketing program directed to Bay Farm residents (2009)	Market Share growth in Bay Farm Area by 2% (2010)	Implemented outreach program to Bay Farm based on focus group results, emphasizing physician specialists and primary care. (4 mailings) Have sought location for primary care practitioner practice in Bay Farm retail development without success so far. RECOMMENDED SCORE: 3	3
Reduce Waste & Drive Operational Efficiency		Formulate Master Plan options by 06/30/09	Presented 4 different master plan scenarios to Board and Strategic Planning and Community Relations Committee. Also have developed framework to meet 2013 standards for which we are currently developing definitive plans and pricing.	4
		Finalize master facility plan (late 2009)	RECOMMENDED SCORE: 4	

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: OCTOBER 12, 2009

TO: BOARD OF DIRECTORS

FROM: ALKA SHARMA, MD
CHAIRMAN, MEDICAL EXECUTIVE COMMITTEE

SUBJECT: **PROPOSED REVISION TO MEDICAL STAFF RULES AND REGULATIONS**

The Medical Executive Committee respectfully requests your consideration in approving the proposed amendment to Article I-A, Section H, Physician Assistant Performance Standards, Section B.b). If approved, subsequent paragraphs under Section B of the Performance Standards will be re-lettered.

The proposed amendment allows physician assistants in the Emergency Department to provide an appropriate EMTALA compliant medical screening examination.

>><<

Attachment

TITLE:	EFFECTIVE DATE:
ARTICLE: 1-A ALLIED HEALTH PROFESSIONAL STATUS	12/09/97 12.08.98 10/01/02 12/10/02 06/09/03 01/28/05
	PAGE: 1 OF 2

A. Allied Health Professional Status

1. Eligibility to Apply for Allied Health Professional Status

The Governing Body shall determine, based upon recommendation of the Medical Executive Committee and such other information as it has before it, those categories of allied health professionals (AHPs) that shall be eligible to exercise privileges in Alameda Hospital (hereafter referred to as Hospital).

2. Qualifications of Allied Health Professionals

Allied health professionals are not eligible for Medical Staff membership. An AHP may be granted practice privileges if he/she holds a current, unrestricted California license, certificate or other legal credential in a category of AHP that the Governing Body has identified as eligible to apply for practice privileges and only if the AHP is professionally competent and continuously meets the qualifications, standards and requirements set forth in these rules.

3. Requirements for Supervision

AHPs shall be subject to the supervision requirements of state and federal regulatory and licensing agencies as well as any additional requirements developed by the service committees and approved by the Interdisciplinary Practice Committee, the Medical Executive Committee and the Governing Body.

B. Categories of Allied Health Professionals

1. Approved Categories

The categories of AHPs currently eligible to apply for practice privileges are:

a. Physician Assistant
b. RN First Assistant
c. Clinical Psychologist
d. Certified Registered Nurse Anesthetist

ALAMEDA HOSPITAL
PHYSICIAN'S ASSISTANT PERFORMANCE STANDARDS

A. REQUIREMENTS:

1. A Certified Physician's Assistant shall be currently licensed by the Examining Committee of the Medical Board of California.

2. A Certified Physician's Assistant shall maintain certification throughout the term of his affiliation with the Hospital.

3. A Certified Physician's Assistant shall maintain a current D.E.A. number if application is made for prescribing privileges.

4. A Certified Physician's Assistant shall have a supervising physician who:

   a) Is a physician currently licensed by the State of California;

   b) Is a current member in good standing of the Medical Staff of the Hospital and practices actively at the Hospital; and meets the requirements set forth in Section C below.

B. SCOPE OF PRACTICE:

1. A Certified Physician's Assistant may receive privileges to perform the following professional services at the Hospital:

   a) Take an appropriate history, perform an appropriate physical examination, make an assessment of the patient, and record the pertinent data in a manner meaningful to the supervising physician;

   b) Provide an appropriate EMTALA compliant medical screening examination in the Emergency Department.

   b) Perform or assist in performing screening procedures delegated by the supervising physician, provided that the procedures are consistent with the supervising physician's practice and with the patient's condition;

   c) Perform or assist in procedures such as wound care, aspiration of seromas, removal of superficial foreign bodies, staple/suture removal, wound closure, suturing, soft tissue injection; IV starts, NG tube insertion, foley catheter insertion;

   d) Recognize and evaluate situations which call for the immediate attention of the supervising physician and institute, when necessary, treatment procedures essential for the life of the patient including CPR and ACLS;

   e) Instruct and counsel patients regarding matters pertaining to their physical and mental health, such as diets, social habits, family planning normal growth and development, aging, and long term management of disease;

   f) Assist the supervising physician by arranging admissions, making appropriate entries in the patient's medical record, reviewing treatment and therapy plans, transmitting orders for routine diagnostic laboratory tests and radiological services, ordering therapeutic diets, ordering physical therapy treatment, ordering occupational therapy treatment, ordering respiratory care services;

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: October 12, 2009

To: City of Alameda Health Care District Board of Directors

Through: Strategic Planning and Community Relations Committee

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Recommendation to Approve Capital Expenditure Authority for Seismic Planning

---

Background:

Under the direction of the Strategic Planning Committee, management has been working with outside consultants, architects and engineers to better understand the scope of work and options available to comply with the 2013 California seismic retrofit requirements (SB 1953). After considering various master plan options with the Strategic Planning Committee, it was discussed that management should proceed with developing the plans required to comply with the most immediate 2013 seismic requirements while simultaneously pursuing legislation that would delay the date of compliance.

Recommendation:

By recommendation of the Strategic Planning and Community Relations Committee, it is hereby being requested that the Board of Directors authorize the Chief Executive Officer with spending authority up to $200,000 to be used for the sole purpose of advancing the planning process as required to comply with the California Seismic requirements as outlined in SB 1953. This $200,000 request is inclusive of the $71,000 recommendation to engage Fugro West that was presented at the September Board Meeting. It is also inclusive of the $34,700 ($22,000 + $12,700) spent to date on engineering fees to Thornton Tomasetti for services provided as outlined above. This would leave a balance of approximately $94,300 for future services to be provided by Ratcliff Architects, The Marshall Associates and Thornton Tomasetti. Management will continue to provide monthly status updates to the Strategic Planning Committee and Board of Directors.

Discussion:

There are five main components that need to be addressed to meet the requirements of the hospitals Structural Performance Criteria (SPC). These include: External bracing of the Stephens and West buildings, removal of the bridge between the 1925 building and the

Stephens building, resolution to the potential liquefaction concern with the Stephens and West buildings, removal of all "essential" services from the 1925 building (Dietary Services, Health Information Management, the Morgue, and Administrator's Office), and finally, decommissioning the 1925 building.

The hospital has been working with the structural engineering firm Thornton Tomasetti on the structural and non-structural components of these projects. Our contact at Thornton Tomasetti is structural engineer, Bill Dasher, who has been working with the hospital with its seismic planning, on and off, over the past several years. Because of his historical knowledge of our seismic deficiencies and the fact that much of the initial planning and document preparation has already been complete, it is recommended that the hospital continue with this contractor.

Non-Structural Performance Criteria (NPC) Work:

To date, Thornton Tomasetti has updated, revised and is in the process of submitting plans to the Office of Statewide Health Planning and Development (OSHPD) for the NPC work. The cost incurred to date for this component has been $22,000 and it is substantially complete except for any plan revisions that may come back from OSHPD.

Liquefaction Risk:

Thornton Tomasetti has consulted with representatives from the California Geological Surveyor's office at the State, as well as, representatives from Fugro West, the geological engineering firm, on the best approach to determine the degree of liquefaction risk below the Stephens and West buildings. We believe the approach deemed to be most efficient and effective is contained in the Fugro Proposal and is being recommended under a separate memorandum. The approach being recommended will be most effective in determining whether liquefaction is an issue. If the results of this testing are favorable (i.e. demonstrating minimal risk of liquefaction), it could save the hospital several hundred thousand dollars in additional engineering and construction costs. If the results are unfavorable, the goal would be to use the data gathered to incorporate into construction plans for OSHPD approval.

Kitchen Relocation:

Nearly as complicated as the liquefaction risk component, is determining the scope of work and best approach for relocation of dietary services. Management has had initial discussions with Ratcliff Architects and Steve Marshall, with The Marshall Associates, who specializes in hospital kitchen design and install. A proposal will be forthcoming in October to develop plan options for this component. Note: In 2003 – 2004, the hospital worked with Ratcliff and The Marshall Associates who have already performed a significant amount of the initial concept planning for a new kitchen.

External Bracing & Bridge Planning:

In the meantime, Thornton Tomasetti continues to develop the specifications that will be required to address this component of the project. Expenditures to date for this work is $12,700.

Summary:

In order for the architectural and engineering firms to develop meaningful proposals to complete the planning, plan development / OSHPD approval work, additional consultation with management, testing and discovery are required to understand the scope of work and what will be involved on most of these project components. We recommend the above in order to facilitate this work and to keep the hospital's seismic project moving forward.

Audited Financial Statements

CITY OF ALAMEDA
HEALTH CARE DISTRICT

Dba ALAMEDA HOSPITAL

June 30, 2009

Audited Financial Statements

CITY OF ALAMEDA HEALTH CARE DISTRICT

June 30, 2009

Management's Discussion and Analysis 1

Report of Independent Auditors 8

Audited Financial Statements
- Balance Sheets 9
- Statements Revenues, Expenses and Changes in Net Assets 10
- Statements of Cash Flows 11
- Notes to Financial Statements. 13

Management's Discussion and Analysis

CITY OF ALAMEDA HEALTH CARE DISTRICT

June 30, 2009

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, 2009 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's 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, 2009 and accompanying notes to the financial statements to enhance one's understanding of the Hospital's financial performance.

Volumes and Statistics

- Acute care patient days were 11,787 for fiscal year 2009 as compared to 11,276 for the prior year. Discharges were 2,812 for the current year versus 2,885 for the prior year resulting in lengths of stay of 4.19 for 2009 as compared to 3.91 for 2008.

- Sub-acute and skilled nursing days were 18,676 for fiscal year 2009 as compared to 11,411 for fiscal year 2008, equaling an average daily census of 51.17 for 2009 versus 31.18 for 2008. The significant increase in volume in this category was the result of the acquisition of a 26-bed skilled nursing facility on August 16, 2008 as well as increasing the number of certified sub-acute beds from 30 to 35 during fiscal year 2008.

- Overall combined occupancy for the Hospital, including the sub-acute and skilled nursing programs, was 52.94% for the year ended June 30, 2009 versus 45.92% for the year ended June 30, 2008.

- Surgery cases for the fiscal year 2009 were higher than the prior year. There were 5,885 cases (690 inpatient and 5,195 outpatient) as compared to 5,410 cases for the prior fiscal year (706 inpatient and 4,704 outpatient). Kaiser cases were 4,009 in 2009 versus 3,382 in 2008.

- Outpatient registrations decreased by 995 registrations over the prior year (29,948 for 2009 versus 30, 943 for 2008).

- Emergency room visits were 17,337 in the fiscal year 2009 as compared to 17,922 for the prior year.

- FTE's per adjusted occupied bed were 2.93 for 2009 versus 3.69 for the prior year.

Financial Highlights

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

The current economic conditions have also added challenges to the health care market. As the economy has weakened during this past fiscal year, there have been inflationary pressures on medical supplies, devices and pharmaceuticals. The expectation by labor for increased wages and benefits continues to exceed the rate of inflationary growth. Employers have reduced healthcare coverage for employees and increased deductibles. Unemployment across the nation has increased significantly and, with an increase in unemployment, there is a corresponding increase in uncompensated care and bad debt.

Despite these challenges, the Hospital was able to continue to improve its financial performance overall. Some of the factors that contributed to the Hospital's improved financial performance include:

- The acquisition of a 26-bed skilled nursing facility in August, 2008 that added to the Hospital's continuum of care for residents of Alameda.
- The opening of the Alameda Hospital Physicians Community Clinic at the Alameda Town Center in January, 2009. The Clinic will provide additional primary care and specialty physician care services to the community.
- The increase in the number of certified sub-acute beds from 30 to 35 during fiscal year 2008.
- Continued focus on ensuring that Hospital operating expenses are maintained at optimal levels while ensuring that each department delivers the highest quality of care to our patients.
- Modifications to the employee health care plan design that requires greater employee participation, including employee contributions for dependant coverage.

Those factors resulted in the following highlights:

- Net assets increased by $730,000 in 2009 as compared to a decrease in 2008 of $2,350,000
- Net patient service revenues increased by $6,825,000 while total operating expenses increased by $3,742,000 over the prior fiscal year.

- The Hospital's operating loss, before parcel tax revenue, was $5,414,000 for fiscal year 2009 as compared to $8,537,000 for fiscal year 2008.

- Current assets decreased by $516,000 while current liabilities decreased by $3,574,000 over the prior fiscal year. The current ratio at June 30, 2009 was 1.15 as compared to 0.98 for the prior year.

- Total assets decreased by $1,201,000 over the prior fiscal year. Total operating cash and cash equivalents decreased by $2,656,000 over the prior year (see the *Statements of Cash Flows* for changes). In addition, net patient accounts receivable increased by $2,125,000. Net days in patient accounts receivable were 57.26 at June 30, 2009 as compared to 51.70 at June 30, 2008.

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

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

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

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

Balance Sheet - Assets

For the fiscal year ended June 30, 2009, the Hospital's total unrestricted and restricted cash and investments totaled $2.5 million as compared to $5.3 million in the prior fiscal year. At June 30, 2009, days cash on hand was 13.56 as compared to 30.61 for the prior year. The Hospital's goal is to maintain sufficient cash and cash equivalent balances to pay all short-term liabilities.

During the year, the Hospital added $862,000 in capital assets. The development of a new community clinic at he Alameda Town Center made up the largest of the construction projects at $189,000 of the total construction in progress accounts of $533,000. Additionally, the Hospital purchased $349,000 of various medical equipment items with the largest item in this category being a $128,000 surgical sterilization unit.

Balance Sheet - Liabilities

As previously noted, current liabilities of the Hospital decreased by $3.6 million from the prior year. This was due mainly to decreases in current maturities of debt borrowings by $2,297,000, decreases in trade payables by $856,000, decreases in deferred revenues by $827,000, decreases in third party payor settlements by $135,000, decreases in health insurance claims by $91,000. Offsetting these decreases was an increase in accrued payroll and related liabilities of $632,000.

Balance Sheet - Net Assets

The Hospital reports its net assets in three categories:

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

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

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

Statement of Revenues, Expenses and Changes in Net Assets

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

Gross Patient Charges

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

Acute inpatient gross charges increased by $10.2 million or 8.2% mainly due the volume increases as previously stated and a mid-year price increase. Subacute and skilled nursing unit charges increased by $8.2 million or 46% as a result of the addition of the 26-bed unit and the mid-year price increase.

Outpatient gross charges increased by $14.2 million or 13.2%. due to the mid-year price increase, increases in surgical volumes and continued revenue cycle enhancements to ensure that all services provided are captured as other outpatient volumes decreased slightly from the prior year.

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 2009 and fiscal year 2008 were $7.6 million and $6.1 million, respectively. As a percentage of gross patient charges, the allowance has increased from 2.4% in fiscal year 2008 to 2.7% in fiscal year 2009.

Contractual allowances and the provision for bad debts (as a percentage of gross patient charges) were 77.7% for fiscal year 2009 as compared to 77.5% for fiscal year 2008. The increase in contractual allowances was due primarily to the price increase implemented during fiscal year 2009, offset by increases in reimbursement from third party contracts and slight increases from government based programs.

Net Patient Service Revenues

Net patient service revenues is the difference between gross patient charges and the deductions from revenue. Net patient service revenues increased by $6,825,000 or 12.1% as a result of increased inpatient acute census levels, the newly added 26-bed distinct part skilled nursing unit, increased sub-acute unit capacity, a mid-year price increase and improved reimbursement from third-party payors.

Operating Expenses

Total operating expenses were $68.67 million for fiscal year 2009 compared to $64.92 million for fiscal year 2008. The 5.8% increase is due primarily to:

- A $3.8 million or 8.8% increase in salaries, wages, registry and benefits. Total full time equivalents (FTE's) were 430.99 in 2009 versus 400.47 in 2008, a 7.4% increase over the prior year. Of this increase, approximately $1.0 million and 19.7 FTE's were the result of the new 26-bed skilled nursing unit that was added in August, 2008.

- Other variable expenses (generally volume driven) such as professional fees, supplies and purchased services increased slightly during the year by approximately $343,000 while other somewhat fixed expenses decreased. The most significant item in this category was insurance, which decreased by $187,000 as a result of the Hospital's continued ability to minimize exposure to malpractice claims. Depreciation expense decreased by $372,000 due to certain assets becoming fully depreciated during the year.

Statement of Cash Flows

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

The main sections of the statement of cash flows include:

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

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

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

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

Economic Factors and Next Fiscal Year's Budget

The Hospital's board approved operating and capital budgets for fiscal year ending June 30, 2010 at the June 2009 Board meeting. For fiscal year 2010, the Hospital is budgeted to increase its net assets by $359,000. The increase is due to several assumptions:

- A conservative increase in volumes for fiscal year 2010 was budgeted, with consideration given to increased expectations within inpatient services resulting from a full year of the skilled nursing unit and increased outpatient services resulting from the formation of a community clinic.

- 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 7.0% or $4.8 million over 2009. The cost for labor (salaries and registry) is projected to increase by $2.8 million. Consumer price index (CPI) increases of 3% were applied to the cost of supplies and purchased services.

Management believes that the 2010 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 ensure the provision of quality health care services to the residents of the City of Alameda Health Care District.

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: ricteca@aol.com

Report of Independent Auditors

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

We have audited the accompanying balance sheets of the City of Alameda Health Care District (the Hospital) as of June 30, 2009 and 2008, and the related statements of revenues, expenses, and changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. 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 audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the City of Alameda Health Care District at June 30, 2009 and 2008, and the changes in its net assets and its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

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

TCA Partners, LLP

September 9, 2009

Balance Sheets

CITY OF ALAMEDA HEALTH CARE DISTRICT

	June 30 2009	2008
Assets		
Current assets:		
Cash and cash equivalents	$ 2,034,709	$ 4,690,518
Patient accounts receivable, net of allowances	10,069,536	7,944,522
Other receivables	6,206,763	6,682,339
Estimated third party payor settlements	351,648	245,115
Inventories	1,291,072	1,048,503
Prepaid expenses and deposits	729,301	587,777
Total current assets	20,683,029	21,198,774
Assets limited as to use	468,209	602,817
Capital assets, net of accumulated depreciation	7,237,461	7,789,004
Total assets	$ 28,388,699	$ 29,590,595
Liabilities and Net Assets		
Current liabilities:		
Current maturities of debt borrowings	$ 447,948	$ 2,744,870
Accounts payable and accrued expenses	6,200,897	7,057,073
Accrued payroll and related liabilities	3,765,683	3,133,574
Deferred revenues	6,524,800	7,351,860
Estimated third party payor settlements	306,588	441,409
Health insurance claims payable (IBNR)	747,912	838,670
Total current liabilities	17,993,828	21,567,456
Debt borrowings, net of current maturities	1,722,417	80,992
Total liabilities	19,716,245	21,648,448
Net assets:		
Invested in capital assets, net of related debt	7,195,316	7,468,754
Restricted, by contributors	468,209	602,817
Unrestricted	1,008,929	(129,424)
Total net assets	8,672,454	7,942,147
Total liabilities and net assets	$ 28,388,699	$ 29,590,595

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	
	2009	2008
Operating revenues		
Net patient service revenue	$ 63,066,682	$ 56,241,823
Other operating revenue	185,056	144,451
Total operating revenues	63,251,738	56,386,274
Operating expenses		
Salaries and wages	35,025,781	32,022,845
Registry	2,685,554	1,864,163
Employee benefits	10,102,828	10,079,998
Professional fees	3,270,038	4,030,212
Supplies	9,106,288	8,483,048
Purchased services	4,132,484	3,651,663
Building and equipment rent	662,854	581,198
Utilities and phone	840,808	865,943
Insurance	533,366	720,305
Depreciation and amortization	1,415,682	1,787,352
Other operating expenses	890,175	836,768
Total operating expenses	68,665,858	64,923,495
Operating income (loss)	(5,414,120)	(8,537,221)
Nonoperating revenues (expenses)		
District tax revenues	5,764,021	5,745,308
Investment income	48,073	122,247
Interest expense	(143,167)	(156,562)
Rent and other income	234,037	340,921
Grants and contributions	241,463	134,859
Total nonoperating revenues (expenses)	6,144,427	6,186,773
Increase (decrease) in net assets	730,307	(2,350,448)
Net assets at beginning of the year	7,942,147	10,292,595
Net assets at end of the year	$ 8,672,454	$ 7,942,147

See accompanying notes and auditor's report

Statements of Cash Flows

CITY OF ALAMEDA HEALTH CARE DISTRICT

	Year Ended June 30	
	2009	2008
Cash flows from operating activities:		
Cash received from patients and third-parties on behalf of patients	$ 60,700,314	$ 54,903,738
Cash received from operations, other than patient services	89,572	705,781
Cash payments to suppliers and contractors	(23,708,594)	(19,597,435)
Cash payments to employees and benefit programs	(44,496,500)	(42,121,402)
Net cash provided by operating activities	(7,415,208)	(6,109,318)
Cash flows from noncapital financing activities:		
District tax revenues	5,764,021	5,745,308
Grants and contributions	241,463	134,859
Net cash provided by noncapital financing activities	6,005,484	5,880,167
Cash flows from capital financing activities:		
Purchase and donations of capital assets, net of loss on disposals	(630,102)	(224,495)
Proceeds from debt borrowings	2,260,000	1,524,741
Principal payments on debt borrowings	(2,915,497)	(779,072)
Interest payments on debt borrowings	(143,167)	(156,562)
Net cash provided by (used in) capital financing activities	(1,428,766)	364,612
Cash flows from investing activities:		
Net change in assets limited as to use and other assets	134,608	(134,859)
Investment income	48,073	122,247
Net cash provided by (used in) investing activities	182,681	(12,612)
Net increase (decrease) in cash and cash equivalents	(2,655,809)	122,849
Cash and cash equivalents at beginning of year	4,690,518	4,567,669
Cash and cash equivalents at end of year	$ 2,034,709	$ 4,690,518

See accompanying notes and auditor's report

Statements of Cash Flows (continued)

CITY OF ALAMEDA HEALTH CARE DISTRICT

	Year Ended June 30	
	2009	2008
Reconciliation of operating income to net cash provided by operating activities:		
Operating income (loss)	$ (5,414,120)	$ (8,537,221)
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	1,415,682	1,787,352
Provision for bad debts	7,563,989	6,080,303
Changes in operating assets and liabilities:		
Patient accounts receivables	(9,689,003)	(6,828,439)
Other receivables	475,576	(447,002)
Inventories	(242,569)	(98,723)
Prepaid expenses and deposits	(141,524)	633,321
Accounts payable and accrued expenses	(856,176)	512,597
Accrued payroll and related liabilities	632,109	(18,559)
Estimated third party payor settlements	(241,354)	(589,949)
Deferred revenues	(827,060)	1,008,332
Health insurance claims payable (IBNR)	(90,758)	388,670
Net cash provided by operating activities	$ (7,415,208)	$ (6,109,318)

See accompanying notes and auditor's report

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES

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

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

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

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

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

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES (continued)

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

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

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

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

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

Capital Assets: Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 40 years for buildings and improvements, and 3 to 10 years for major moveable equipment. The Hospital periodically reviews its capital assets for value impairment. As of June 30, 2009 and 2008, 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, 2009 and 2008 are $2,378,301 and $2,168,214, respectively.

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

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

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

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

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

NOTE A - ORGANIZATION AND ACCOUNTING POLICIES (continued)

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

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

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

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

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

NOTE B - CASH AND CASH EQUIVALENTS

As of June 30, 2009 and 2008, the Hospital had deposits invested in various financial institutions in the form of cash and cash equivalents in the amounts of $2,501,718 and $5,291,885 respectively. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code (CGC), except for $250,000 per account that is federally insured.

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

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

NOTE C - NET PATIENT SERVICE REVENUES

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

Medicare: Payments for inpatient acute care services rendered to Medicare program beneficiaries are based on prospectively determined rates, which vary accordingly to the patient diagnostic classification system. Outpatient services are paid under an outpatient classification system subject to certain limitations. Certain reimbursement areas are still subject to final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. At June 30, 2009, cost reports through June 30, 2007 have been final settled.

Medi-Cal: For traditional Medi-Cal (non-HMO) services, payments for inpatient services rendered to patients 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, 2009, cost reports through June 30, 2007, 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 service line are as follows:

	2009	2008
Inpatient acute and inpatient ancillary services	$134,838,882	$124,647,003
Long-term care routine services	26,062,608	17,855,653
Outpatient acute services	121,919,175	107,724,923
Gross patient service revenues	282,820,665	250,227,579
Less deductions from revenue and related allowances	(219,753,983)	(193,985,756)
Net patient service revenues	$ 63,066,682	$ 56,241,823

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, 2009 and 2008 were as follows:

	2009	2008
Medicare	$ 13,381,412	$ 13,571,657
Medi-Cal	13,770,546	9,542,914
Other third party payors	12,793,302	11,623,307
Self pay and other	5,510,776	4,653,744
Gross patient accounts receivable	45,456,036	39,391,622
Less allowances for contractual adjustments and bad debts	(35,386,500)	(31,446,100)
Net patient accounts receivable	$ 10,069,536	$ 7,944,522

NOTE E - OTHER RECEIVABLES

Other receivables as of June 30, 2009 and 2008 were comprised of the following:

	2009	2008
Alameda County property taxes	$ 6,014,003	$ 6,121,501
Kaiser contract receivable	70,092	274,187
Insurance recoveries related to self-funded programs		160,000
Due from Alameda Foundation		65,285
Rents receivable	6,857	26,293
Other various receivables	115,811	35,073
	$ 6,206,763	$ 6,682,339

NOTE F - ASSETS LIMITED AS TO USE

Assets limited as to use as of June 30, 2009 and 2008 were comprised of the following:

	2009	2008
Cash and cash equivalents restricted by contributors	$ 468,209	$ 602,817

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 $1,247,261 at June 30, 2009 and 2008, respectively.

NOTE G - CAPITAL ASSETS (continued)

Capital assets as of June 30, 2009 and 2008 were comprised of the following:

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

	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

NOTE H - DEBT BORROWINGS

As of June 30, 2009 and 2008, debt borrowings were as follows:

	2008	2008
Note payable to a bank; interest at 4.80% due monthly with the principal due February 14, 2014; collateralized by Hospital receivables:	$ 2,089,343	
Bank line of credit; interest at prime, due monthly with the principal due February 15, 2010; collateralized by Hospital receivables:		$ 2,400,000
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
Capital lease due to a financial institution; principal and interest at 2.57% due in monthly installments of $4,155 each 21st of the month through February 10, 2010; collateralized by Hospital property:	35,187	84,378
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:	38,877	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	6,958	22,800
	2,170,365	2,825,862
Less current maturities of debt borrowings	(447,948)	(2,744,870)
	$ 1,722,417	$ 80,992

Future principal maturities for debt borrowings for the next succeeding years are: $447,948 in 2010; $450,765 in 2011; $457,605 in 2012; $480,509 in 2013; and $333,538 in 2014.

Line of Credit: The Hospital has a $1,500,000 bank line of credit available at year end with a variable interest rate. Any advances on this line are due at the time of maturity and interest is due and payable monthly. There were no borrowings under this line of credit agreement as of June 30, 2009.

NOTE I - RETIREMENT PLANS

Contributions to Retirement Plans: Total contributions to all of the retirement plans for the years ended June 30, 2009 and 2008 were approximately $1,977,000 and $1,714,000, respectively.

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

Defined Benefit Plan: The Hospital provides retirement benefits under a noncontributory, single-employer defined benefit pension plan (the Plan) for employees not covered under collective bargaining agreements and who have completed one year of continuous service during which they worked at least 1,000 hours. The Plan, administered by the Hospital, provides benefits based on each employee's years of service and annual compensation through December 31, 2004. The Plan's annual pension cost and net pension assets for the years ended June 30, 2009 and 2008 are as follows:

	2009	2008
Annual required contribution	$ 128,149	$ 51,789
Interest on net pension asset	(6,072)	(10,281)
Adjustment to net pension obligation	11,143	10,570
Annual pension cost	133,220	52,078
Contributions made	(128,149)	(45,000)
Increase (decrease) in net pension obligation	5,071	7,078
Net pension asset at the beginning of the year	(121,440)	(128,518)
Net pension asset at the end of the year	$ (116,369)	$ (121,440)

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 2009 and 2008 do not apply as the Plan has been frozen and has no covered payroll.

The required contribution for the year ended June 30, 2009, was determined as part of the July 1, 2008 actuarial valuation using the unit credit actuarial cost method. The actuarial valuation method was changed from the entry age normal method in 2005 because benefit accruals under the Plan were frozen at December 31, 2004. The actuarial assumptions include an investment rate of return of 8% and no salary increases in the future. The actuarial value of the Plan's assets was equal to the fair value of the assets. The Plan's unfunded actuarial accrued liability is being amortized as a level dollar using a fixed amortization period of 15 years. The remaining amortization period at July 1, 2008 was 14 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 $
2007	$ 42,649	117.2%	$ (128,518)
2008	$ 52,078	86.4%	$ (121,440)
2009	$ 133,220	100.0%	$ (116,369)

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
7/1/06	$ 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
7/1/08	$ 2,700,503	$ 1,370,353	$ 1,330,150	50.7%	N/A	N/A

NOTE J - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of June 30, 2009 and 2008, the Hospital had recorded $533,294 and $38,526, 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, 2009 and 2008. Estimated cost to complete these projects as of June 30, 2009 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, 2009 and 2008, were $662,854 and $581,198, respectively. Future minimum lease payments for the succeeding years under operating leases as of June 30, 2009, 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, 2009 will be resolved without material adverse effect on the Hospital's future financial position, results from operations or cash flows.

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

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

Health Insurance Portability and Accountability Act: The Health Insurance Portability and Accountability Act (HIPAA) was enacted August 21, 1996, to ensure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Management believes the Hospital is in compliance with HIPAA as of June 30, 2009 and 2008.

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.

RAC Audits: Hospitals in California are subject to nationwide Medicare claim audits by Recovery Audit Contractors (RAC's). In March, 2007, RAC auditors examined certain Medicare claims for services provided to Medicare beneficiaries during the years end June 30, 2003, and thereafter. Pursuant to this review, RAC auditors reviewed medical records and compared them to billing records for "perceived" discrepancies. This audit resulted in a recovery process of Medicare payments which to date have been $352,280. It is anticipated that additional recoveries of approximately $200,000 may be collected in the future and which the Hospital has recorded as a liability as of June 30, 2009. The Hospital does have appeal rights for RAC audit findings.

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 were reopened and were settled during the 2009 year by the Medicare intermediary resulting in a payback of approximately $90,000 to the Medicare program. The Hospital has no more recorded liability as of June 30, 2009.

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, 2009 and 2008, 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 $165,000 and $181,058 for the years ended June 30, 2009 and 2008 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 - 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, 2009 and 2008 of these component units are included within the financial statements of the Hospital. Net assets of these units were $558,395 for 2009 and $509,122 for 2008. Net increase in assets for these units were $49,096 for 2009 and $73,238 for 2008. 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 N - CHARITY CARE AND COMMUNITY BENEFIT SERVICES

The Hospital maintains records to identify and monitor the level of charity care and community service it provides. These records include the amount of collections foregone, (based on established rates), for services and supplies furnished under its charity care and community service policies. In addition, the Hospital provides services to other medically indigent patients under certain government public aid reimbursement programs. The following is a summary of the Hospital's charity care and community benefit foregone collections for the years ended June 30, 2009 and 2008, in terms of services to the poor and benefits to the broader community:

	2009	2008
Benefits for the poor:		
Traditional charity care	$ 1,117,378	$ 1,187,169
Unpaid Medi-Cal and other public aid programs	7,167,070	6,897,566
Total quantifiable benefits for the poor	8,284,448	8,084,735
Benefits for the broader community:		
Unpaid Medicare program charges	74,174,087	70,456,378
Total quantifiable benefits for the broader community	74,174,087	70,456,378
Total quantifiable community benefits	$ 82,458,535	$ 78,541,113