Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT

BOARD OF DIRECTORS

AGENDA

Monday, November 8, 2010 – 6:00 p.m.

Location: Alameda Hospital (Dal Cielo Conference Room)

2070 Clinton Avenue, Alameda, CA 94501

Office of the Clerk: (510) 814-4001

Special Meeting

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

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

II. Roll Call Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A. Approval of Closed Session Minutes

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

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

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

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

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

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

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

A. Announcements from Closed Session — Jordan Battani

VI. Consent Agenda

A. Approval of October 4, 2010 Regular Meeting Minutes **ACTION ITEM** [enclosure] (PAGES 4-10)

B. Approval of October 11, 2010 Special Meeting Minutes **ACTION ITEM** [enclosure] (PAGES11-15)

C. Acceptance of September 2010 Financial Statements **ACTION ITEM** [enclosure] (PAGES 16-36)

D. Approval of Administrative Policies and Procedures **ACTION ITEM** [enclosure] (PAGE 37)

E. Approval to Enter into an Agreement Ratcliff Architects for Seismic Project **ACTION ITEM** [enclosure] (PAGES 38-39)

F. Approval to Enter into an Agreement with Fugro for Geo-Technical Testing **ACTION ITEM** [enclosure] (PAGES 40-41)

G. Approval of 401(a) Retirement Plan Amendment **ACTION ITEM** [enclosure] (PAGES 42)

VII. Regular Agenda

A. Action Items

1) Approval of Seismic Budget **ACTION ITEM** [enclosure] (PAGES 43-51) — Kerry Easthope

2) Acceptance of Annual Compliance Report **ACTION ITEM** [enclosure] (PAGES 52-58) — Joyce Walker

3) CEO Employment Agreement Renewal **ACTION ITEM** [enclosure] (PAGES 59-76) — Jordan Battani

B. Finance and Management Committee Report

1) Committee Report - October 27, 2010 — Jordan Battani

2) Administrative Pension Plan Oversight Committee Report **INFORMATIONAL** [enclosure] (PAGES 77-84) — Michael McCormick

C. President's Report — Jordan Battani

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

1) Monthly Statistics

E. Community Relations and Outreach Report — Robert Bonta

F. Medical Staff President Report — Alka Sharma, MD

G. Facilities Report — Kerry Easthope

1) Wound Care Center Update

2) Seismic Update

VIII. General Public Comments

IX. Board Comments

XIII. Adjournment

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

DRAFT

Minutes of the Board of Directors

October 4, 2010

Directors Present:		Management Present:	Legal Counsel Present:	Medical Staff Present:	Excused:
Jordan Battani	J. Michael McCormick	Deborah E. Stebbins			Leah D. Williams
Robert Bonta	Leah D. Williams	Kerry J. Easthope			Alka Sharma, MD
Robert Deutsch, MD		David A. Neapolitan			

Submitted by: Kristen Thorson

Topic	Discussion	Action / Follow-Up
I. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 6:13 p.m.	
II. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present	
III. Adjourn into Executive Closed Session	At 6:14 p.m. the meeting adjourned to Executive Closed Session.	
IV. Closed Session Agenda		
V. Regular Agenda	A. Announcements from Closed Session The meeting was reconvened into Open Session at 8:22 p.m. Ms. Battani reported that the following actions were taken in Closed Session.	
	1. Closed Session Minutes – September 13, 2010	The Closed Session Minutes for September 13, 2010 were approved.
	2. Board Quality Committee (BQC) Report – June & July 2010	The June and July 2010 BQC reports were accepted as presented.
	3. Medical Executive Committee Report and Approval of Credentialing Recommendations	The Medical Executive Committee Report and Credentialing Recommendations were approved as presented below.

Initial Appointments – Medical Staff

Name	Specialty	Affiliation
○ Giovani Begossi, MD	General Surgery	1st Surgical Consultants
○ Thomas Efrid, MD	Teleradiology	BIC

○ Tamina Isolani-Nagarvale, DO	Internal Medicine / Hospitalist	AIM
○ Christina Kwok, DPM	Podiatry	Drs. Poggio & Mihok
○ Collin Mbanugo, MD	General Surgery	None

Reappointments – Medical Staff

Name	Specialty	Status	
○ Jenna Brimmer, MD	Internal Medicine	Active	11/01/10 - 10/31/12
○ Sophia Chen, MD	Ophthalmology	Active	11/01/10 - 10/31/12
○ Rupert Horoupian, MD	General Surgery	Courtesy	11/01/10 - 10/31/12
○ Robert Kindrachuk, MD	Urology	Active	11/01/10 - 10/31/12
○ Arnold Levine, MD	Vascular Surgery	Courtesy	11/01/10 - 10/31/12

Reappointment – Allied Health Professional Status

Name	Specialty	Appointment Period
○ Sean Parkin, PA-C	Physician Assistant	11/01/10 - 10/31/12
○ Teresa Thomas, PhD	Psychology	11/01/10 - 10/31/12

Resignations

Name	Specialty
○ Ravi Alagappan, MD	Radiology
○ Charu Puri, MD	Internal Medicine/Hospitalist

VI. Consent Agenda	A. Approval of September 13, 2010 Regular Meeting Minutes B. Approval of August 31, 2010 Financial Statements C. Approval of 2009 – 2013 Goals and Objectives – FYE 2011 Update	Ms. Battani stated that there was one agenda change that came to the attention of the management and Board late in the day in which incorrect materials were distributed in the Board packet and Item C – Approval of 2009 -2013 Goals and Objectives – FYE 2011 Update therefore needed to be pulled from the consent agenda Approval of the Goals and Objectives – FYE 2011 Update will be brought back to the Board for approval at the next Board meeting. Mr. McCormick made a motion to approve the remaining items on the Consent Agenda as presented. Mr. Bonta seconded the motion. The motion carried unanimously.

VII. Regular Agenda	A. Presidents Report 1. Announcement of Special Board Meeting Scheduled for October 11, 2010 Ms. Battani announced that the District Board of Directors would be having a Special Board Meeting on October 11, 2010.	
	B. Finance and Management Committee Report 1. Committee Report – September 29, 2010 Jordan Battani announced that the results of the FYE 2010 Audited Financial Statements will be presented by our Auditor, Rick Jackson for the committee report. 2. FY 2010 Audit Report Rick Jackson, CPA from TCA Partners presented the Audited Financial Statements. The Final Report was distributed to the Board of Directors. There was one small reclassification made to the draft report that was included in the Board packet. Copies of the Board Report were also presented to the Board. He stated that this year was the best year to date and that the financial situation looks a lot stronger this year for the Hospital. Ms. Battani stated that they had a very thorough discussion at the Finance and Management Committee and that all Board Members were in attendance at that meeting. She also stated that from a board assessment that this too was an outstanding year in terms of financial results. She asked Mr. Jackson is there was anything that as a Board they should be concerned about. Mr. Jackson stated that were very minor adjustments at the end of the year due to accurately stated monthly financial statements. He stated that in the upcoming year that budget challenges at State and Federal levels will be a focus for healthcare and all hospital in the upcoming year. Dr. Deutsch requested information regarding inquires from deductions from gross revenues, and wondering if Mr. Jackson could provide some averages from other institutions, without divulging names, for average deductions from gross revenue for PPO type plans. Mr. Neapolitan stated that he planned to bring that information back to the Finance and Management Committee. Director Battani and Director Bonta thanked Mr. Jackson and staff for a great financial year.	Director Deutsch made a motion to accept the FY 2010 Audit Report as presented. Director Bonta seconded the motion. The motion carried unanimously.

C. Chief Executive Officers Report

1. Approval of FY 2011 Executive Performance Metrics

Director Battani removed Item 1, Approval of FY 2011 Executive Performance Metrics from the Regular Agenda for reasons stated.

Ms. Battani stated that the documents distributed in the Board Packet that related to the Approval of the 2011 Executive Performance Metrics were also incorrect and therefore were pulled from the Regular Agenda. They will be brought back for approval at the next Board Meeting. She reiterated that both the Goals and Objectives – FY 2011 Update and the 2011 Executive Performance Metrics were pulled from the Consent and Regular Agenda and will be considered at the next board meeting

2. Approval of Plan to Mitigate Wage Roll Back for Non Represented and Exempt Employees for FY 2010

Director Bonta made a motion to approve the plan to mitigate the wage roll-back for non represented and exempt employees for FY 2010. Director McCormick seconded the motion. The motion carried unanimously.

Ms. Stebbins stated that in January the decision was made to roll back the wages for management and non-represented personnel, as part of the recovery plan developed in response to Kaiser's decision to take their surgical procedures back in-house. As a part of the plan, management and Board assured staff that the they would continue to monitor the financial situation and if the financial situation should change that the issue would be revisited. Since then the Hospital went on to negotiate wage freezes for several represented unions (CNA, L6 and L29) with the option for reopeners if the hospital's financial situation improved over the course of the contracts. Management first wanted to express appreciation to all employees for making the special sacrifice in that regard and to someway acknowledge the special sacrifice management and non represented staff made with the roll back with a one-time payment to those employees. Management is asking the Board to approve the recommendation to make the one-time "bonus payment" to those affected by the wage roll back. Payment ranges are from $200 - $1000 based on number of hours worked and would be subject to State and Federal taxes. Ms. Battani stated that when the decision was made to roll back the wages, it did not look like we would be in the position to be able to do something like this. This is a good testimony to the good things that staff and management are doing in challenging times.

Director Bonta stated that this was wonderful that we are able to do this and asked for clarification that this payment would not change the $1.8 million positive bottom line. Ms. Stebbins stated that this amount was accrued for in the budget. Ms. Stebbins

stated that despite the $1.8 million positive bottom line which was due to the payment of the onetime payment from the intergovernmental transfer which is now being offset by lower Medi-Cal payments, she did not want to mislead people and stated that we are not out of the woods yet, but people should fell proud of the progress made in the last year. McCormick stated that this is great testimony to the work done.

3. Follow-Up on Board President's Report of September 13, 2010 Regarding City of Alameda

   Management will continue with further discussions with the City on the ambulance service inquiry, working with the VA and the presentation by the Economic Development Commission to the Board.

4. Monthly Statistics

   Ms. Stebbins reviewed the monthly preliminary statistics for September.

Statistics	September Preliminary	September Budget	August Actual
Average Daily Census	81.7	84.4	84.4
Acute	22.8	27.9	29.1
Subacute	32.4	33.5	33.5
South Shore	22.0	23	21.9
Patient Days	2,450	2,532	2,619
ER Visits	1,445	1,471	1,450
OP Registration	1,971	2,256	1,983
Total Surgeries	168	195	229

Ms., Stebbins also stated that the Skilled Nursing Facility and Subacute Unit had recently completed their annual California Department of Public Health State Survey. Overall the survey went well with no major issues and staff was well prepared for the survey.

There will be a presentation to the Medical Staff on October 14 at 12:30 p.m. on Accountable Care Organizations, members of the Board and all Medical Staff are invited to attend.

The annual Health Fair will be held on October 23 from 9-12:30 p.m. There will be a wide array of testing and are expecting approximately 1,500 people to attend.

Under the work of Director Bonta and McCormick's community Relations Committee, the hospital has had a many good meetings with local business association over the last couple of months and most recently with the Peralta College District. The meeting focused on ways the hospital could work in collaboration with their health care services.

D Community Relations and Outreach Report

1. Committee Report – September 28, 2010

   Director Bonta reported that at the meeting there was an update on our ongoing outreach efforts in the community and business associations (WABA, GABA, PISBA and Towne Centre). GABA was potentially interested in a presentation on Health Care Reform and Towne Center expressed interest in partnerships in respects to disaster planning. There were also updates regarding ongoing discussions with the Boys and Girls Club and College of Alameda (Peralta Colleges) as Ms. Stebbins mentioned earlier. Director Bonta stated that these are all potential partnerships that are growing and moving in a positive direction. The Committee got an early look at the Community Newsletter that will be going out to the Alameda Community. He stated that the newsletter is very sharp as always, outlines our financial position, quality care and other updates in the hospital. The Committee received information on the health fair and invited the Board to be present at the fair as an opportunity to interface with the community.

   Director McCormick stated that he has seen over the last couple of months a synergy that has developed and people are answering the bell and moving forward with outreach to the community.

E. Medical Staff President's Report

In the absence of Dr. Sharma, Director Deutsch gave the Medical Staff President's Report. He announced that there was a very effective CME (Continuing Medical Education) schedule for the month of October for the Medical Staff. In addition, the Medical Staff continues to work with Nursing personnel in developing protocols and best practices for the Hospital. He also announced that the Medical Staff would be hosting the Post Holiday Party at the O'Club again this year on January 14, 2010.

VIII. General Public Comments		
IX. Board Comments		
X. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 8:48 p.m.

Attest:

Jordan Battani
President

Robert Bonta
Secretary

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

DRAFT

Minutes of the Board of Directors

October 11, 2010

Directors Present:		**Management Present:**	**Legal Counsel Present:**	**Medical Staff Present:**	**Excused:**
Jordan Battani	J. Michael McCormick	Deborah E. Stebbins			Alka Sharma, MD
Robert Bonta	Leah D. Williams	Kerry J. Easthope			Thomas Driscoll, Esq.
Robert Deutsch, MD		David A. Neapolitan			

Submitted by: Kristen Thorson

Topic	Discussion	Action / Follow-Up
I. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 6:10 p.m.	
II. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present	
III. Adjourn into Executive Closed Session	At 6:11 p.m. the meeting adjourned to Executive Closed Session.	
IV. Closed Session Agenda		
V. Regular Agenda	A. Announcements from Closed Session The meeting was reconvened into Open Session at 7:50 p.m. Ms. Battani reported that no action was taken in Closed Session.	
VI. Consent Agenda	A. Approval of 2009-2013 Goals and Objective – FYE 2011 Update	Director McCormick made a motion to approve the Consent Agenda as presented. Director Bonta seconded the motion.
VII. Regular Agenda	A. Presidents Report Director Battani did not have a report for this meeting. B. Chief Executive Officer's Report 1. Approval of Recommendations for FY 2010 Executive Incentive Compensation Pay-out	Director Deutsch made a motion to approve the FY 2010 Executive Incentive Compensation Pay-out.

The supporting documents for the above recommendation were distributed to the Board members. Ms. Stebbins recommended that the Board approve the following:

1. The detailed assessment of the performance against the FY 2010 metrics and the recommended scores contained in the memorandum, and

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

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

Ms. Stebbins stated that there are two levels of executive compensation. The first tripwire for whether any incentive payment should be made is achievement of the budgeted revenue in excess of expenses or a bottom line of $358,000. Two other levels of financial performance if achieved, "target" and "high", would provide for an additional incentive payment if achieved.

The financial performance did exceed the first level tripwire which was worth 50% of base bonus. The other 50% is based on achievement of other goals in the areas of Quality/Satisfaction (10%), Workforce Success (10%), Operational Success (20%), and Business Development /Long Term Financial Viability (10%). Management self ranked the achievement of the goals as follows:

Financial Success (50%) = 50%. Goal achieved as stated above.

Quality/Satisfaction (10%) = 9 %. One of the measures was improvement of patient satisfaction on noise on the nursing units. This goal was not reached.

Workforce Success (10%) = 9%. One of the measure was to reassess employee satisfaction to establish whether there was improvement with employee satisfaction in regards to the training that was offered to them. Due to the budget and Kaiser changes and did not do a second survey. The Hospital will do the second survey in FY 2011.

Operational Success (20%) = 15%. The major reason for not achieving the goal was that there were net revenue increases set and the Hospital did not meet those increases. Also the market share increase for Bay Farm was not reached.

Director McCormick seconded the motion. The motion carried unanimously.

	Business Development /Long Term Financial Viability (10%) = 10%. Goal was achieved. In addition, Ms, Stebbins recommended that that the net excess of revenue over expense reported in the FY 2010 audit be amended to exclude the IGT income impact ($2.017 million), and the Non-Operating Contributions and the Grants for Equipment ($194,000), but to add back the repayment of overpayments by CMS from prior years ($652,000). This calculation was summarized on Attachment C and results in an amended net excess of revenue of expense of $558,000 only for purposes of incentive payment calculation. . Since this figure exceeds the "target" stretch objective of $543,000, this would result in the payout of an additional Target Level 6.25% x Base Annual Salary with 5% reduction. Director Bonta asked if all of the payments presented have been accounted for and would not change the bottom line. Ms. Stebbins stated all the incentive payments had been accrued for in the budget. Director Battani stated that there was a lot of discussion of how to treat the IGT monies and was very pleased with the outcome and how it has been presented. 2. Approval of FY 2011 Executive Performance Metrics Ms. Stebbins presented the Proposed FY 2011 Executive Performance Metrics. She reported that there was a similar structure for FY 2011 with slightly different weighting percentages. She recommended that 40% be weighted to Financial Success which has the three levels of achievement, Threshold ($490,853), Target ($750,000), and High ($1.8 million). Other areas were weighted as follows: Growth (25%), Quality/Satisfaction (5%), Physicians - a new category (10%), Operational Success (15%) and Workforce Success (5%). Director Bonta commented the he liked the redistribution of the weighting points for FY 2011 with the focus on growth. Director Battani commented that the physician goals were also very key component to the growth success.	Director Bonta made a motion to accept the FY 2011 Executive Performance Metrics as presented. Director McCormick seconded the motion. The motion carried unanimously.

C. Facilities Report

1. Seismic

Mr. Easthope stated that work to test the soil to determine soil characterization, is scheduled to begin on November 1, 2010. Mr. Easthope reviewed key dates associated with the Seismic Retrofit plan noting the following. Mr. Easthope also stated that the seismic budget would be presented to the Finance and Management Committee in October and then be brought to the Board for approval in November. He also stated that he would be bringing the final contracts for Fugro Geo-Technical Testing and the Ratcliff Architects Agreement for review and approval at the next set of meetings.

- Finalize Cal Mortgage Financing - 01/15/11
- Issue Public Notice of Bid - 02/14/11
- Anticipated OSHPD approval - 03/10/11
- Complete pre-construction enabling moves - 03/15/11
- General contractor selection - 04/11/11
- Estimated start of construction - 05/06/11
- Estimated Certificate of Occupancy - 10/12/12
- Estimated decommission of 1925 bldg - 01/01/13

In addition, the SB 499 Annual Report was submitted on September 8th; Non-Structural Performance Category (NPC) 3 extension applications were filed in early October; and asbestos testing was completed and Abatement Report pending.

2. New Program Development – Wound Care

Mr. Easthope stated that he continues to work to secure a lease for the space at Marina Village that would potentially house the Wound Care Center. He stated that an Architect has been engaged to help with the preliminary design of the center. The architect is scheduled to complete an initial study of the space in October.

VIII. General Public Comments	No Comments	
IX. Board Comments	Director Battani asked Ms. Stebbins how the Bonus payment that was approved at the last Board meeting. Ms. Stebbins stated that is was very well received.	
X. Adjourn into Executive Closed Session	At 8:27 p.m. the meeting adjourned back to Executive Closed Session.	
XI. Closed Session Agenda		
XII. Reconvene to Public Session	The meeting was reconvened into Open Session at 10:00 p.m. Ms. Battani reported that no action was taken in Closed Session.	
XIII. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 10:01 p.m.

Attest:

_____
Jordan Battani
President

_____
Robert Bonta
Secretary

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING SEPTEMBER 30, 2010

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
SEPTEMBER 30, 2010

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
SEPTEMBER, 2010

The management of the Alameda Hospital (the "Hospital") has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending September 30, 2010 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of September 30, 2010

- Gross patient revenue for the month of September was greater than budget by $166,000 or 0.8%. Inpatient revenue was less than budgeted by 0.2% while outpatient revenue was 2.8% greater than budgeted for the month. However, on an adjusted patient day basis gross patient revenue was 3.3% greater than budgeted at $5,555 compared to a budgeted amount of $5,378 for September. Both inpatient and outpatient gross revenue per adjusted patient day was greater than budgeted.

- Total patient days for the month were 2,446 compared to the prior month's total patient days of 2,619 and the prior year's 2,481 total patient days. The average daily acute care census was 27.2 compared to a budget of 27.9 and an actual average daily census of 29.1 in the prior month; the average daily Sub-Acute census was 32.4 versus a budget of 33.5 and 33.5 in the prior month and the Skilled Nursing program had an average daily census of 22.0 versus a budget of 23.0 and prior month census of 21.9, respectively.

- Emergency Care Center (ECC) visits were 1,445 or 1.8% less than the budgeted 1,471 visits and were 9.8% less than the prior year's visits of 1,479.

- Total surgery cases were less than budgeted expectations for the month at 168 cases versus the budgeted 195 cases. The current month's surgical volume was 1.8% greater than the same month prior year's 165 cases.

- Outpatient registrations were 12.9% below budgeted targets at 1,964.

- Combined excess revenue over expenses (profit) for September was $52,000 versus a budgeted excess of expense over revenues (loss) of $113,000. This brings our year-to-date loss to $262,000 versus a budget profit of $166,000.

  - Total assets decreased by $258,000 from the prior month as a result of a decrease in current assets of $419,000, a increase in net fixed assets of $154,000 and an increase in restricted contributions of $8,000. The following items make up the increase in current assets:

  - Total unrestricted cash and cash equivalents for September increased by $58,000. As a result day's cash on hand increased slightly to 9.7 at September 30, 2010 from 9.2 days at August 31, 2010.

  - Net patient accounts receivable decreased in September by $692,000 compared to increase of $731,000 in August. Day's in outstanding receivables decreased to 62.1 in September from 66.7 at August 31, 2010. This decrease in day's outstanding was primarily the result of a decrease in gross accounts receivable of $1,940,000 resulting from increased collections in September totaled $5.3 million compared to $4.3 million in August.

- Other receivables increased by $215,000 as a result of the accrual of $180,000 in estimated 2010/2011 intergovernmental transfer that is expected during the fiscal year.

- Total liabilities decreased by $317,000 compared to an increase of $423,000 in the prior month. This increase in the current month was the result of the following:

  - Accounts payable and accrued expenses increased by $276,000 while payroll and accrued expenses increased by an additional $71,000. As a result of this increase of $347,000 and decrease in average daily expenses as of September 30th, the average payment period increased in September to 67.1 from 64.6 as of August 31, 2010.

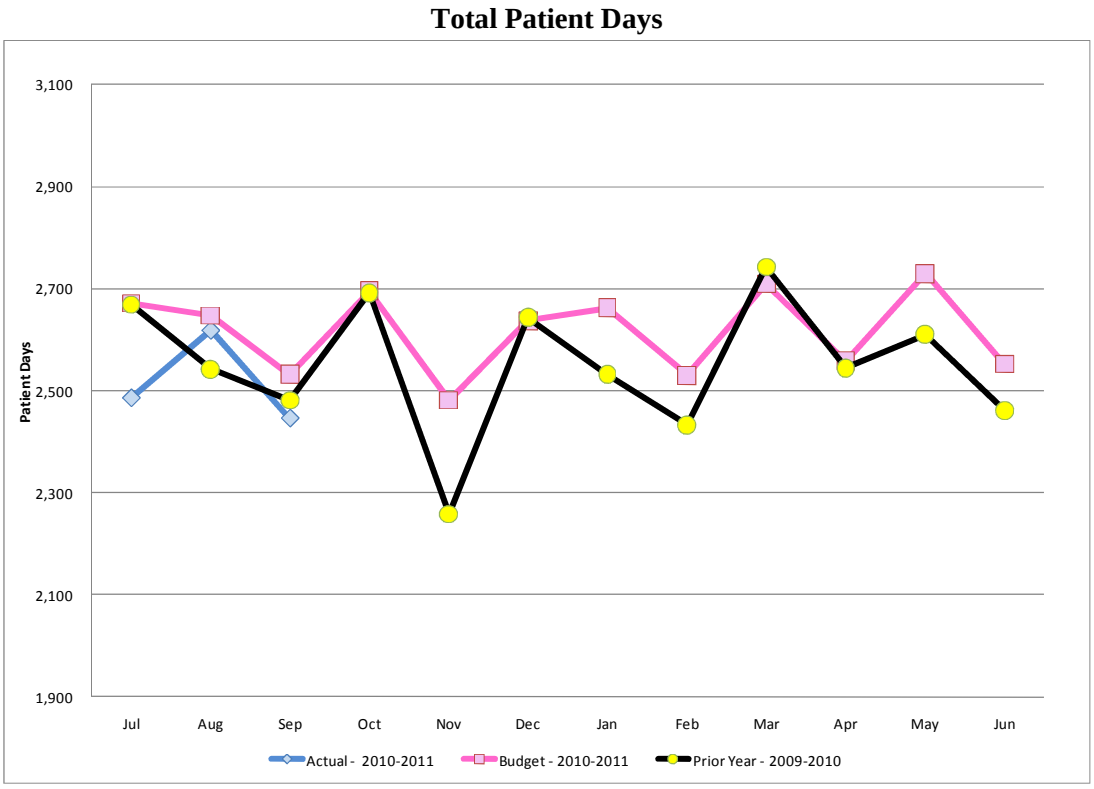
  - Payroll and benefit related accruals increased by $71,000 from the prior month. This increase was primarily the result of an increase in accrued payroll and related payroll tax accruals of $154,000 offset by a reduction in accrued time off of $61,000.

  - Deferred revenues decreased by $480,000 as a result of the amortization of one-twelfth of the annual parcel tax revenues for the 2011 fiscal year.

Volumes

The combined actual daily census was 81.5 versus a budget of 84.4. The current month's unfavorable variance from the budgeted census was the result of lower than budgeted census in all three inpatient programs. The acute care program was slightly below budget by 0.8% with an average daily census of 27.2 versus the budgeted 27.9. The Sub-Acute program was below budgeted expectations with an average daily census of 32.4 versus the budgeted 33.5. In the Skilled Nursing unit the average daily census was 22.0 versus the budgeted average daily census of 23.0. This resulted in an overall unfavorable variance of 3.4% from budgeted expectations for inpatient utilization in the month of September.

The graph below shows the total patient days by month for fiscal year 2011.

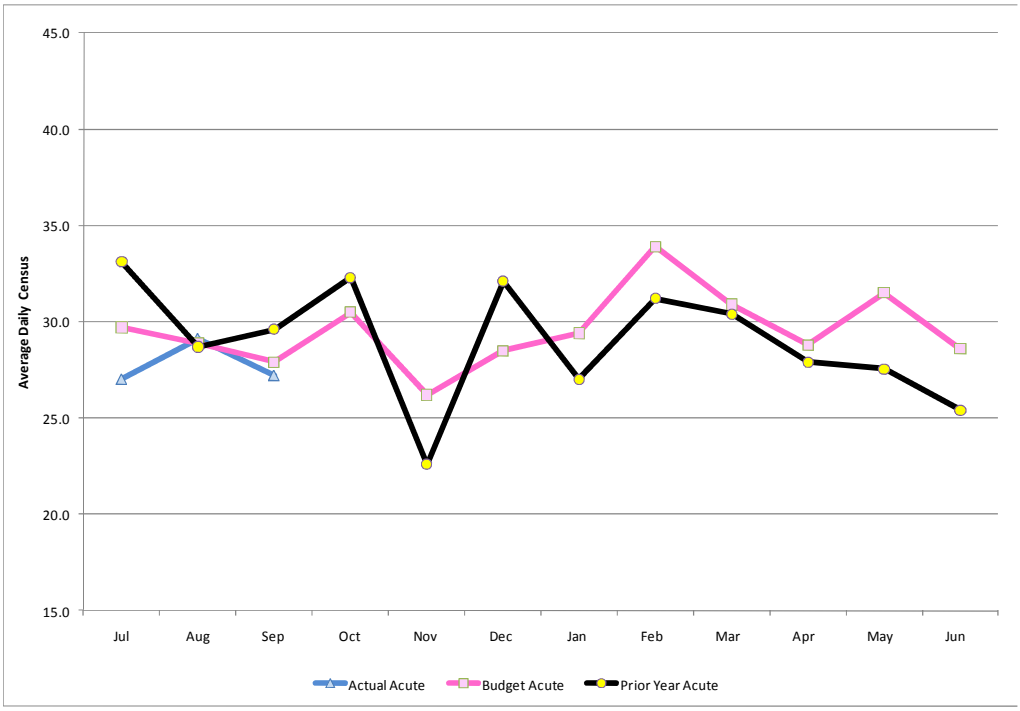


The various inpatient components of our inpatient volumes for the month of September are discussed in the following sections.

Acute Care

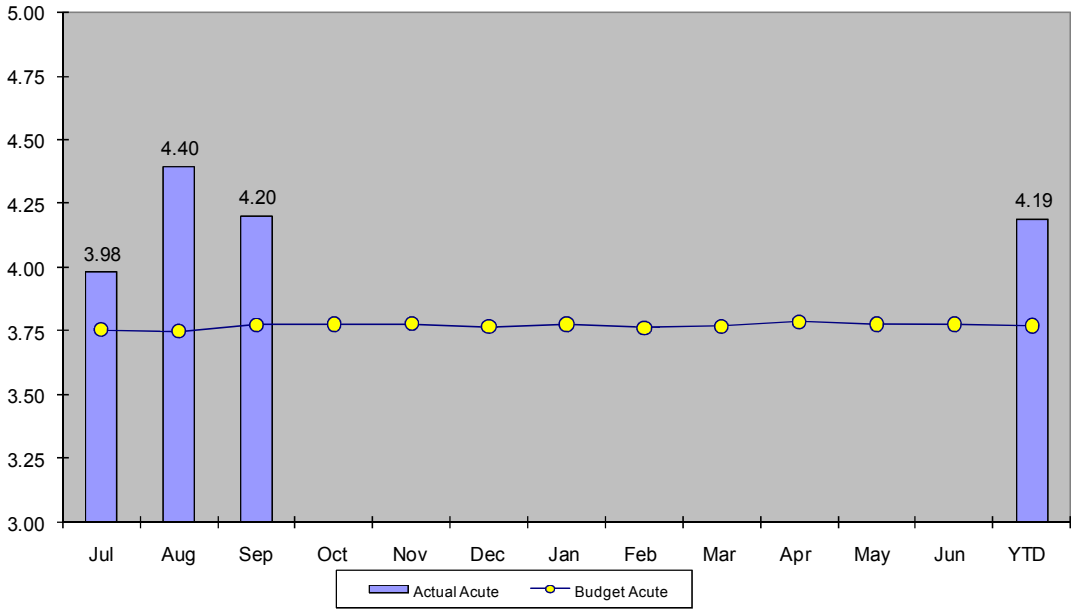
The acute care patient days were 2.7% (23 days) less than budgeted and were 8.2% less than the prior year's average daily census of 29.6. The acute care program was comprised of Critical Care Unit (4.5 ADC, 32.4% favorable to budget), Definitive Observation Unit (7.1 ADC, 30.4% unfavorable to budget) and Med/Surg Units (15.6 ADC, 9.1% favorable to budget). The graph on the following page shows the inpatient acute care census by month for the current fiscal year.

Inpatient Acute Care Average Daily Census



The average length of stay (ALOS) decreased from that of the prior month to 4.20 days for the month of September versus the budgeted FY 2011 average of 3.75. The graph below shows the month ALOS by month and the budgeted ALOS for fiscal year 2011.

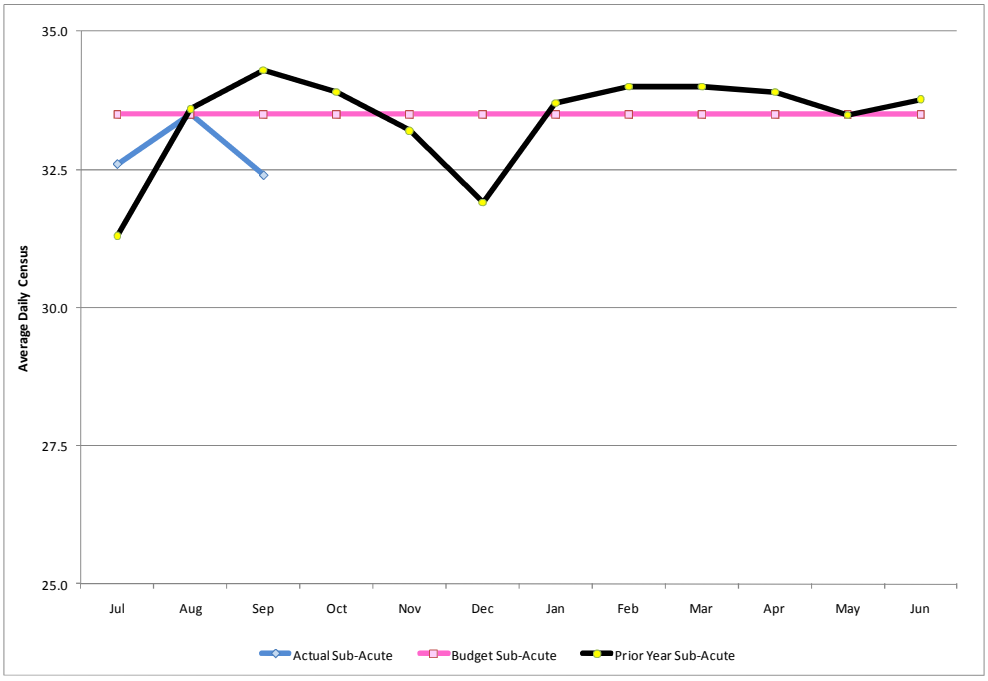
Average Length of Stay



Sub-Acute Care

The Sub-Acute program patient days were below budgeted projections with an average daily census of 32.4 for the month of September. The graph on the following page shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

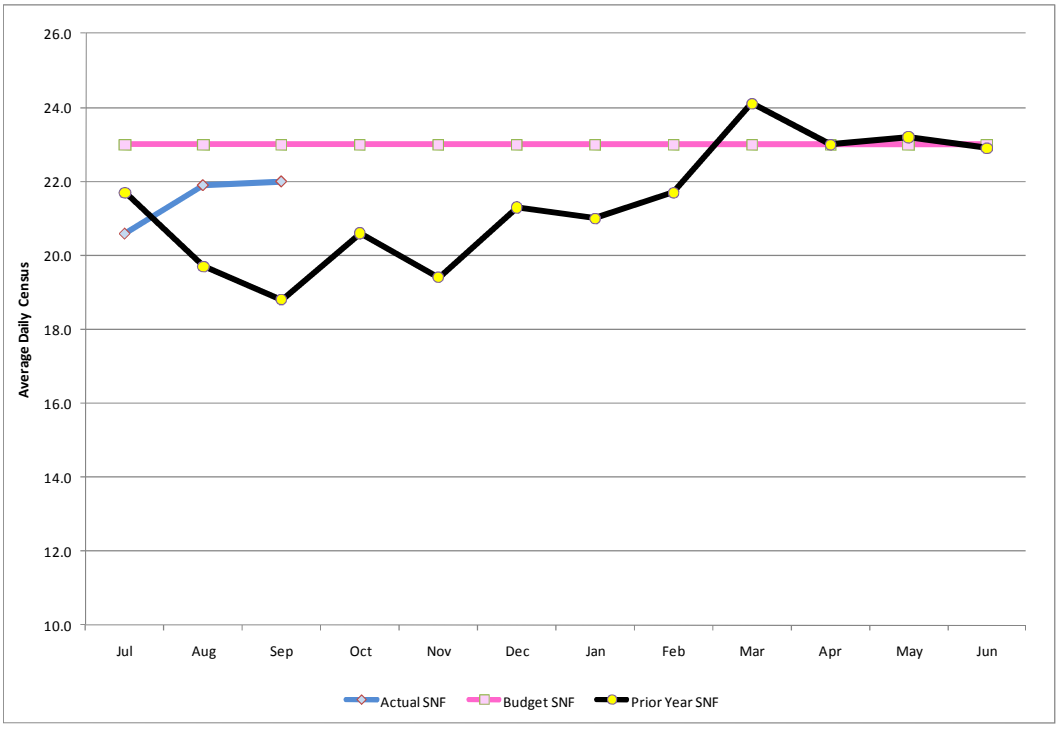
Sub-Acute Care Average Daily Census



Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were 4.3% or 30 patient days less than budgeted for the month of September. Comparing performance to the prior year this program remains slightly greater than the first quarter of fiscal year 2010 with an average daily census of 21.5 versus 20.1. The following graph shows the Skilled Nursing Unit average daily census as compared to budget and the prior year by month.

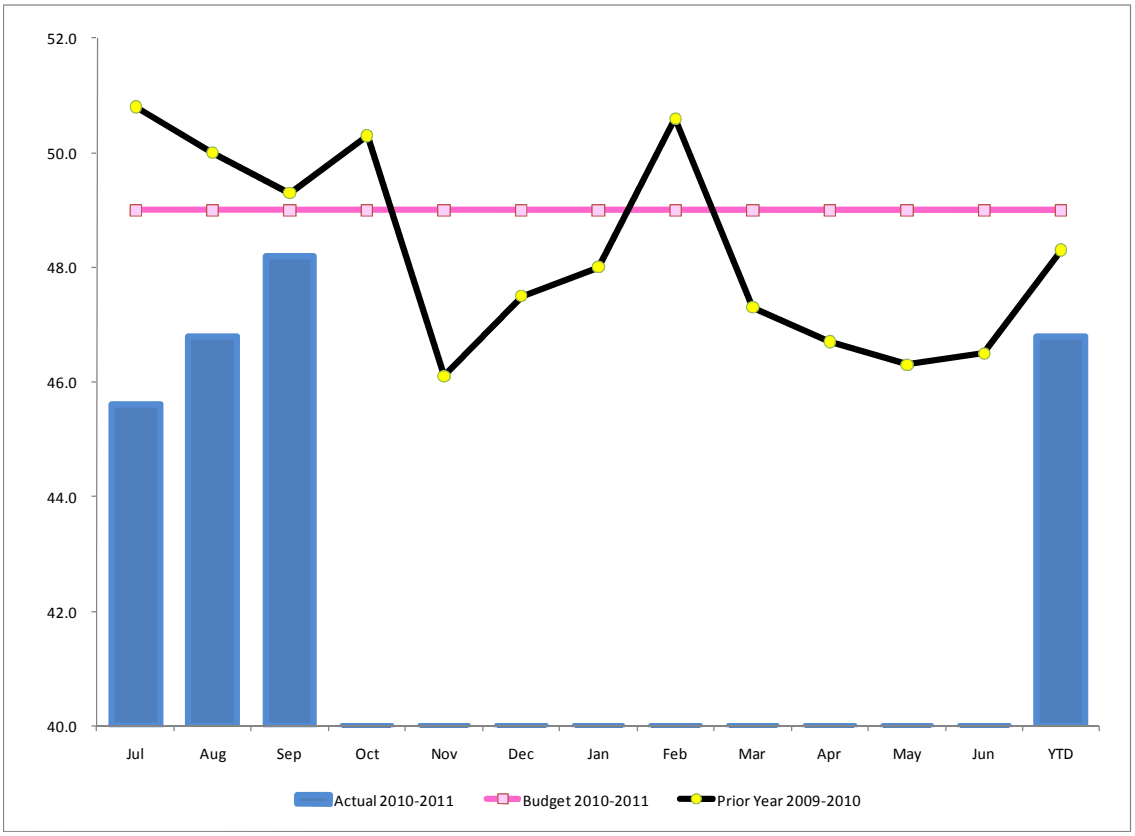
Skilled Nursing Unit Average Daily Census



Emergency Care Center (ECC)

Emergency Care Center visits in September totaled 1,445 and were 1.8% less than budgeted for the month and 14.1% of these visits resulted in inpatient admissions versus 15.2% in August. In September there were 284 ambulance arrivals versus 280 in the prior month, an increase of 1.4%. Of the 284 ambulance arrivals in the current month 153 or 53.9% were from Alameda Fire Department (AFD) ambulances. The graph below shows the Emergency Care Centers average visits per day for fiscal year 2011 as compared to budget and the prior year performance.

Emergency Care Center Visits per Day

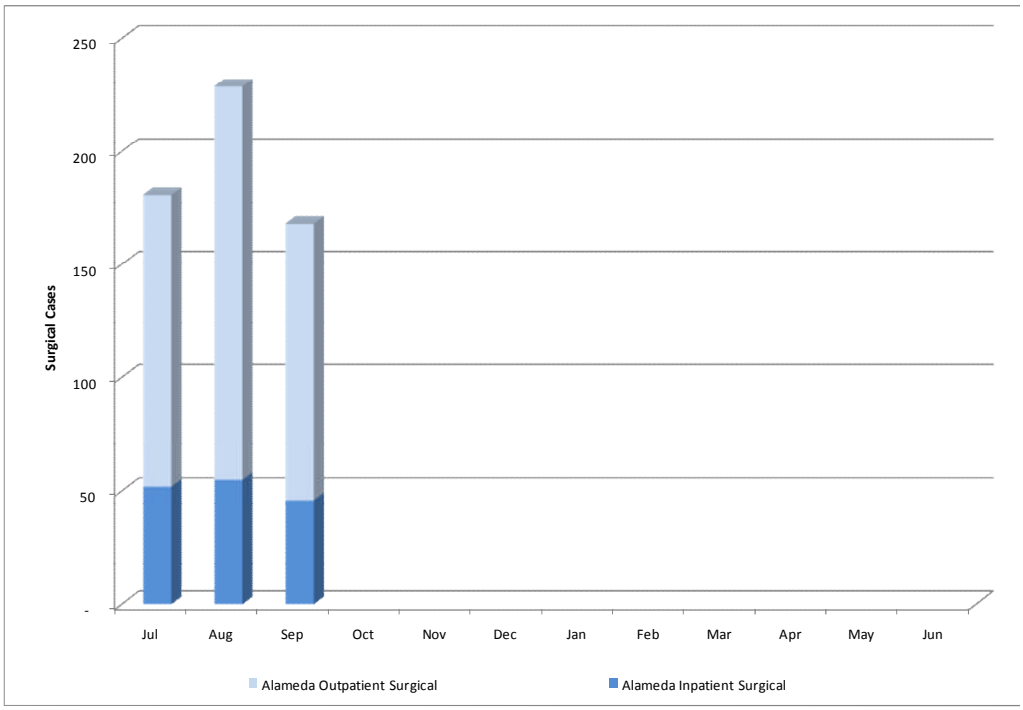


Surgery

Surgery cases were 168 versus the 195 budgeted and 165 in the prior year. In September, surgery cases decreased over the prior month by 26.5%. The decrease of 61 cases over the prior month was the result of a decrease 52 outpatient cases and 9 inpatient cases. Inpatient and outpatient cases totaled 46 and 122 versus 55 and 174 in August, respectively. The decrease from the prior month was driven by decreases in outpatient GI cases (37), Ophthalmology cases (13). On the inpatient side the decrease was primarily in the general surgery category.

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

Surgical Cases

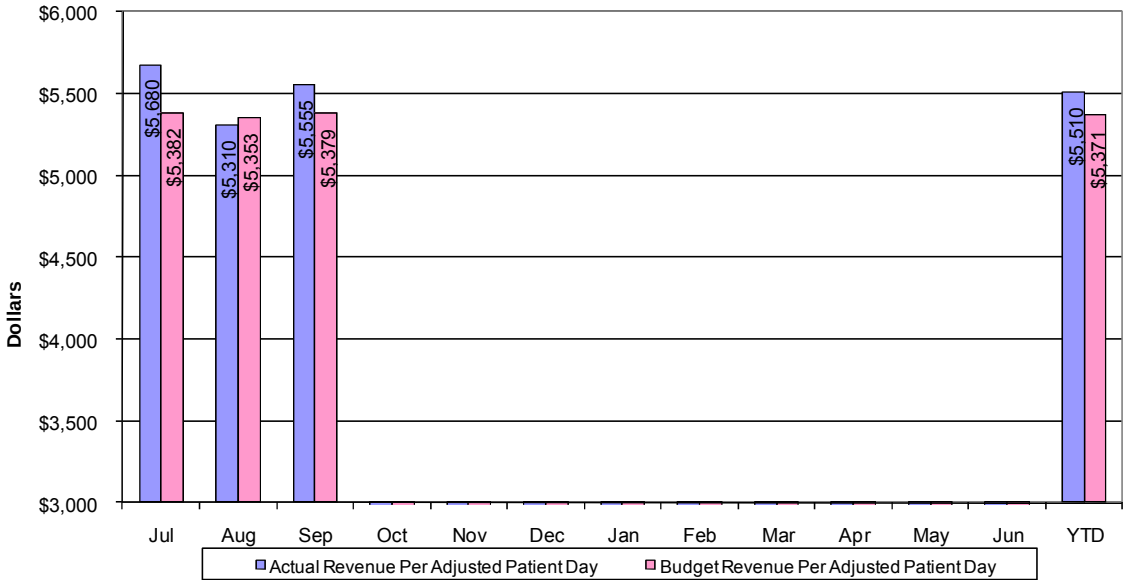


Income Statement

Gross Patient Charges

Gross patient charges in September were greater than budgeted by $166,000. This favorable variance was comprised of an unfavorable variance of $30,000 and a $197,000 favorable variance in inpatient and outpatient revenues respectively. On an adjusted patient day basis total patient revenue was $5,555 versus the budgeted $5,378 or a favorable variance of 3.3% from budget for the month of September. For the first quarter of fiscal year 2011 gross charges per adjusted patient day are 2.9% favorable to budget at $5,510

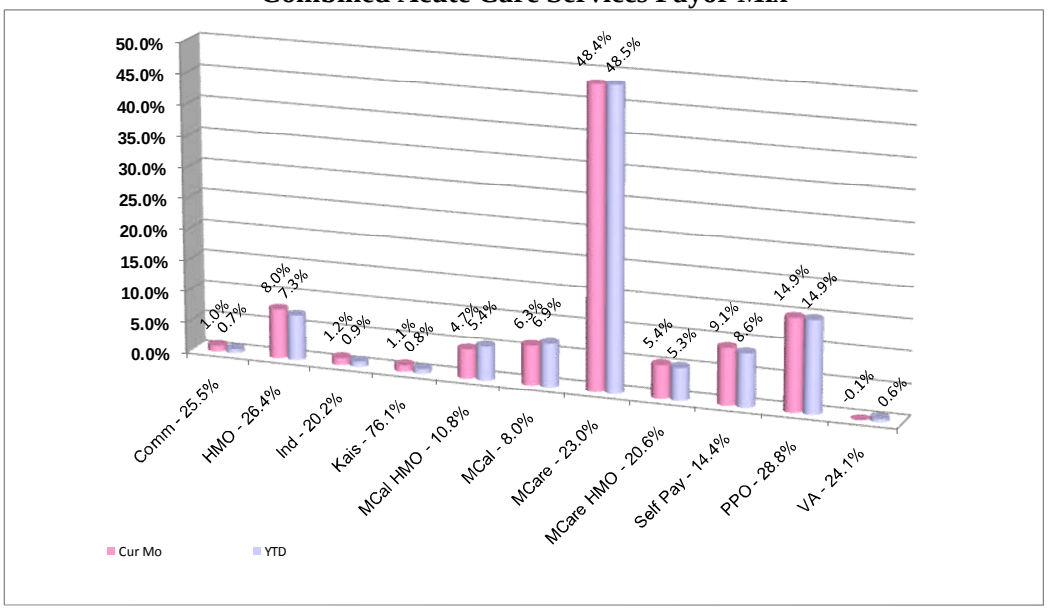
Gross Charges per Adjusted Patient Day



Payor Mix

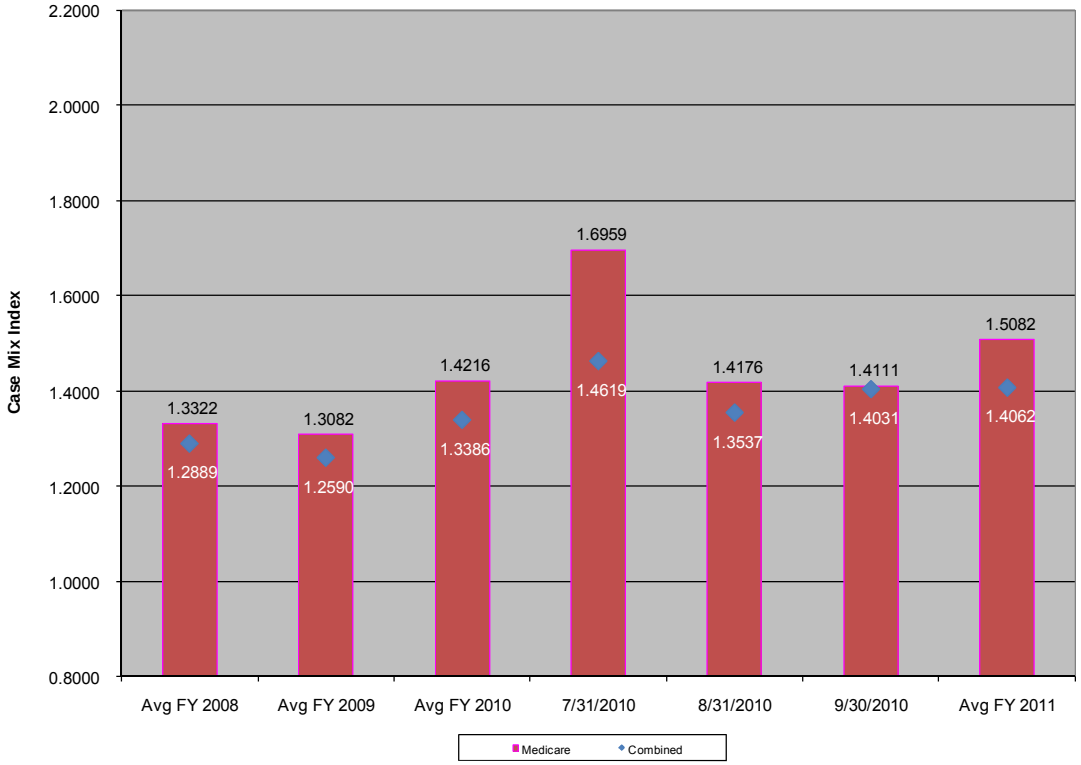
Combined inpatient and outpatient acute care Medicare and Medicare Advantage total gross revenue in September made up 53.8% of the months total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 22.9%, Medi-Cal Traditional and Medi-Cal HMO utilization at 11.0% and self pay at 9.1%. The graph below shows the percentage of gross revenues generated by each of the major payors for the current month and fiscal year to date as well as the current months estimated reimbursement for each payor for the combined inpatient and outpatient acute care services.

Combined Acute Care Services Payor Mix



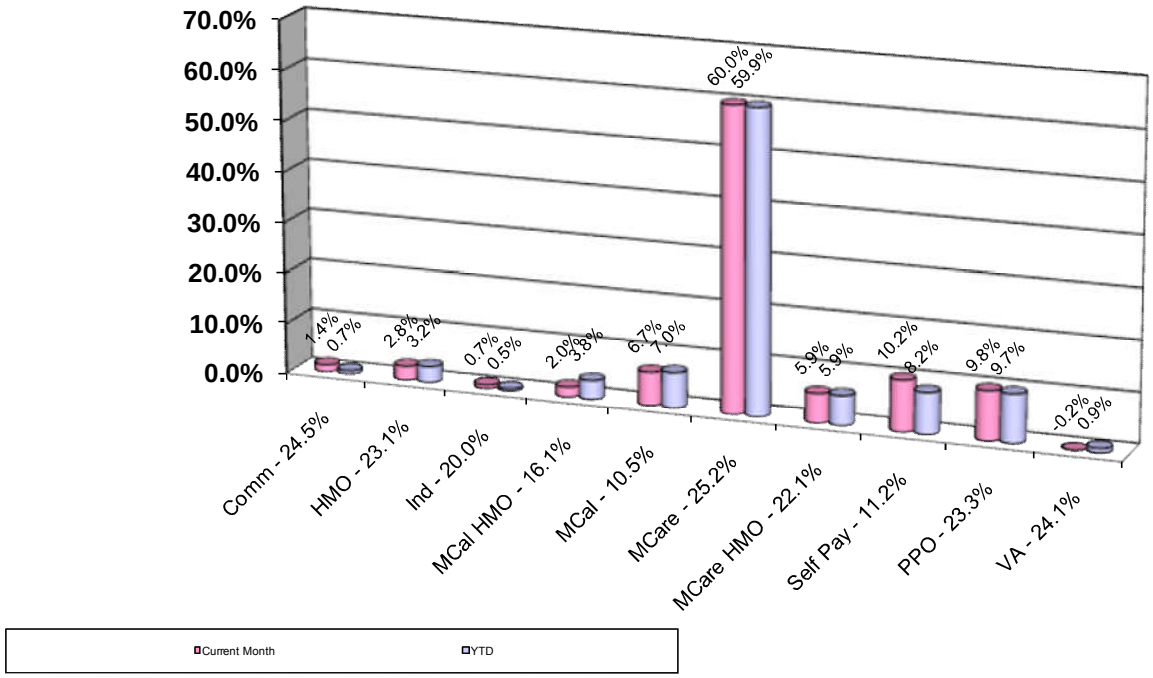
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 65.9% of our total inpatient acute care gross revenues followed by HMO/PPO at 12.6%, Self Pay at 10.2% and Medi-Cal and Medi-Cal HMO was 8.7% of the inpatient acute care revenue. The hospitals overall Case Mix Index (CMI) increased to 1.4031 from 1.3537 in the prior month while the Medicare CMI decreased slightly over the prior month from 1.4176 in August to 1.4111 in September. In September there were no outlier cases in the month. The overall Medicare reimbursement increased to 25.2% in September versus 24.6%. The graph on the following page shows the CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

Case Mix Index Comparison



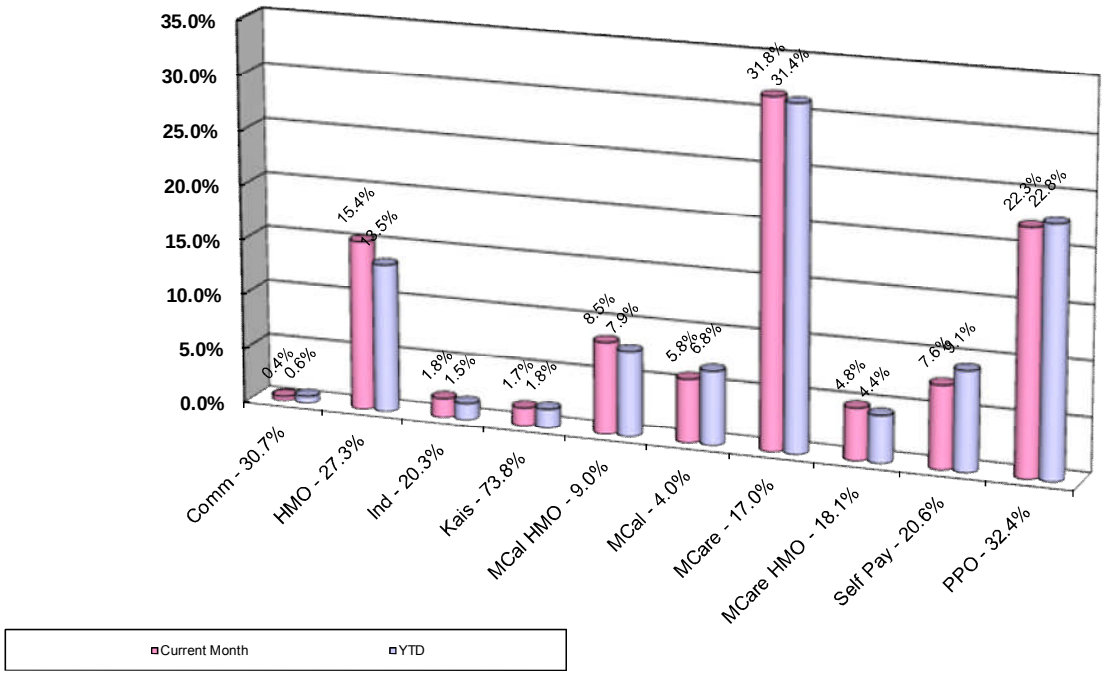
The overall net inpatient revenue percentage increased slightly from the prior month to 22.5% in September versus 21.7% in August. The graph below shows inpatient acute care current month and year to date payor mix and current month estimated net revenue percentages for fiscal year 2011.

Inpatient Acute Care Payor Mix



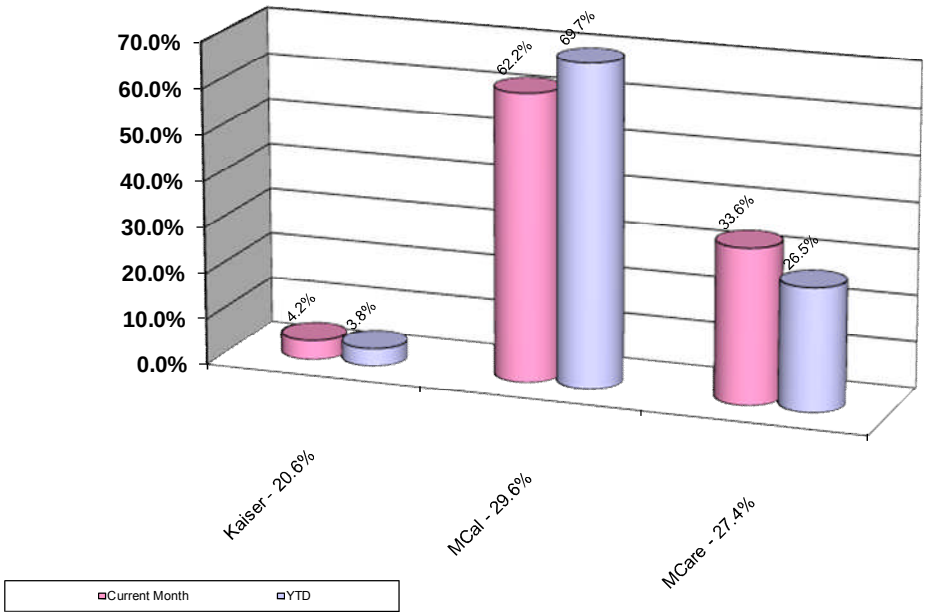
The outpatient gross revenue payor mix for September was comprised of 37.7% HMO/PPO, 36.6% Medicare and Medicare Advantage, 14.4% Medi-Cal and Medi-Cal HMO, and 7.6% self pay. The graph below shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

Outpatient Services Payor Mix



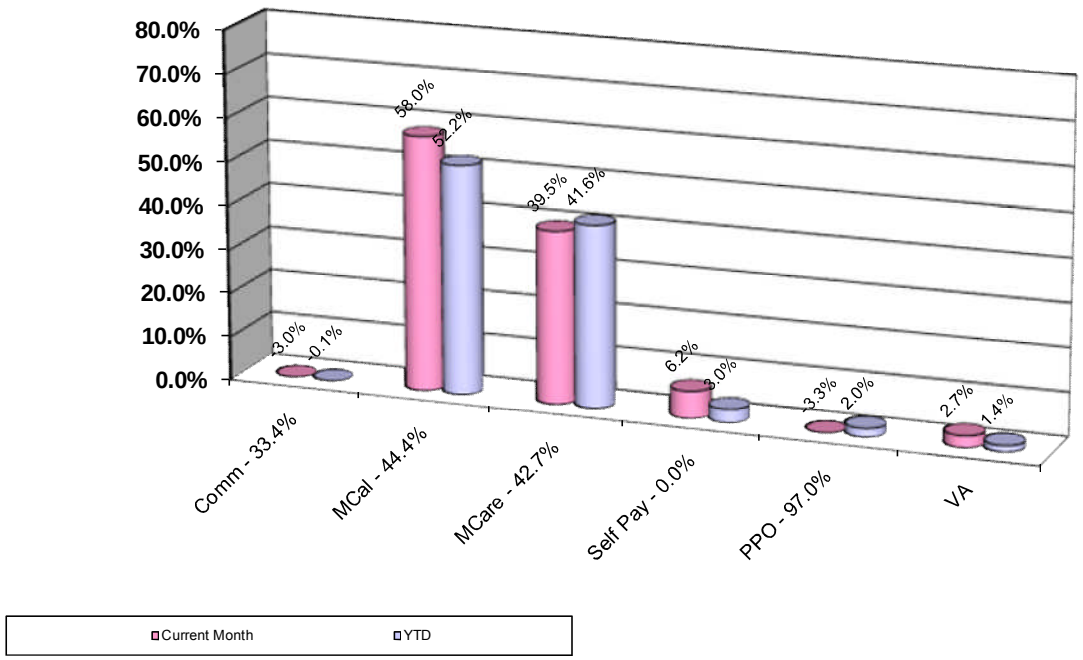
In September the Sub-Acute care program again was dominated by Medi-Cal utilization of 62.2% versus 73.5% in August. The graph below shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.

Inpatient Sub-Acute Care Payor Mix



In September the Skilled Nursing program was again comprised primarily of Medi-Cal at 58.0% and Medicare at 39.5%. The graph below shows the current month and fiscal year to date skilled nursing payor mix and the current months estimated level of reimbursement for each payor.

Inpatient Skilled Nursing Payor Mix

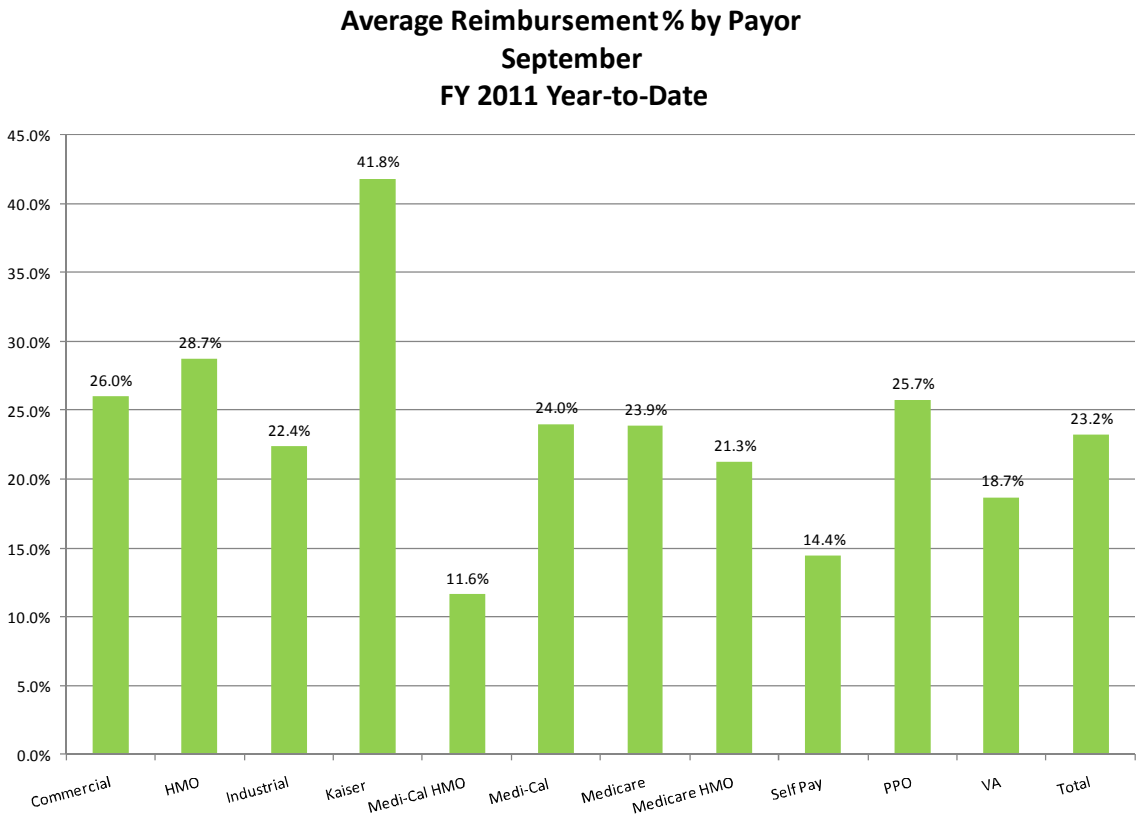


Deductions from Revenue

Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross. In the month of September contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 76.4% versus the budgeted 76.1%.

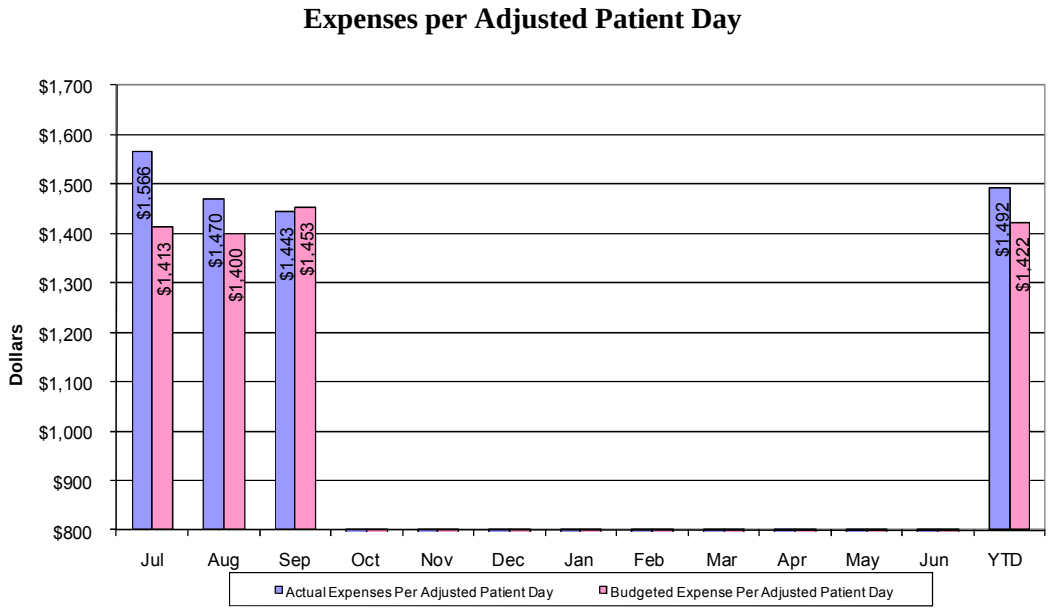
Net Patient Service Revenue

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



Total Operating Expenses

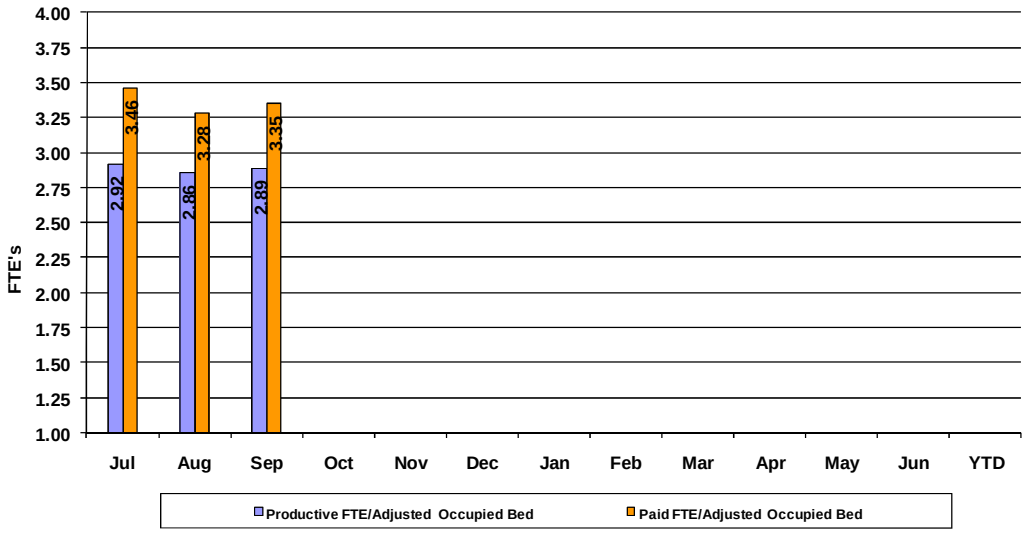
Total operating expenses were less than the fixed budget by $169,000 or 3.0%. On an adjusted patient day basis, our cost per adjusted patient day was $1,443 which was $10 per adjusted patient day favorable to budget. This variance in expenses per adjusted patient day was primarily the result of an favorable variance in salaries and benefits offset by an unfavorable variance in supply costs experienced in the month of September. The graph below shows the hospital operating expenses on an adjusted patient day basis for the 2011 fiscal year by month and is followed by explanations of the significant areas of variance that were experienced in the current month.



Salary and Registry Expenses

Salary and registry costs combined were unfavorable to the fixed budget by $87,000 and were unfavorable to budgeted levels on a per adjusted patient day basis by $42. The current month's unfavorable variance in salary costs was comprised of unfavorable variances of $12,000 and $75,000 in productive and non-productive salary costs. On an adjusted occupied bed basis, productive FTE's were favorable to budget by 0.5% at 2.90 FTE's versus the budgeted 2.91 FTE's. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2011 by month and year to date.

FTE's per Adjusted Occupied Bed



Non-productive salary costs were over budget by $75,000 in the month. This unfavorable variance was the result of the payment of accrued time off benefits $23,000 (earned time is reflected in benefit costs), surgical staff stand-by costs of $20,000 (offset by favorable variance in productive salaries), moving expenses in the amount of $10,000 related to the relocation of nursing staff and higher than budgeted nursing inservice / orientation costs of $4,000 and call back pay that exceeded budget by $4,000.

Benefits

Benefits were favorable to the fixed budget by $365,000 or 41.3%. On an adjusted patient day basis benefits were favorable to budget by $92 or 39.9%. This favorable variance was the result of lower than budgeted health insurance costs of $236,000 ($96,000 related to stop loss recoveries and $44,000 related to reduced IBNR requirements and the remainder from lower overall utilization) the utilization of paid time off resulted in a favorable variance from budget of $93,000 in accrued time off benefits. Additional favorable variances in workers compensation insurance costs and pension contributions of $25,000 and $14,000, respectively, made up the remainder of the favorable variance.

Supplies

Supply costs were $188,000 unfavorable to the fixed budget and were $55 unfavorable to budget on an adjusted patient day basis. The primary cause of the unfavorable variance from the fixed budget was from unfavorable variances of $74,000, $67,000 and $21,000 in surgical supplies pharmacy supplies and nonmedical supplies, respectively.

Purchased Services

Purchased services were $80,000 favorable to the September operating budget as a result of lower than budgeted costs incurred for medical purchased services, collection agency fees, repairs and maintenance and other purchased services of $38,000, $12,000, $5,000 and $25,000, respectively.

Other Operating Expenses
Other operating expenses were greater than budgeted by $17,000 as a result of higher than budgeted dues and subscription costs incurred in the month of $7,000 and recruitment expenses that exceeded budget by $10,000.

The following pages include the detailed financial statements for the three months ended September 30, 2010, of fiscal year 2011.

ALAMEDA HOSPITAL
KEY STATISTICS
SEPTEMBER 2010

	ACTUAL SEPTEMBER 2010	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	SEPTEMBER 2009	YTD SEPTEMBER 2010	YTD FIXED BUDGET	VARIANCE	%	YTD SEPTEMBER 2009
Discharges:										
Total Acute	194	222	(28)	-12.6%	218	609	706	(97)	-13.7%	722
Total Sub-Acute	2	1	1	100.0%	2	5	4	1	25.0%	5
Total Skilled Nursing	7	13	(6)	-46.2%	17	28	39	(11)	-28.2%	38
	203	236	(33)	-14.0%	237	642	749	(107)	-14.3%	765
Patient Days:										
Total Acute	815	838	(23)	-2.7%	888	2,552	2,654	(102)	-3.8%	2,802
Total Sub-Acute	971	1,004	(33)	-3.3%	1,028	3,021	3,080	(59)	-1.9%	3,041
Total Skilled Nursing	660	690	(30)	-4.3%	565	1,978	2,116	(138)	-6.5%	1,849
	2,446	2,532	(86)	-3.4%	2,481	7,551	7,850	(299)	-3.8%	7,692
Average Length of Stay										
Total Acute	4.20	3.77	0.43	11.3%	4.07	4.19	3.76	0.43	11.5%	3.88
Average Daily Census										
Total Acute	27.17	27.93	(0.77)	-2.7%	29.60	27.74	28.85	(1.11)	-3.8%	30.46
Total Sub-Acute	32.37	33.47	(1.10)	-3.3%	34.27	32.84	33.48	(0.64)	-1.9%	33.05
Total Skilled Nursing	22.00	23.00	(1.00)	-4.3%	18.83	21.50	23.00	(1.50)	-6.5%	20.10
	81.53	84.40	(2.87)	-3.4%	82.70	82.08	85.33	(1.75)	-2.1%	83.61
Emergency Room Visits	1,445	1,471	(26)	-1.8%	1,479	4,310	4,511	(201)	-4.5%	4,603
Outpatient Registrations	1,964	2,256	(292)	-12.9%	2,623	5,938	6,647	(709)	-10.7%	7,691
Surgery Cases:										
Inpatient	46	53	(7)	-13.2%	56	153	156	(3)	-1.9%	190
Outpatient	122	142	(20)	-14.1%	463	425	432	(7)	-1.6%	1,331
	168	195	(27)	-13.8%	519	578	588	(10)	-1.7%	1,521
Kaiser Inpatient Cases	-	-	-	-	3	-	-	-	-	34
Kaiser Eye Cases	-	-	-	-	176	-	-	-	-	493
Kaiser Outpatient Cases	-	-	-	-	175	-	-	-	-	512
Total Kaiser Cases	-	-	-	-	354	-	-	-	-	1,039
% Kaiser Cases	0.0%	0.0%			68.2%	0.0%	0.0%			68.3%
Adjusted Occupied Bed	123.95	127.62	3.67	2.9%	148.02	123.31	129.11	(5.80)	-4.5%	147.79
Productive FTE	358.92	371.25	12.33	3.3%	402.24	359.02	362.06	3.04	0.8%	394.73
Total FTE	416.54	422.86	6.32	1.5%	454.55	417.56	417.54	(0.02)	0.0%	448.89
Productive FTE/Adj. Occ. Bed	2.90	2.91	0.01	0.5%	2.72	2.91	2.80	(0.11)	-3.8%	2.67
Total FTE/ Adj. Occ. Bed	3.36	3.31	(0.05)	-1.4%	3.07	3.39	3.23	(0.15)	-4.7%	3.04

City of Alameda Health Care District
Statements of Financial Position
September 30, 2010
$ in thousands

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 1,742,907	$ 1,685,140	$ 3,480,668
Patient Accounts Receivable, net	9,802,096	10,494,127	9,558,147
Other Receivables	6,851,838	6,636,843	6,654,035
Third-Party Payer Settlement Receivables	444,202	420,987	374,557
Inventories	1,153,441	1,144,782	1,149,706
Prepaids and Other	685,024	717,440	453,872
Total Current Assets	20,679,508	21,099,319	21,670,985
Assets Limited as to Use, net	507,717	499,942	476,630
Property, Plant and Equipment, net	7,162,621	7,008,419	6,993,735
Total Assets	**$ 28,349,846**	**$ 28,607,680**	**$ 29,141,350**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 409,761	$ 413,003	$ 450,831
Accounts Payable and Accrued Expenses	6,471,170	6,195,642	6,112,296
Payroll Related Accruals	5,134,632	5,063,883	4,351,133
Deferred Revenue	4,301,670	4,781,188	5,736,951
Employee Health Related Accruals	591,933	636,365	645,750
Third-Party Payer Settlement Payable	400,000	500,000	500,000
Total Current Liabilities	17,309,166	17,590,081	17,796,961
Long Term Debt, net	1,164,499	1,200,734	1,236,831
Total Liabilities	18,473,665	18,790,815	19,033,792
Net Assets:			
Unrestricted	9,298,464	9,246,923	9,560,928
Temporarily Restricted	577,717	569,942	546,630
Total Net Assets	9,876,181	9,816,865	10,107,558
Total Liabilities and Net Assets	**$ 28,349,846**	**$ 28,607,680**	**$ 29,141,350**

City of Alameda Health Care District

Statements of Operations

September 30, 2010

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,446	2,532	(86)	-3.4%	2,481	7,551	7,850	(299)	-3.8%	7,692
Discharges	203	235	(32)	-13.6%	235	642	748	(106)	-14.2%	763
ADC (Average Daily Census)	81.5	84.4	(2.87)	-3.4%	82.7	82	85.3	(3.25)	-3.8%	83.6
CMI (Case Mix Index)	1.4031				1.3103	1.4062				1.3417
Revenues										
Gross Inpatient Revenues	$ 13,588	$ 13,618	$ (30)	-0.2%	$ 13,556	$ 41,615	$ 42,163	$ (548)	-1.3%	$ 42,767
Gross Outpatient Revenues	7,143	6,946	197	2.8%	10,714	20,958	21,549	(591)	-2.7%	32,836
Total Gross Revenues	20,730	20,564	166	0.8%	24,271	62,573	63,712	(1,138)	-1.8%	75,603
Contractual Deductions	15,062	14,866	(196)	-1.3%	18,070	45,146	45,849	703	1.5%	56,557
Bad Debts	659	627	(33)	-5.2%	656	1,873	1,940	67	3.4%	1,456
Charity and Other Adjustments	118	157	39	24.8%	103	496	485	(11)	-2.3%	294
Net Patient Revenues	4,891	4,915	(24)	-0.5%	5,441	15,058	15,437	(380)	-2.5%	17,297
Net Patient Revenue %	23.6%	23.9%			22.4%	24.1%	24.2%			22.9%
Net Clinic Revenue	43	28	15	55.4%	9	112	84	28	33.3%	9
Other Operating Revenue	9	14	(5)	-36.2%	213	28	42	(14)	-33.0%	269
Total Revenues	**4,944**	**4,957**	**(13)**	-0.3%	**5,664**	**15,197**	**15,563**	**(365)**	-2.3%	**17,575**
Expenses										
Salaries	2,900	2,783	(117)	-4.2%	3,108	8,943	8,484	(458)	-5.4%	9,575
Registry	137	167	30	17.9%	184	485	522	36	7.0%	572
Benefits	519	884	365	41.3%	804	2,135	2,654	519	19.6%	2,741
Professional Fees	312	313	1	0.4%	352	926	940	14	1.5%	1,013
Supplies	877	689	(188)	-27.3%	891	2,421	2,097	(324)	-15.4%	2,711
Purchased Services	315	394	80	20.2%	429	1,089	1,162	73	6.3%	1,206
Rents and Leases	71	68	(3)	-3.8%	73	193	207	14	7.0%	205
Utilities and Telephone	52	71	19	26.7%	73	168	217	48	22.3%	214
Insurance	31	38	8	20.1%	44	96	109	14	12.6%	136
Depreciation and amortization	82	73	(9)	-12.4%	100	247	220	(27)	-12.3%	301
Other Opertaing Expenses	92	75	(17)	-22.6%	100	246	250	4	1.4%	272
Total Expenses	**5,387**	**5,555**	**169**	3.0%	**6,158**	**16,949**	**16,863**	**(86)**	-0.5%	**18,947**
Operating gain (loss)	**(443)**	**(599)**	**156**	26.0%	**(495)**	**(1,752)**	**(1,300)**	**(452)**	34.7%	**(1,372)**
Non-Operating Income / (Expense)										
Parcel Taxes	478	477	1	0.2%	477	1,434	1,431	2	0.2%	1,431
Investment Income	1	-	1	0.0%	2	5	-	5	0.0%	6
Interest Expense	(7)	(13)	6	45.0%	(9)	(22)	(32)	10	-32.5%	(27)
Other Income / (Expense)	23	22	1	3.4%	29	72	67	5	7.7%	68
Net Non-Operating Income / (Expense)	**495**	**486**	**9**	**1.8%**	**499**	**1,489**	**1,466**	**23**	**1.6%**	**1,479**
Excess of Revenues Over Expenses	**$ 52**	**$ (113)**	**$ 164**	**-145.9%**	**$ 4**	**$ (262)**	**$ 166**	**$ (428)**	**-258.5%**	**$ 107**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

September 30, 2010

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,641	$ 3,562	$ 79	2.2%	$ 3,052	$ 3,665	$ 3,554	$ 111	3.1%	$ 3,145
Gross Outpatient Revenues	1,914	1,817	97	5.4%	2,412	1,846	1,817	29	1.6%	2,415
Total Gross Revenues	5,555	5,378	177	3.3%	5,464	5,511	5,371	140	2.6%	5,560
Contractual Deductions	4,036	3,888	(148)	-3.8%	4,068	3,976	3,865	(111)	-2.9%	4,159
Bad Debts	177	164	(13)	-7.8%	148	165	164	(1)	-0.9%	107
Charity and Other Adjustments	32	41	9	23.0%	23	44	41	(3)	-6.9%	22
Net Patient Revenues	1,311	1,286	25	2.0%	1,225	1,326	1,301	25	1.9%	1,272
Net Patient Revenue %	23.6%	23.9%			22.4%	24.1%	24.2%			22.9%
Net Clinic Revenue	12	7	4	59.2%	2	10	7	3	39.3%	1
Other Operating Revenue	2	4	(1)	-34.6%	48	2	3	(1)	-30.0%	20
Total Revenues	**1,325**	**1,296**	**28**	2.2%	**1,275**	**1,339**	**1,312**	**27**	2.0%	**1,293**
Expenses										
Salaries	777	728	(49)	-6.8%	700	788	715	(72)	-10.1%	704
Registry	37	44	7	15.8%	41	43	44	1	2.8%	42
Benefits	139	231	92	39.9%	181	188	224	36	16.0%	202
Professional Fees	84	82	(2)	-2.0%	79	82	79	(2)	-2.9%	75
Supplies	235	180	(55)	-30.4%	201	213	177	(36)	-20.6%	199
Purchased Services	84	103	19	18.2%	96	96	98	2	2.1%	89
Rents and Leases	19	18	(1)	-6.3%	16	17	17	0	2.8%	15
Utilities and Telephone	14	18	5	24.9%	16	15	18	3	18.8%	16
Insurance	8	10	2	18.2%	10	8	9	1	8.7%	10
Depreciation and Amortization	22	19	(3)	-15.2%	23	22	19	(3)	-17.3%	22
Other Operating Expenses	25	20	(5)	-25.6%	23	22	21	(1)	-3.0%	20
Total Expenses	**1,443**	**1,453**	**10**	0.7%	**1,386**	**1,493**	**1,422**	**(71)**	-5.0%	**1,393**
Operating Gain / (Loss)	**(119)**	**(157)**	**38**	24.2%	**(111)**	**(154)**	**(109)**	**(45)**	40.9%	**(101)**
Net Non-Operating Income / (Expense)	**133**	**127**	**5**	**4.3%**	**112**	**131**	**124**	**8**	**6.1%**	**109**
Excess of Revenues Over Expenses	**$ 14**	**$ (29)**	**$ 43**	-147.0%	**$ 1**	**$ (23)**	**$ 14**	**$ (37)**	-261.0%	**$ 8**

City of Alameda Health Care District
Statement of Cash Flows
For the Three Months Ended September 30, 2010
$ in thousands

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ 51,707	$ (262,462)
Items not requiring the use of cash:		
Depreciation and amortization	81,828	$ 246,723
Changes in certain assets and liabilities:		
Patient accounts receivable, net	692,031	(243,949)
Other Receivables	(214,995)	(197,803)
Third-Party Payer Settlements Receivable	(123,215)	(169,645)
Inventories	(8,659)	(3,735)
Prepaids and Other	32,416	(231,152)
Accounts payable and accrued liabilities	275,528	358,874
Payroll Related Accruals	70,749	783,499
Employee Health Plan Accruals	(44,432)	(53,817)
Deferred Revenues	(479,518)	(1,435,281)
Cash provided by (used in) operating activities	333,440	(1,208,748)
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(7,775)	(31,087)
Additions to Property, Plant and Equipment	(236,030)	(415,609)
Other	(166)	(2)
Cash provided by (used in) investing activities	(243,971)	(446,698)
Cash flows from financing activities		
Net Change in Long-Term Debt	(39,477)	(113,402)
Net Change in Restricted Funds	7,775	31,087
Cash provided by (used in) financing and fundraising activities	(31,702)	(82,315)
Net increase (decrease) in cash and cash equivalents	57,767	(1,737,761)
Cash and cash equivalents at beginning of period	1,685,140	3,480,668
Cash and cash equivalents at end of period	$ 1,742,907	$ 1,742,907

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: November 1, 2010

To: City of Alameda Health Care District Board of Directors

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Approval of Administrative Policies and Procedures

The following Administrative Policies and Procedures have been updated to reflect current practices, regulatory language and information. Policies and Procedures are available for review upon request.

Management requests approval of the Administrative Policies and Procedures listed below.

Policy #	Policy Title & Purpose Statement
No. 6	Organizational Wide Priorities for Performance Improvement • To meet the Hospital's mission and vision in an atmosphere of safe, cost-effective and personalized care and service.
No. 34b	Victims of Abuse – General • To protect Alameda Hospital patients & staff • To provide an appropriate channel for patients, employees and physicians to report suspected abuse and neglect • To comply with Section 15610 and 15630 of the California Welfare and Institutions Code and other regulatory guidelines
No. 38	Utilization Management Plan • The purpose of this plan is to organize a hospital-wide, collaborative continuous improvement mechanism to promote quality patient care and appropriate utilization of resources and services at Alameda Hospital. These objectives are promoted by an educational process which utilizes concurrent review, reporting and intervention.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: November 1, 2010

TO: City of Alameda Health Care District Board of Directors

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approval of Ratcliff Architect Contract for Seismic Project

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Recommendation:

Hospital management is recommending that the City of Alameda Health Care District Board of Directors approve the Architectural Service Contract (available for review upon request) with Ratcliff Architects for the Seismic Project.

In addition, at the October 27, 2010 Finance and Management Committee, the Committee made the recommendation that the District Board of Directors approve the Architectural Service Contract with Ratcliff Architects for the Seismic Project.

The contract is for the planning, design, development of construction drawings, submittal to OSHPD to obtain the required building permit and construction administration / oversight. The contract includes the work of subcontractors and engineers (electrical, mechanical, kitchen design, structural, soil) that have been required for plan development. The scope of work includes most of the structural work, and all of the kitchen relocation portions of the seismic retrofit project. A portion of the structural design work was performed by Thorton Tomasetti early on before it was determined that all components of the seismic project should be submitted as one project and have Ratcliff as the primary on the entire project. The value of the work performed previously by Thorton Tomasetti was about $197,000.

Not included in the Ratcliff scope of work are plans/permits that may be required for the pre-construction enabling moves, construction phase moves and decommissioning of the 1925 building. Also not included is the additional soil testing that OSHPD is requiring that is being performed by Fugro Engineers, any asbestos abatement and the fire sprinkler / alarm system design and install (design build).

The value of the contract, including all work performed to date on the seismic project is $911,850. The hospital has already obtained board approval and has provided Ratcliff "notice to proceed" on about $650,000 of this contract amount in order to have plans submitted to OSHPD by the required dates.

The contract has been thoroughly reviewed by Jtec, our construction management firm, by legal council and by hospital management. It is part of the Seismic Project budget.

Background:

Alameda Hospital is required to comply with California Senate Bill 1953, which requires that all hospitals achieve specific structural and non-structural standards by 2013 and 2030. Buildings affected at Alameda Hospital include decommissioning the 1925 building and relocating all essential service to a compliant building, the Stephens building and the West building.

The key aspects of the seismic project include:

- Removing all essential services from the 1925 building by 2013. These include: dietary services, the morgue, Administrator's office, and Medical Records.
- Removal of the bridge between the 1925 and Stephens buildings.
- Filling in openings in the north and south wall of the Stephens building.
- Structural reinforcement under the footings and floor slab of the Stephens and potentially the West buildings.
- Strap reinforcement on the north and south sheer walls of the Stephens building.
- Decommission the 1925 building
- Non-Structural work – (we have applied for an extension under SB 499).

Discussion:

This project and need for this work has been discussed at length at previous meetings of the board. We are pleased to finally get the terms & conditions and other contract language that we feel were important incorporated into a formal contract with Ratcliff Architect. Ratcliff has had a long relationship with Alameda Hospital and has performed well on previous projects, as well as, other seismic / hospital building projects in the Bay Area.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: November 1, 2010

TO: City of alameda Health Care District Board of Directors

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approval of Fugro West, Geotechnical Services Contract

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Recommendation:

Hospital management is recommending that the City of Alameda Health Care District Board of Directors approve the Fugro West, Geotechnical Services Contract (available for review upon request).

In addition, at the October 27, 2010 Finance and Management Committee, the Committee made the recommendation that the District Board of Directors approve the Fugro West, Geotechnical Services Contract.

The contract is for an amount not to exceed $101,603 to perform the required CPT testing, analysis, and documentation / reporting to OSHPD and the California Geological Service. This base fee will include 8 CPT test locations. It is believed by Fugro that testing in these locations will provide sufficient data to complete the structural plan design and review. However, an additional 4 CPT tests may be required at an additional cost of $16,987.

Since the Structural plans have already been submitted to OSHPD back on June 30, 2010, and this additional soil investigation and reporting is being required by OSHPD in order to continue with the structural plan review, management has provided Furgo with Notice to Proceed so that the work can be scheduled without further delay. The testing is scheduled to take place the week of November 1, 2010. This contract amount is included in the proposed Seismic Project Budget.

Background:

Alameda Hospital is required to comply with California Senate Bill 1953, which requires that all hospitals achieve specific structural and non-structural standards by 2013 and 2030. Buildings affected at Alameda Hospital include decommissioning the 1925 building and relocating all essential service to a compliant building, the Stephens building and the West building.

Discussion:

One of the key components of this seismic retrofit work is mitigating the liquefaction potential beneath the footings and floor slab of the Stephens building, and possibly a portion of the West building. The soil investigation and reporting that will provided by Fugro in this proposal will substantiate the scope of sub terrain work that will need to be performed and provide the required construction specifications to the structural engineer and architect to include in the Structural Design plans. In addition, by better understanding the scope of construction work that will be required, management will be able to better plan for all pre-construction service relocations, ensure that there is sufficient budget allowance to cover the cost of this work and to provide a more exact scope of work to contractors who will be bidding on this project. It is essential that this testing occur as scheduled to keep the seismic plan development and review progressing as planned.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: November 1, 2010

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

FROM: Mike McCormick, Chair
Administrative Pension Plan Oversight Committee (APPOC)

SUBJECT: Approval of the 401(a) Retirement Plan Amendments

Recommendation:
The APPOC recommends approval of a supplemental good-faith PPA/HEART amendment and an additional amendment reflecting provisions of the Emergency Stabilization Act of 2008 (EESA) to the 401(a) Retirement Plan at Alameda Hospital in order to remain in full compliance with Federal requirements.

Background:
In late 2009 the Hospital amended the 401(a) plan to incorporate provisions related to the:
A. Pension Protection Act of 2006 (PPA), and the
B. Heroes Earnings Assistance & Relief Tax Act of 2008 (HEART).

However, later that same year, the IRS released additional guidance concerning both Acts and, as a result, a supplemental amendment must be added in order to remain in compliance with Federal requirements.

A. The supplemental amendment under **PPA** provides for "Differential Wage Payments" and "Direct Rollovers", and
B. The supplemental amendment under **HEART** provides for Death Benefits for an employee on an approved and qualified active military service leave.

In addition, we are required to amend the plan further to incorporate required regulatory language for the Emergency Stabilization Act of 2008 (ESSA).

This amendment clarifies that participants who were directly affected by floods, severe storms or tornadoes that were declared Midwestern disaster areas between May 21, 2008 and July 31, 2008, would be eligible to apply for a "Qualified Disaster Recovery Assistance Distribution".

Discussion:
Both the supplemental amendment for PPA and HEART and the amendment under ESSA are required to be adopted in order to meet Federal Compliance Standards.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: November 1, 2010

TO: City of Alameda Health Care District Board of Directors

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approval of Seismic Retrofit Budget

Recommendation:

Hospital management is recommending that the City of Alameda Health Care District Board of Directors review and approve the attached capital budget for the seismic retrofit program as required by SB 1953.

In addition, at the October 27, 2010 Finance and Management Committee, the Committee made the recommendation that the District Board of Directors approve the attached capital budget for the seismic retrofit program as required by SB 1953.

Although the attached budget is comprised of four components, the Committee is being asked to approve the total combined project budget in the amount of **$10.3** million. Discussion on the cost categories that make up this total budget will follow.

Contracts for services provided within this budget will follow District policy and will be brought to the Board of Directors for approval as required. In addition, it is understood that being able to act upon the approved budget will depend upon our ability to obtain the necessary capital financing.

Background:

Alameda Hospital has three buildings that do not comply with the structural building standards required under SB 1953. Two of these buildings (the Stephens and West buildings) will be retrofit to comply with the current deadline set for 2013. The 1925 building will not be able to be retrofit under current standards. Upon completion of construction and the removal of the connecting bridge, this building will be decommissioned for medical use and turned to City jurisdiction as a B occupancy building. None of these buildings will be allowed to support or function as inpatient use past 2030 under the current building code.

Over the past year or so, management has engaged the architects and engineers necessary to understand the scope of work required to bring the non compliant buildings up to code. In addition, because of state mandated plan submission filing deadlines, the hospital has

provided the architects and engineers with sufficient "notice to proceed" authorization to have the required construction plan documents submitted to OSHPD for review. During this process, multiple independent project cost estimates have been prepared to help us understand the estimated cost of construction for the project.

Discussion:

The combined project budget is comprised of three sub-budget components that allow management to better track costs associated with the project. The sub-budget components are Structural Work, Kitchen Relocation and Enabling Moves.

The budget is also broken down into eight cost Categories to help organize and track expenditures by type of cost. These categories and amounts are summarized as follows:

Fees, Entitlements & Permits	$418,834
Construction	$6,307,737
Equipment	$121,000
Furniture & Furnishings	$184,300
Communication	$125,000
Professional Services	$2,200,117
Legal & Real Estate Expenses	$15,000
Contingency	$937,199
Total	$10,309,187

Fees, Entitlements & Permits
This category includes the cost of the building permit with OSHPD and the cost of testing and special inspections required before, during and after construction.

Construction
This category includes the cost of construction. Three cost estimates were provided by independent cost estimators as the project progressed through the planning phase. Faithful Gould provided estimates for the structural work, Davis Langdon provided estimates for the kitchen relocation. The entire project was also reviewed by The Hunter Pacific Group, who was engaged through JTEC our construction management firm.

Also included in this category is an allowance for Non Structural work if we are not able to obtain an extension until 2030, make ready enabling moves, lead asbestos sampling and abatement, waterproofing of the room and foundation and decommissioning of the 1925 building.

Equipment
This category is for the installation of kitchen equipment, cost of decommissioning the equipment in the 1925 building and includes a contingency of 10%. Specific equipment

items have been specified for the new kitchen and cost estimated by Marshall & Associates (kitchen design consultant).

Furniture & Furnishings
This category allows for the cost of furniture and furnishings (e.g. chairs, tables, plants, artwork etc) as well as, signage, lockers for staff and makes ready moves furniture.

Communications
This category includes the cost to provide data and telephone lines for the newly constructed area in the Stephens building. The most significant portion of this relating to the redesign and relocation of the Servers, CPU and phone switch in the IT room which is adjacent to the structural work and has become part of this project.

Professional Services
This category includes all of the Architectural and engineering costs to develop the construction drawings and provide project oversight. It also includes the cost of construction management and OSHPD IOR fees as is required. There is an allowance for reimbursable expenses (plan reproduction, shipping & postage, bid documents, community communication boards and materials etc) and about a 5% contingency.

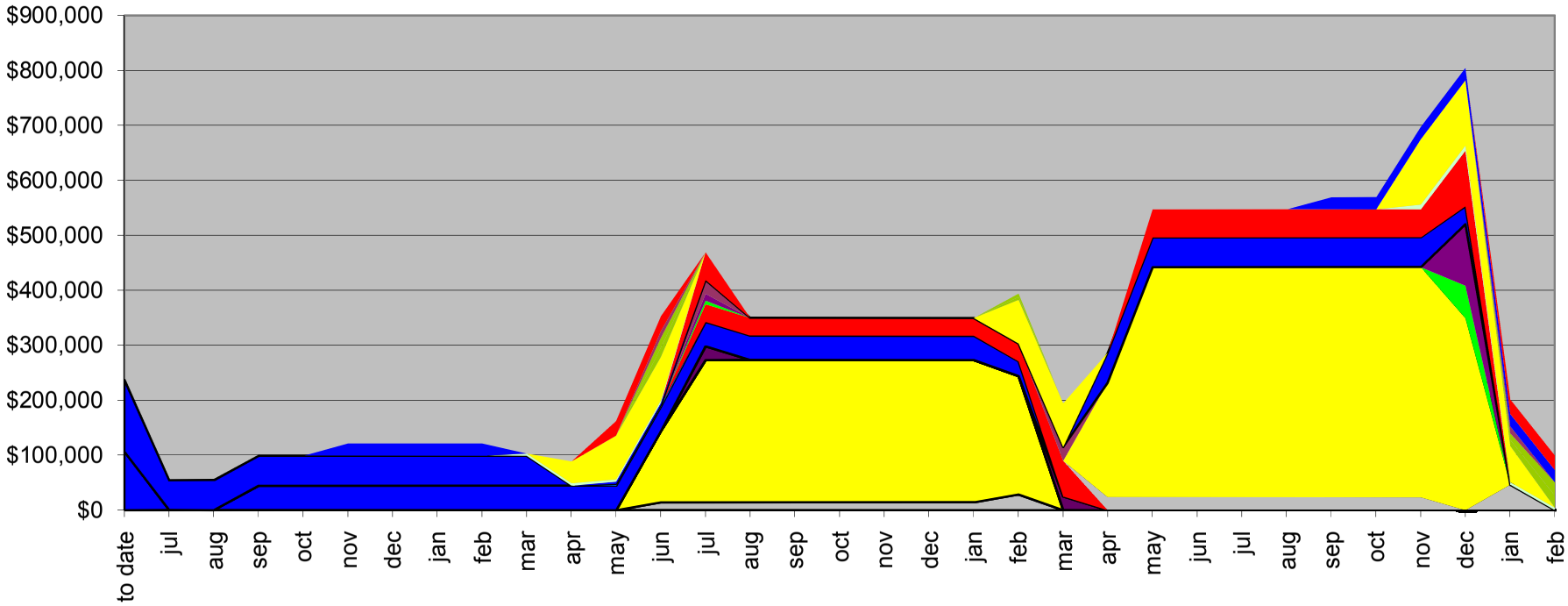
Legal & Real Estate Expense
The costs in this category are quite low as the hospital already owns the real estate associated with this project. There is an allowance for legal review of contracts such as the architectural contract, the bid documents and ultimately the Contractors contract.

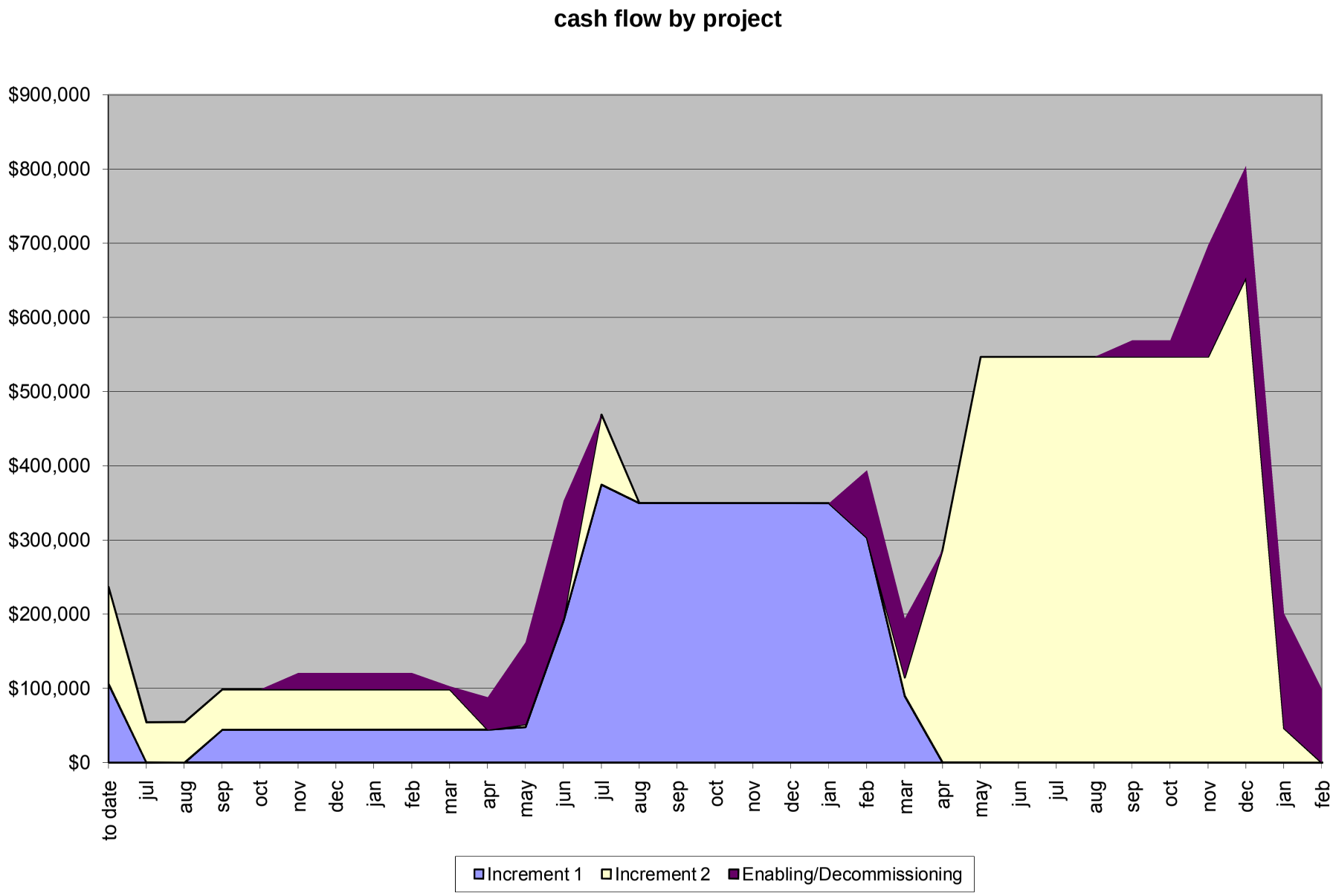
Contingency
This category is an overlaying contingency of 10% of the estimated total project cost, including the Construction cost category. This amount is deemed appropriate based upon Jtec's, experience with similar type construction projects. This is especially important given the nature of this construction project and the unforeseen variables that will present themselves as we move forward.

The budget document will be updated monthly to reflect the actual amount "Committed" to date, the amount "Spent to Date" and the "Remaining Budget". This document will be reported to the board each month going forward.

We feel that this budget accurately reflects the current scope of the project and the areas and operations that will be impacted. Although we know there will be unknown variables, we have made efforts to discover as many as we could to develop a solid budget necessary to complete this project.

Alameda Hospital - Capital Projects Cash Flow




cash flow by project
$900,000
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0
to date
jul
aug
sep
oct
nov
dec
jan
feb
mar
apr
may
jun
jul
aug
sep
oct
nov
dec
jan
feb
mar
apr
may
jun
jul
aug
sep
oct
nov
dec
jan
feb
Increment 1
Increment 2
Enabling/Decommissioning

Project Budget Alameda Hospital

10/29/2010

Combined Project budget

Description	2010 Budget	Committed	Spent to date	Budget remaining
Fees, Entitlements & Permits	**$418,834**	***$0***	***$0***	***$418,834***
Construction	**$6,307,737**	***$0***	***$0***	***$6,307,737***
Equipment	**$121,000**	***$0***	***$0***	***$121,000***
Furniture and Furnishings	**$184,300**	***$0***	***$0***	***$184,300***
Communications	**$125,000**	***$0***	***$0***	***$125,000***
Professional services	**$2,200,117**	***$1,240,450***	***$674,882***	***$1,525,235***
Legal and Real Estate	**$15,000**	***$0***	***$0***	***$15,000***
Contingency	**$937,199**	***$0***	***$0***	***$937,199***
total	**$10,309,187**	**$1,240,450**	***$674,882***	***$9,634,305***

Description	2010 Budget	Committed	Spent to date	Budget remaining	NOTES/Risks
Fees, Entitlements & Permits					
OSHPD Permit Fees (1.64% of Constr.)	$103,447	$0	$0	$103,447	
Testing & Special Inspection (5%)	$315,387	$0	$0	$315,387	
Roof Testing	$0	$0	$0	$0	
Contingency	$0	$0	$0	$0	
TOTAL CATEGORY #1	**$418,834**	***$0***	***$0***	***$418,834***	
Construction					
NPC-3 Work (Surgery Area)	$500,000	$0	$0	$500,000	
Bridge Removal, Liquefaction Mitigation, Shear Walls	$1,455,237	$0	$0	$1,455,237	per Faithful Gould 6/1/10
Make Ready enabling Moves	$300,000	$0	$0	$300,000	
Kitchen Café	$3,460,000	$0	$0	$3,460,000	per Davis Langdon 8/17/10
Lead/Asbestos - Sampling	$27,500	$0	$0	$27,500	
Lead/Asbestos - Abatement	$60,000	$0	$0	$60,000	
West Wing subgrade improvements	$75,000	$0	$0	$75,000	
Waterproofing allowance	$50,000	$0	$0	$50,000	
Miscellaneous utility bracing allowance	$30,000	$0	$0	$30,000	
Decommissioning projects	$350,000	$0	$0	$350,000	East kitchen dining renovation
TOTAL CATEGORY # 2	**$6,307,737**	***$0***	***$0***	***$6,307,737***	
Equipment					
Kitchen Equipment Allowance	$15,000	$0	$0	$15,000	
Decommissioning Equipment Allowance	$50,000	$0	$0	$50,000	
Contingency 10%	$56,000	$0	$0	$56,000	per kitchen equpiment in DL
TOTAL CATEGORY # 3	**$121,000**	***$0***	***$0***	***$121,000***	
Furniture and Furnishings					
Artwork and Plants	$5,000	$0	$0	$5,000	
Furniture and Furnishings	$80,000	$0	$0	$80,000	
Lockers Allowance	$8,000	$0	$0	$8,000	
Signage Fabrication and Install allowance	$50,000	$0	$0	$50,000	
Make Ready Moves furniture Allowance	$30,000	$0	$0	$30,000	
contingency 10%	$11,300	$0	$0	$11,300	
TOTAL CATEGORY # 4	**$184,300**	***$0***	***$0***	***$184,300***	
Communication					
IT Cabling & Equipment	$108,276	$0	$0	$108,276	
Contingency	$16,724	$0	$0	$16,724	
TOTAL CATEGORY # 5	**$125,000**	***$0***	***$0***	***$125,000***	
Professional Services					
Previous struct/geotech fees paid	$197,190	$197,190	$197,190	$0	
Make Ready Design	$80,000	$0	$0	$80,000	
Architecture/engineering	$883,960	$650,000	$445,772	$438,188	
CD add services (server room / increment 3)	$27,900	$27,900	$7,000	$20,900	
Fugro Liquefaction Additional testing	$16,987	$0	$0	$16,987	
Geo Technical Field Administration	$101,603	$0	$0	$101,603	
Pre-Construction Project Management	$131,400	$131,400	$24,920	$106,480	
Construction Management	$207,730	$0	$0	$207,730	
OSHPD Field Observation (IOR) 3% Construction	$189,232	$0	$0	$189,232	
FA design	$40,000	$0	$0	$40,000	
Reimburseables	$111,115	$0	$0	$111,115	
Nursecall upgrade allowance	$100,000	$0	$0	$100,000	
Contingency	$113,000	$0	$0	$113,000	
TOTAL CATEGORY #6	**$2,200,117**	***$1,006,490***	***$674,882***	***$1,525,235***	
Legal & Real Estate Expenses					
Contract review	$10,000	$0	$0	$10,000	
Insurance policy review	$5,000	$0	$0	$5,000	
TOTAL CATEGORY # 7	**$15,000**	***$0***	***$0***	***$15,000***	
SUBTOTAL CATEGORIES 1-7	**$9,371,988**	***$1,006,490***	***$674,882***	***$8,697,106***	
Contingency					
Owner's Contingency (10%)	$937,199	$0	$0	$937,199	
TOTAL CATEGORY #8	**$937,199**	***$0***	***$0***	***$937,199***	
TOTAL PROJECT	**$10,309,187**	***$1,006,490***	***$674,882***	***$9,634,305***	

Project Budget Alameda Hospital

10/29/2010

Increment 1

Description	2010 Budget	Committed	Spent to date	Budget remaining
Fees, Entitlements & Permits	**$143,108**	**$0**	**$0**	***$143,108***
Construction	**$2,155,237**	**$0**	**$0**	***$2,155,237***
Equipment	**$0**	**$0**	**$0**	***$0***
Furniture and Furnishings	**$0**	**$0**	**$0**	***$0***
Communications	**$50,000**	**$0**	**$0**	***$50,000***
Professional services	**$886,657**	**$515,830**	**$321,828**	***$564,830***
Legal and Real Estate	**$7,500**	**$0**	**$0**	***$7,500***
Contingency	**$324,250**	**$0**	**$0**	***$324,250***
total	**$3,566,752**	**$515,830**	**$321,828**	***$3,244,925***

Description	2010 Budget	Committed	Spent to date	Budget remaining	NOTES/Risks
Fees, Entitlements & Permits					
OSHPD Permit Fees (1.64% of Constr.)	$35,346			$35,346	
Testing & Special Inspection (5%)	$107,762			$107,762	
TOTAL CATEGORY #1	**$143,108**	***$0***	***$0***	***$143,108***	
Construction					
NPC-3 Work (Surgery Area)	$500,000			$500,000	
Bridge Removal, Liquefaction Mitigation, Shear Walls	$1,455,237			$1,455,237	per Faithful Gould 4/2/10
Lead/Asbestos - Sampling and clearances	$25,000			$25,000	
Lead/Asbestos - Abatement	$50,000			$50,000	
West Wing subgrade improvements	$75,000			$75,000	moves and added allowance
Waterproofing allowance	$50,000			$50,000	
TOTAL CATEGORY # 2	**$2,155,237**	***$0***	***$0***	***$2,155,237***	
Equipment					
				$0	
				$0	
				$0	
TOTAL CATEGORY # 3	**$0**	***$0***	***$0***	***$0***	
Furniture and Furnishings					
				$0	
				$0	
				$0	
				$0	
TOTAL CATEGORY # 4	**$0**	***$0***	***$0***	***$0***	
Communication					
IT Cabling & Equipment relocations	$33,276	$0	$0	$33,276	next level estimate 7/27/10
Contingency	$16,724	$0	$0	$16,724	
TOTAL CATEGORY # 5	**$50,000**	***$0***	***$0***	***$50,000***	
Professional Services					
Previous struct/geotech fees paid	$197,190	$197,190	$197,190	$0	
Architecture/engineering	$259,960	$259,960	$114,710	$145,250	
Fugro Liquefaction Additional testing	$16,987			$16,987	four additional tests
Geo Technical Reporting and CA	$101,603			$101,603	
Pre-Construction Project Management	$58,680	$58,680	$9,928	$48,753	
Construction Management	$103,865			$103,865	
OSHPD Field Observation (IOR) 3% Construction	$64,657			$64,657	
Reimburseables	$45,715			$45,715	
Contingency	$38,000			$38,000	
TOTAL CATEGORY #6	**$886,657**	***$515,830***	***$321,828***	***$564,830***	
Legal & Real Estate Expenses					
contract review	$5,000	$0	$0	$5,000	
insurance policy review	$2,500	$0	$0	$2,500	
TOTAL CATEGORY # 7	**$7,500**	***$0***	***$0***	***$7,500***	
SUBTOTAL CATEGORIES 1-7	**$3,242,502**	***$515,830***	***$321,828***	***$2,920,674***	
Contingency					
Owner's Contingency (10%)	$324,250	$0	$0	$324,250	
TOTAL CATEGORY #8	**$324,250**	***$0***	***$0***	***$324,250***	
TOTAL PROJECT	**$3,566,752**	***$515,830***	***$321,828***	***$3,244,925***	

Increment 2

Description	2010 Budget	Committed	Spent to date	Budget remaining
Fees, Entitlements & Permits	**$231,736**	***$0***	***$0***	***$231,736***
Construction	**$3,490,000**	***$0***	***$0***	***$3,490,000***
Equipment	**$66,000**	***$0***	***$0***	***$66,000***
Furniture and Furnishings	**$124,300**	***$0***	***$0***	***$124,300***
Communications	**$50,000**	***$0***	***$0***	***$50,000***
Professional services	**$1,089,545**	**$710,580**	**$347,990**	***$741,556***
Legal and Real Estate	**$7,500**	**$0**	**$0**	***$7,500***
Contingency	**$505,908**	***$0***	***$0***	***$505,908***
total	**$5,564,989**	**$710,580**	**$347,990**	***$5,217,000***

Description	2010 Budget	Committed	Spent to date	Budget remaining	NOTES/Risks
Fees, Entitlements & Permits					
OSHPD Permit Fees (1.64% of Constr.)	$57,236			$57,236	
Testing & Special Inspection (5%)	$174,500			$174,500	
Roof Testing				$0	
Contingency				$0	
TOTAL CATEGORY #1	**$231,736**	***$0***	***$0***	***$231,736***	
Construction					
				$0	
Kitchen Café	$3,460,000			$3,460,000	per Davis Langdon 8/17/10
				$0	
				$0	
Miscellaneous utility bracing allowance	$30,000			$30,000	
TOTAL CATEGORY # 2	**$3,490,000**	***$0***	***$0***	***$3,490,000***	
Equipment					
Kitchen Equipment Allowance	$15,000			$15,000	installation and miscellaneous
Kitchen Contingency 10%	$51,000			$51,000	510K equipment in construction
TOTAL CATEGORY # 3	**$66,000**	***$0***	***$0***	***$66,000***	
Furniture and Furnishings					
Artwork and Plants	$5,000			$5,000	
Furniture and Furnishings	$80,000			$80,000	Café Seating
Lockers Allowance	$8,000			$8,000	
Signage Fabrication and Install allowance	$20,000			$20,000	
				$0	
contingency 10%	$11,300.0			$11,300	
TOTAL CATEGORY # 4	**$124,300**	***$0***	***$0***	***$124,300***	
Communication					
IT Cabling & Equipment & design	$50,000		$0	$50,000	
Contingency	$0	$0		$0	
TOTAL CATEGORY # 5	**$50,000**	***$0***	***$0***	$50,000	
Professional Services					
Architecture/engineering	$624,000	$624,000	$331,062	$292,938	
CD add services (server room / increment 3)	$27,900	$27,900	$7,000	$20,900	
Pre-Construction Project Management	$58,680	$58,680	$9,928	$48,753	
Construction Management	$103,865			$103,865	
OSHPD Field Observation (IOR) 3% Construction	$104,700			$104,700	
FA design	$40,000			$40,000	
Reimburseables	$65,400			$65,400	
Contingency	$65,000			$65,000	
TOTAL CATEGORY #6	**$1,089,545**	***$710,580***	***$347,990***	***$741,556***	
Legal & Real Estate Expenses					
contract review	$5,000	$0	$0	$5,000	
insurance policy review	$2,500	$0	$0	$2,500	
TOTAL CATEGORY # 7	**$7,500**	***$0***	***$0***	$7,500	
SUBTOTAL CATEGORIES 1-7	**$5,059,081**	***$710,580***	***$347,990***	***$4,711,092***	
Contingency					
Owner's Contingency (10%)	$505,908			$505,908	
TOTAL CATEGORY #8	**$505,908**	***$0***	***$0***	***$505,908***	
TOTAL PROJECT	**$5,564,989**	***$710,580***	***$347,990***	***$5,217,000***	

Enabling / Decommissioning

Description	2010 Budget	Committed	Spent to date	Budget remaining
Fees, Entitlements & Permits	**$43,990**	***$0***	***$0***	***$43,990***
Construction	**$662,500**	***$0***	***$0***	***$662,500***
Equipment	**$55,000**	***$0***	***$0***	***$55,000***
Furniture and Furnishings	**$60,000**	***$0***	***$0***	***$60,000***
Communications	**$25,000**	***$0***	***$0***	***$25,000***
Professional services	**$223,915**	**$14,040**	**$5,065**	***$218,850***
Legal and Real Estate	**$0**	**$0**	**$0**	***$0***
Contingency	**$107,041**	***$0***	***$0***	***$107,041***
total	**$1,177,446**	**$14,040**	**$5,065**	***$1,172,381***

Description	2010 Budget	Committed	Spent to date	Budget remaining	NOTES/Risks
Fees, Entitlements & Permits					
OSHPD Permit Fees (1.64% of Constr.)	$10,865			$10,865	
Testing & Special Inspection (5%)	$33,125			$33,125	
Roof Testing				$0	
Contingency				$0	
TOTAL CATEGORY #1	**$43,990**	***$0***	***$0***	***$43,990***	
Construction					
				$0	
Make Ready enabling Moves	$300,000			$300,000	
Lead/Asbestos - Sampling East building	$2,500			$2,500	
Lead/Asbestos - Abatement East building	$10,000			$10,000	
				$0	
Decommissioning projects	$350,000			$350,000	East kitchen dining renovation
TOTAL CATEGORY # 2	**$662,500**	***$0***	***$0***	***$662,500***	
Equipment					
Decommissioning Equipment Allowance	$50,000			$50,000	
Decommissioning Contingency 10%	$5,000			$5,000	
TOTAL CATEGORY # 3	**$55,000**	***$0***	***$0***	***$55,000***	
Furniture and Furnishings					
Artwork and Plants				$0	
Furniture and Furnishings				$0	
Lockers Allowance				$0	
Signage Fabrication and Install allowance	$30,000			$30,000	
Make Ready Moves furniture Allowance	$30,000			$30,000	
Contingency				$0	
TOTAL CATEGORY # 4	**$60,000**	***$0***	***$0***	***$60,000***	
Communication					
IT Cabling & Equipment Allowance	$25,000		$0	$25,000	
Contingency	$0			$0	
TOTAL CATEGORY # 5	**$25,000**	***$0***	***$0***	$25,000	
Professional Services					
Make Ready Design	$80,000			$80,000	
Pre-Construction Project Management	$14,040	$14,040	$5,065	$8,975	
Construction Management					
OSHPD Field Observation (IOR) 3% Construction	$19,875			$19,875	
Nursecall upgrade allowance	$100,000			$100,000	
Contingency	$10,000			$10,000	
TOTAL CATEGORY #6	**$223,915**	***$14,040***	***$5,065***	***$218,850***	
Legal & Real Estate Expenses					
contract review		$0		$0	
insurance policy review					
TOTAL CATEGORY # 7	**$0**	***$0***	***$0***	$0	
SUBTOTAL CATEGORIES 1-7	**$1,070,405**	***$14,040***	***$5,065***	***$1,065,340***	
Contingency					
Owner's Contingency (10%)	$107,041			$107,041	
TOTAL CATEGORY #8	**$107,041**	***$0***	***$0***	***$107,041***	
TOTAL PROJECT	**$1,177,446**	***$14,040***	***$5,065***	***$1,172,381***	

Alameda Hospital
Compliance Program

Annual Report
To
Board of Directors

January 2009 – June 2010

Privileged & Confidential

Presented by:
Joyce Walker
Compliance Officer

ANNUAL COMPLIANCE REPORT
January 2009 through June 2010

Background

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

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

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

DHHS/OIG Work Plan – 2009/2010

The mission of the Office of Inspector General (OIG) is to protect HHS program integrity and beneficiary well-being by detecting and preventing waste, fraud and abuse; identifying to Congress, HHS, and the public opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who violate program requirements.

Four components carry out OIG's mission-related activities:

- The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others.

- The Office of Evaluations and Inspections (OEI) conduct national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues.

- The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries.

- The Office of Counsel to the Inspector General (OCIG) provides general and legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support to OIG's internal operations.

Annually, the OIG conducts a comprehensive work-planning process to identify the areas most worthy of attention in the coming year. The factors taken into account to produce the final Work Plan include:

- requirements for OIG reviews, as set forth in laws, regulations, or other directives,
- requests made or concerns raised by Congress and HHS's management,
- significant management and performance challenges facing HHS, which are identified as part of HHS's annual agency financial report,
- work performed by HHS and other organizations, such as the Government Accountability Office and the Office of Management and Budget (OMB); and
- Management's actions to implement OIG recommendations from previous reviews.

At Alameda Hospital, each year's OIG Work Plan is used as a guide to focus our efforts to review internal practices, policies, and procedures as they apply to hospital compliance.

Summary of 2009 Compliance Activity

Compliance Committee

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

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

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

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

Standards of Conduct and Training

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

The Deficit Reduction Act of 2005 requires any entity that receives or makes payments under Medicaid of at least five million dollars to have established written policies and procedures regarding the Federal and State False Claims Act for their employees, agents and contractors. In the fall of 2008, the Hospital implemented Administrative Policy #53 which provides important information concerning false claims liability, anti-retaliation protections, and detecting and responding to fraud, waste and abuse.

Each new employee and member of the Medical Staff receives a copy of the Compliance Plan document and Administrative Policy #53.

At each new employee orientation session held during 2009 and fiscal 2010, there has been a presentation on the Compliance Program at Alameda Hospital, including a review of the plan document and Administrative Policy #53, and a discussion of the employee's compliance rights and responsibilities. A separate presentation on the Health Insurance Portability and Accountability Act (HIPAA) was also done as a part of the orientation program.

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

Reports, Inquiries and Audits

The compliance hotline was established in 2004 to provide a confidential mechanism for employees to report issues, complaints or problems to the Compliance Committee. The hotline number is found in the Compliance Plan as well as in the hospital internal telephone directory. It is checked weekly to collect any complaints, problems or issues for review at the next scheduled Compliance Committee meeting.

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

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

The hospital has made necessary coding and billing changes its patient accounting systems based upon periodic updates published by the Centers for Medicare and Medicaid Services.

Policies and Procedures

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

From time to time, new procedures are developed and implemented based upon State and Federal mandates or other changes in hospital procedures. To comply with sections 114 and 315 of the Fair and Accurate Credit Transactions Act of 2003 (enforced by the Federal Trade Commission), an Identity Theft policy (Administrative Policy #86) was implemented at the hospital. The policy identifies the hospital's procedure to detect, prevent and mitigate identity theft in connection with opening a "covered account" A "covered account" is any account Alameda Hospital offers or maintains primarily for personal, family or household purposes that involves or is designed to permit multiple payments or transactions; and any other account Alameda Hospital offers or maintains for which there is a reasonably foreseeable risk to patients or to the safety and soundness of Alameda Hospital from identity theft. The Federal Trade Commission has announced that it will not enforce the "Red Flag Rule" until January 2011.

Disciplinary Procedures

No compliance issues have resulted in disciplinary actions over the last eighteen months.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided for the implementation of Public law 104-191. This law was intended to guarantee the confidentiality of

records by establishing a three-pronged security process including electronic data interchange, privacy of patient health information, and security of patient records. Alameda Hospital has taken steps to comply with this law:

- Developed updates to keep staff informed about HIPAA, patient privacy, and the security of patient records.
- Developed a Notice of Privacy Practices (NPP) which is distributed to all patients during the registration process.
- Developed and implemented Business Associate agreements with all vendors that have access to protected patient information.
- Upgraded the hospitals computer network, including the segmentation of the network to increase network security, a new firewall to monitor all inbound and outbound network traffic, and software that monitors network security events and notifies staff in the event of a breach.
- Created disaster recovery resources including restoration of the Hospital's backup tapes and assistance for 30 days in the event of a disaster that causes the loss of data storage and access software.

In February of 2009, President Obama signed into law the American Recovery and Reinvestment Act (ARRA). A part of this act, the Health Information Technology for Economic and Clinical Health Act (HITECH) included numerous provisions that will impact the way health care providers handle and protect patient health information. Highlights of the HITECH law include:

- Financial incentives, grants and loans to assist hospitals in adopting electronic health records;
- Penalties in the future for hospitals that fail of adopt electronic health records;
- Stricter privacy and security provisions including breach notification requirements, new restrictions on disclosure of protected health information, new rights for patients regarding electronic health records, and regulations to extend security provisions to business associates.

Alameda Hospital has begun to take steps to come into compliance with the new laws. Plans are underway to enhance systems software to enable the hospital to adopt electronic health records. This will be a four step process called Advanced Clinical Services which will include the implementation of Patient Care System (PCS), Physician Care Manager (PCM), Emergency Department Manager (EDM), and ORM (Operating Room Manager). This process will be spread over several years. Revisions to the current Business Associate agreements have been finalized and the new agreements are being forwarded to vendors for signature. During the next

year, the hospital plans to assess security controls currently in place, perform security risk analyses, and develop a risk management plan to address identified issues.

Medicare Program

The permanent Medicare Recovery Audit Contractor (RAC) program was implemented in California in early 2010. This program was derived from the demonstration program that was instituted in California, New York and Florida. The RAC auditors are for-profit companies which have been given the authority to aggressively take back overpayments on behalf of Medicare.

To prepare for the permanent RAC program, which will be administered in California by Health Data Insights (HDI), Alameda Hospital has assembled a multidisciplinary RAC team, and has contracted with The Advisory Board to use its web based Revenue Integrity Compass (RIC). This tool will enable the hospital to be proactive in assessing its audit risk, to aggressively manage the audit process, and to help guarantee the safeguarding of its revenue.

Recommendations

Although the hospital has experienced very few compliance related issues, it is still imperative that the program remain current in scope and visible to its employees, volunteers and medical staff. The following recommendations should help in this process.

Review and revise the hospitals HIPAA policies and procedures, paying particular attention to the new rules and regulations around the HITECH act. Develop more stringent staff training regarding this issue. Continue to update all Business Associate agreements with appropriate vendors.

Schedule and document proactive internal and external audits that demonstrate the hospital's commitment to the evaluation of its billing and coding processes.

Establish a Compliance site on the hospital's intranet which will include pertinent training and reference information, as well as copies of all compliance policies and links to other internal and external compliance related sites.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: November 1, 2010

To: City of Alameda Health Care District Board of Directors

From: Jordan Battani, Board President

Subject: CEO Employment Agreement Renewal

Recommendation:

Authorize the renewal of the CEO employment agreement with Deborah Stebbins effective November 1, 2010 including the revisions and adjustments detailed in the memo below.

Background:

The original CEO employment agreement with Deborah Stebbins is due for update and renewal effective November 1, 2010 at the conclusion of the one-year extension period on the original 2007 agreement.

Stebbins performance, leadership and results have consistently exceeded expectations, based on her annual performance appraisals and the overall performance of the Hospital.

Alameda Hospital and the Health Care District face significant challenges over the next few years, and continuity and excellence in leadership will be a key success factor for the organization.

Discussion:

Under the terms of the existing employment agreement, Stebbins base compensation was due for evaluation and adjustment on November 1, 2009. Although her performance evaluation was completed by the Board at that time, the review of compensation did not take place and no adjustment was made. Based on the Alameda Hospital pay practices, and budget, in place at that time Stebbins would have been eligible for an increase of 3% to her base compensation.

There is some evidence (see attached materials) that total compensation for the CEO at Alameda Hospital does not reflect current market conditions in terms of base compensation, and in terms of the distribution of total compensation between base compensation and incentive based earnings. In order to properly evaluate this evidence, the Board requires a fact based, systematic assessment of relevant market comparisons – which is not possible based on the information available at the time of employment

agreement renewal. Accordingly, we have commissioned a survey and evaluation of relevant hospital CEO total compensation which will be completed in the first quarter of FY2011. This market survey approach will become a standard periodic evaluation going forward.

A number of provisions in the existing employment require updating in order to align the renewed agreement with

- the strategic objectives of the Hospital and the District
- relevant market conditions and comparisons of total compensation for hospital executives
- pay and performance evaluation policies established for the Hospital
- relevant regulatory requirements

Summary of changes to the existing employment agreement.

Term
The term of the agreement will be three years beginning on November 1, 2010. At the end of this three year period the agreement can be extended for an additional one year. In the event that the contract is extended for the additional year, all of the terms and conditions of the employment agreement will remain in force.

Termination
This agreement can be terminated by Stebbins or the District. Stebbins agrees to provide at least 90 days notice of resignation.

In the event that the District terminates Stebbins employment during the duration of this agreement (three years, plus any extensions as noted above) ***other than for cause or disability*** the District will pay Stebbins severance according to the terms described below.

Severance
Severance payment will be paid under the following circumstances:

- Termination of Stebbins employment with the District ***other than for cause or disability***

- Elimination of Stebbins position with the District in the event of an organizational change or restructuring that does not offer a position comparable in compensation, authority or scope of responsibility

- Severance payment will be equal to Stebbins monthly base compensation times the number of months remaining on the employment agreement. The severance payment will not exceed 18 months of base compensation. (Note that this is in compliance with Gov't. Code Section 53260)

Compensation
Base compensation will be evaluated annually, at the anniversary date of the employment agreement, and will be subject to the standards, policies and practices in place for all non-represented Alameda Hospital employees.

A market assessment of the total compensation package will be conducted by the Board at least once during the duration of the employment agreement. Any adjustments to total compensation that result from that review will be approved and finalized in conjunction with the annual planning and budget cycle for Alameda Hospital and the District.

Summary of Adjustments

- A one-time payment to Stebbins of $8700.00 to reflect the 3% increase to her base compensation that should have taken place on 11.1.2009

Date	Corrected Base (annual)	Actual Base (annual)	# of months	Variance
11.1.2009 to 2.28.2010	302,000	300,000	4	$3000
3.1.2010 to 10.31.2009	293,550*	285,000	8	$5700
Total				$8700

*Reflects the 5% wage rollback for all non-represented employees

- Increase CEO base compensation to $293,550 effective 11.1.2010 to reflect the 2009 increase

- Evaluate findings from market survey of total compensation. Determine approved changes for incorporation to FY2012 budget and planning cycle with an expected effective date of July 1, 2011.

PAYERS & PROVIDERS

WHITE PAPER

A Survey Of Not-For-Profit Hospital CEO Salaries

Many Are Paid Above The Nationwide Average; Some Earn Millions

By RON SHINKMAN

INTRODUCTION

Those employed by hospitals – as well as elsewhere – often wonder how much their superiors are paid. It's a seminal workplace question.

When I first began writing about healthcare in the early 1990s, such questions were as mystery-shrouded for journalists as they were for employees.

Not-for-profit institutions such as hospitals were required to file 990-Form tax returns with the **Internal Revenue Service**. However, an actual member of the public obtaining them was another matter. You could file a state public records act or Freedom of Information Act request, but it was a time-consuming process that could take months to produce results.

> *"If you want excellence, you need to be able to attract those people, and be able to compete against the investor-owned hospitals."*
>
> ***– Michael Landes, Eisenhower Medical Center Foundation***

When I worked as a reporter at ***Modern Healthcare*** magazine in the latter half of the 1990s, some of the rules regarding such data had begun to be relaxed. Hospitals and other non-profit institutions were required to have their most recent tax returns on hand, or mail them out upon request.

That led to an interesting although not terribly fruitful interlude at the magazine, wherein the 990s of various healthcare lobbying groups were obtained and scrutinized. Yet few of the juiciest items from those forms ever made it into print. I could probably author another white paper on the articles that were killed or watered down by my editors at ***Modern Healthcare*** out of concerns of being sued or offending potential advertisers.

Much has changed in the decade after I left the magazine and began working as an independent journalist and consultant. First, I am no longer beholden to the interest of other editors who are themselves beholden (whether this is good or bad is a matter of debate).

Secondly, the Internet, in its infancy as a research tool in the 1990s, has now transformed how journalists obtain and process information. Today, 990s are obtainable from virtually any computer, with the waiting time for downloads the only obstacle.

Lastly, the reporting process for 990s have been modified to provide greater transparency as to executive compensation. Not only is compensation

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CEO Salaries White Paper (Continued From Page 1)

clearly stated, it is broken up into definable categories.

METHODOLOGY

I want to make clear that I am trained as a journalist rather than a statistician. The data in this survey reflects that. It may be skewed in some ways that someone with more training in statistics may have spotted more readily and controlled for specifically. I therefore offer it as a snapshot of salary conditions among California's not-for-profit hospital CEOs – not as a scientifically rigorous, peer-reviewed study. However, it does contain many of the elements a survey reader would look for. That would include averages, medians and ranges. I also conducted interviews with salary experts – who have far more expertise in this arena than myself – and the data I shared with them suggests that the survey presented here is accurate.

The focus of this survey was on not-for-profit hospitals because their tax returns are publicly available. They were obtained via **Guidestar** (www.guidestar.org), which provides data on non-profit organizations.

Altogether, tax returns were obtained for 118 hospitals in California, about 30% of the overall total. The bed size of the participating hospitals ranged from 14 to 1,072 beds.

The average hospital size in the survey was 267 beds, and the median hospital size was 224 beds. According to data gathered by the **Office of Statewide Health Planning and Development**, the average hospital in California is licensed for 205 beds. A median was unavailable.

Although the transparency of tax data is fairly uniform for not-for-profit hospitals, its availability is not. Some hospitals file extensions for their tax returns that may last six months or longer. As a result, the tax returns obtained for this survey are either for the 2007 or 2008 calendar or fiscal years, whichever was the most currently available. Altogether, 64 tax returns were from 2007 and 54 were from 2008. For those who have purchased the raw data on which this survey was based, the specific reporting year is noted for each hospital.

This survey includes few district hospitals, which as public agencies are not usually required to file tax returns. Some separate entities operate district hospitals and are required to file a tax return. Only a handful of such returns were obtained for this survey. I acknowledge this may skew the data away from rural hospitals, many of which are operated by healthcare districts, and often compensate their executives at a level significantly lower than larger urban facilities. It is hoped that the resources will be available for the next survey to obtain the salary information for the district hospitals.

This relative dearth of rural hospitals is counterbalanced to some extent in that hospitals operated by the **University of California** and county-based, publicly-operated facilities were also excluded. They are among the largest hospitals in California, and some presumably pay their executives higher-than-average salaries due to the complexity of their operations.

OSHPD data was used for the net income and charity care figures included in this survey. The data was correlated to the most recently available year for each hospital's tax return. The data is self-reported by the hospitals and audited by OSHPD for accuracy. Of course, there has been much debate over how hospitals report their charity care data, and how it should be compared to its overall expenditure on public benefits. That will be discussed in some depth here.

NOTES ON THE SURVEY

The salaries of 119 CEOs and one senior executive were obtained in total. Along with the CEO of **Hoag Memorial Hospital Presbyterian,** the pay of a retiring executive vice president was included because his exit package was larger than the CEO's compensation in the available year. **San Gorgonio Memorial Hospital** had two CEOs during their available reporting year.

The compensation of three system CEOs were also included. They were **Gregory Adams** and **Benjamin Chu** of **Kaiser Permanente's** Northern California and Southern California divisions, and **Chris Van Gorder** of **Scripps Health**. The reason that their salaries were included is that the salary data for the individual hospitals within each of these systems could not be obtained. Kaiser's individual hospitals also are not required to report their financial data to OSHPD.

Although most salary data experts separate data between systems and hospitals, I felt it appropriate to report what I could find in these instances, given these are two significant hospital operators in California. Their salaries were also in line with CEOs of some of the larger hospitals, so if they do skew the data, it is not significantly so.

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CEO Salaries White Paper (Continued From Page 2)

In a few instances, salary data was reported for hospital CEOs who are also system CEOs, such as James Yoshioka at **Citrus Valley Health Partners, Ronald Werft of Cottage Health System** and **J. Kendall Anderson** of **John Muir Health**. They are listed as the individual CEO for each of their hospitals, and their compensation is reported on the individual tax returns for their hospitals.

I was able to obtain virtually all of the salary data for the individual CEOs at **Sutter Health** and **Adventist Health's** hospitals, and therefore they were broken down and reported separately.

In stark contrast was **Catholic Healthcare West**, the state's largest hospital operator. No salary data was available at all for CHW at either the hospital or system level, despite filing a tax return that is significantly longer than all the others that were obtained.

The Five Most Highly Compensated Hospital CEOs/Executives

1. **J. Kendall Anderson, John Muir Health, $7.45 million (2008)**
2. **Thomas Priselac, Cedars-Sinai Medical Center, $2.99 million (2007)**
3. **Peter Foulke, EVP, Hoag Memorial Hospital Presbyterian, $2.38 million (2007)**
4. **Chris Van Gorder, Scripps Health (system), $1.66 million (2007)**
5. **Martha Marsh, Stanford Hospital & Clinics, $1.58 million (2007)**

How Some Other CEOs Fare

1. **Warren Kirk, Alta Bates Medical Center, $845,237 (2007)**
2. **Jon Van Boening, Bakersfield Memorial Hospital, $650,360 (2007)**
3. **Barry Wolfman, Providence St. Joseph Medical Center, $514,024 (2008)**
4. **Catherine Fickes, St. Vincent Medical Center, $440,274 (2007)**
5. **John Frye, Madera Community Hospital, $239,917 (2007)**

BASE SALARIES

The average base salary for the CEOs surveyed was $514,237, and the median was $442,000. Base salaries ranged from $169,789 to $2.375 million.

According to data from **Integrated Healthcare Strategies** (IHS) in Minneapolis, the median base salary among hospital CEOs nationwide was $434,000 in 2009, the most recent year for which data was available.

According to a **Hay Group** survey published in 2001, hospital CEO base salaries nationwide reached a median of $231,000, while the median of overall compensation totaled $242,000. Pay was significantly higher if the CEO ran a hospital with revenue of more than $200 million: base pay reached a median of $306,400, while the median of overall compensation reached $316,400.

That's obviously changed. Industry observers say that the competition to find qualified CEOs has put a lot of pressure on hospital boards to ratchet up compensation.

"The challenge is that the average has been creeping nationwide up over the years," said **Kathryn Peisert**, managing editor of the **Governance Institute** in San Diego.

Moreover, compensation experts say pay among hospital CEOs in California anywhere from 5% to 12% higher than the nationwide average due to a variety of factors.

"The cost of living is higher in California, particularly in Los Angeles and the Bay Area, than in many other parts of the country," said **Kevin Talbot**, an IHS senior vice president.

"There are more regulatory requirements and more union activity in California, which would also impact pay," said **Claudia Wyatt-Johnson**, co-founder of **PINP, Inc.**, a Chicago-based healthcare executive compensation consulting firm.

ADDITIONAL COMPENSATION

Most of the CEOs in this survey also received additional compensation on top of their base salaries. There are a wide range of categories for additional compensation, but for most of the tax returns it was counted as either incentive pay, bonus pay, deferred compensation, lump sum retirement pay, nontaxable benefits or expense account reimbursement.

Additional compensation averaged $216,210, or slightly more than 40% of the base salary. However, the median additional compensation was $88,965, suggesting that such pay was heavily weighted toward the highest overall earners. The range of additional compensation was zero (three CEOs received no additional compensation) to $6.7 million.

Traditionally, not-for-profit CEOs earn less in additional compensation than their counterparts at for-

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profit or investor-owned hospitals. "That is where for-profit pay tends to be quite a bit higher," Talbot said. Wyatt-Johnson also noted that non-cash extras that for-profit CEOs may receive (such as country club memberships) are off-limits in the not-for-profit realm.

Nonetheless, three CEOs earned more than $1 million in additional compensation, and account for about one-third of the entire total of additional compensation. **Bernadette Smith** of **Seton Medical Center** and **Thomas Priselac** of **Cedars-Sinai Medical Center** each earned slightly more than $1 million. **J. Kendall Anderson**, CEO of **John Muir Health,** earned $6.7 million.

Of Anderson's additional compensation, $5.3 million comprised a lump sum retirement payout John Muir was required to pay under IRS guidelines when he turned 65 in 2008, according to **Alice Villanueva**, John Muir's vice president of human resources. Anderson received another $540,000 retirement payout in 2009. He has been with John Muir since the mid-1970s.

In 2007, Anderson received $823,000 in long-term and short-term performance incentives in addition to his base salary of $675,000. The long-term incentives represented the culmination of a three-year performance incentive program, according to Villanueva.

"Basically, his salary is set at the 50th percentile of the market, and he has the opportunity to reach the 75th percentile based on performance," Villanueva said.

John Muir uses data from the benefits consulting firm **Mercer** to set Anderson's salary. Mercer officials declined to comment.

Wyatt-Johnson noted that about two-thirds of hospitals and hospital systems peg compensation at the fiftieth percentile of salaries.

"There was a time when everyone wanted to pay at the 75th percentile, but that was sort of like Garrison Keillor, where everybody had a child that was above average," she said.

TOTAL COMPENSATION

Total compensation averaged $732,004 per CEO/Highest Paid Executive. That compares to the nationwide median total compensation of $511,000, according to Talbot. The median total compensation was $575,545. Total compensation ranged from $204,487 to $7.45 million.

Altogether, 18 CEOs and one senior executive earned more than $1 million per reporting year. Thirteen of those reporting years were in 2007; five in 2008.

COMPENSATION PER BED

Hospital pay in this survey was pegged to overall compensation per licensed bed. The average compensation per bed averaged $4,102. The median compensation per bed was $2,611. Compensation per bed ranged from $486 to $22,354.

FEMALE CEOs – A SIGNIFICANT COMPENSATION DISPARITY

There were 27 female hospital CEOs included in this study, and there is a distinct pay gap between this group and their male counterparts. Their average base pay was $426,879 – 17% below the overall average for the survey. Their median base pay was $358,467, 19% below the median for the entire survey. Base pay ranged from $169,789 to $1.54 million.

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The average additional compensation for female CEOs averaged $130,364, 39.8% below that of the survey as a whole. The median was $73,589, 17.3% below the median of the entire survey. Additional compensation ranged from $3,509 to $1.023 million.

Total compensation averaged $557,071, which was 23.9% below the average for the complete survey. The median total compensation was $426,250, 26% below the median for the entire survey.

To be fair, many female hospital CEOs are in charge of smaller rural hospitals. However, the average size of the hospitals overseen by women CEOs is 255 beds, only 4.5% below the average hospital size in this survey.

Overall compensation per bed for female CEOs was $3,630, 11.6% below the overall average. Overall compensation ranged from $204,487 to $1.58 million.

The salary experts did not have any comment on the pay gap between male and female hospital CEOs, as it is data they do not normally track. My suggestion: start tracking it.

"If you are providing more to your CEO than the community, that should require a revisiting of your non-profit tax status."

–Anthony Wright, Health Access

CHILDRENS' HOSPITALS – WHERE IT'S GOOD TO BE KING

The CEOs of five childrens' hospitals were included in this survey, and their compensation was on the high end. Their base salaries averaged $747,185, with a median of $777,293. Total overall compensation averaged $887,122, with a median of $999,787. Two of the CEOs – **Richard Cordova** of **Childrens Hospital Los Angeles** and **Kimberly Cripe** of **Childrens Hospital Orange County/Mission** – earned over $1 million in total compensation in 2007.

Talbot noted two factors that affect the pay of childrens' hospital CEOs: the complexity of operations tends to be higher than that of an acute care facility, with a difficult payer mix and a research component attached. Moreover, the pool of candidates is relatively limited.

"People from childrens' hospitals tend to be recruited from childrens' hospitals, so it's a bit of a supply and demand thing," he said.

NET INCOME

Although all the hospitals surveyed here are not-for-profit institutions, they are allowed to have net incomes, so long as that net is used for capital projects or other operations related to the hospitals and not distributed to individuals or shareholders.

Many hospitals have been under financial pressures due to payer mix, unfunded mandates such as **SB 1953**, or other issues. As a result, 33 of the hospitals in this survey posted losses. Of those, three had CEOs whose total compensation above $1 million. The remainder of the hospitals posted fairly strong bottom lines, with five reporting net incomes above $100 million. The average net income for the hospitals in this survey was $15.9 million. The median was $11.9 million.

THE CHARITY CARE QUESTION

Of course, charity care is a touchy subject in hospital circles. What specifically defines this category? Is it just the care rendered in the hospital to patients, or does it include the total overall community benefit?

For this study, I relied on the OSHPD data reported to the agency by the hospitals, which focuses on the cost of charity care rendered to patients.

For this survey, the average amount of charity care rendered by the hospitals was just under $5 million. The median was $1.93 million. The charity care costs ranged from $0 to $58.55 million.

Although most of the hospitals were more munificent toward their patients than their CEOs, there were still some aberrations. A total of 17 CEOs received more in compensation than their hospitals spent on charity care for the most recently available reporting year, or 14% of the total surveyed.

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This disparity came under fire from both salary experts and consumer advocates, who note that a hospital's not-for-profit status obliges it to spend a significant amount on charity care.

"I really can't see how you can defend that," Wyatt-Johnson said, adding that charity care goes to the essence of a not-for-profit hospital's mission.

Anthony Wright, executive director of **Health Access**, a Sacramento-based consumer advocacy group, concurred with Wyatt-Johnson.

"It paints a certain picture," he said. "If you are providing more to your CEO than the community, that should require a revisiting of your not-for-profit tax status."

Some of the 17 CEOs are themselves an aberration. John Muir's Anderson made the list because his 2008 lump sum retirement pay catapulted him past what his hospitals spent on charity care. However, the amount spent on charity care at John Muir decreased by about $2.3 million between 2007 and 2008, suggesting that some dollars may have been diverted to cover Anderson's payout (Net income also declined by about $13 million). Anderson declined to be interviewed.

Anderson does return some of the money to John Muir, recently donating $250,000 toward a capital campaign, according to spokesman **Ben Drew**. But that sum represents less than 3% of his overall compensation between 2007 and 2008.

Other CEOs fairly consistently earn more than their hospitals spend on charitable care. **G. Aubrey Serfling**, the CEO of **Eisenhower Medical Center** in Rancho Mirage, drew a larger total compensation package in 2006 and 2007 – about $1 million per year – than what his hospital spent on charity care.

Michael Landes, president of the **Eisenhower Medical Center Foundation**, noted the hospital's service area is one of the nation's toniest cities. "We're located in a place surrounded by country clubs," Landes said. "We don't have a lot of Medi-Cal and charity patients." However, the hospital is located in Riverside County, which has been hit particularly hard by the recession.

Wyatt-Johnson was skeptical of such an explanation. She suggested that if Eisenhower's service area was too affluent, it might consider a joint venture with a hospital in a poorer area to try and boost its level of charity care for patients who need it.

"If you are not serving a charitable purpose, you should not have that tax exemption," she said.

Landes also noted that Serfling, who received much acclaim for turning around the finances of **California Pacific Medical Center** in the mid-1990s, did much the same for Eisenhower, which was losing money when he took over a decade ago. The hospital reported net income of $30.5 million in 2007.

Moreover, Serfling transformed fundraising for the hospital, which raised less than $10 million a year before he took over. It now averages about $50 million a year – more than enough to pay for a seismically updated replacement facility.

"For us, I just cannot see penalizing a guy who took this place out of a firestorm," Landes said. "If you want excellence, you need to be able to attract those people, and be able to compete against the investor-owned hospitals."

Landes noted that if shortfalls to Medi-Cal and Medicare were included and toted up with overall community benefits, it costs the hospital about $40 million per year.

Eisenhower did spend $1.8 million on charity care in 2009, about double what it spent in 2007 – partly as a result of the deteriorating economic climate, according to Landes. That is likely to outstrip Serfling's overall compensation – unless he qualified for a lump-sum retirement payout. Serfling turned 65 last year.

WHAT'S NEXT

Although hospital CEOs have been doing quite well over the past decade, the Great Recession, which began in December 2007, has exerted a gravitational pull on salaries.

"Once we hit 2008 (salary increases) went down across the board," Talbot said. Whereas 4% annual increases in compensation were commonplace, that's down to 2.5% to 3%, he added.

Wyatt-Johnson sees an even harsher environment.

"According to our data, about 50% of CEOs received no base salary increase in 2009, and another 50% received significantly diminished incentive pay, or none at all," she said, adding that most hospitals are being hit hard by decreases in elective procedures and increases in the number of uninsured patients.

Conversely, that has also pushed hospital boards to take a harder look at how they compensate their CEOs.

"They're getting a little more assertive as to their responsibilities," Wyatt-Johnson said.

Moreover, as the facets of federal healthcare reform kick in over much of the next decade, the Governance Institute's Peisert believes hospitals will have to take a harder look at their charity policies.

"There will be less direct charity care, and hospitals will have to compensate by providing more

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community benefits," she said, adding that hospitals will also come under greater scrutiny as to the compensation-versus-charity equation.

"The tax-exempt status challenges are going to be a lot more difficult once more people are insured," Peisert said.

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Hospital Name	Year of Tax Return	Name of CEO/Highest Paid Executive	Base Salary	Additional Compensation	Total Compensation	Number of Hospital Beds	Total Compensation Per Bed	Hospital's Net Income For Year Reported
Alameda Hospital	2007	Deborah Stebbins	$192,691	$21,634	$214,325	161	$1,331	-2,448,146
Alta Bates Summit	2007	Warren J. Kirk	$664,536	$180,701	$845,237	1072	$788.46	$7,631,386
Anaheim Memorial Medical Center	2007	Byron Schweigert	$459,618	$66,614	$526,232	223	$2,360	$6,839,786
Bakersfield Memorial Hospital	2007	Jon Van Boening	$326,128	$324,232	$650,360	283	$2,298	$34,273,389
Barlow Respiratory Hospital	2007	Margaret Crane	$236,882	$11,420	$248,302	105	$2,365	$2,010,693
Barton Memorial	2007	John Williams	$399,103	$16,466	$415,569	119	$3,492	$12,242,614
Biggs-Gridley Memorial Hospital	2007	Theresa Hamilton	$365,158	$47,069	$412,227	45	$9,161	$254,013
Casa Colina Rehabilitation Center	2007	Felice Loverso	$739,009	$229,264	$968,273	68	$14,239	-1,307,320
Cedars-Sinai Medical Center	2007	Thomas Priselac	$1,960,583	$1,024,927	$2,985,510	952	$3,136	$139,687,695
Central Valley General Hospital	2008	Richard Rawson	$358,390	$219,951	$578,341	49	$11,803	$9,279,076
Childrens Hospital Central California	2007	William F. Haug	$777,622	$21,319	$798,941	297	$2,690	$22,502,605
Childrens Hospital Los Angeles	2007	Richard Cordova	$794,450	239,316	$1,033,766	286	$3,615	$26,011,525
Childrens Hospital Oakland	2007	Frank Tiedemann, M.D.	$511,342	$91,987	$603,329	190	$3,175	($1,696,624)
Childrens Hospital OC/Mission	2007	Kimberly Cripe	$875,547	$145,443	$1,020,990	48	$21,270	$2,539,106
Chinese Hospital	2008	Brenda Yee Ngou	$388,275	$151,158	$539,433	54	$9,990	$11,036,256
Citrus Valley Medical Center	2008	James Yoshioka	$680,913	$22,650	$703,563	518	$2,191	($11,009,118)
City of Hope	2007	Michael A. Freedman	$713,923	$420,814	$1,134,737	217	$5,229	$15,400,872
Colusa Regional Medical Center	2008	Dale Kirby	$212,971	$21,888	$234,859	42	$5,592	($138,848)
Community Hospital of Long Beach	2007	Ray Jankowski	$285,480	$12,418	$297,898	256	$1,164	($319,533)
Community Hospital of San Bernardino	Fiscal 2008	Jeff Winter	$570,775	$461,041	$1,031,816	321	$3,214	$787,143
Community Hospital of the Monterey Peninsula	2008	Steve Packer	$659,481	$76,616	$736,097	313	$2,352	$35,331,453
Community Memorial Hospital of San Buenavent	2008	Gary Wilde	$605,371	$248,157	$853,328	220	$3,880	($11,612,103)
Community Regional Medical Center of Fresno	2007	Tim Joslin	$802,877	$371,102	$1,173,979	648	$1,812	($8,738,852)
Dameron Hospital	2008	Christopher Arismendi	$247,219	$246,499	$493,718	188	$2,626	$7,297,061
Delano Regional Medical Center	2008	Bahram Ghaffri	$320,910	$116,184	$437,094	156	$2,801	$2,739,820
Eden Medical Center	2008	George Bischalaney	$482,286	$219,579	$701,865	347	$2,022	$19,060,650
Eisenhower Medical Center	2007	G. Aubrey Serfling	$578,531	$447,823	$1,026,354	289	$3,551	$30,514,639
Emanuel Medical Center	2007	John Sigsbury	$511,785	$79,458	$591,243	411	$1,439	($1,219,904)
Enloe Medical Center	2007	Deborah Yancer	$425,514	$154,031	$575,545	391	$1,472	$21,517,213
Fairchild Medical Center (Siskiyou Hospital)	2008	Dwayne Jones	$204,480	$19,881	$224,361	28	$8,013	$1,644,369
Feather River Hospital	2008	Wayne Ferch	$304,910	$286,369	$591,279	101	$5,854	($700,804)
Foothill Presbyterian	2008	James Yoshioka	$680,913	$22,650	$703,563	105	$6,701	$386,020
Gateways Hospital	2007	Mara Pelsman	$224,507	$31,380	$255,887	55	$4,652	$808,788
Glendale Adventist	2008	Morre Dean	$436,093	$103,702	$539,735	457	$1,181	$11,185,557
Glenn Medical Center	2007	William Casey (1)	$280,392	$0	$280,302	14	$20,021	$238,339
Goleta Valley Cottage Hospital	2008	Ronald Werft	$565,917	$829,755	$1,395,672	122	$11,440	$5,878,371
Good Samaritan Hospital	2007	Andrew Leeka	$461,477	$23,900	$485,377	408	$1,190	$41,819,398
Hanford Community Medical Center	2007	Richard Rawson	$358,390	$12,368	$560,078	121	$4,629	$7,814,821
Henry Mayo Newhall Memorial	2007	Roger Seaver	$374,372	$11,500	$385,872	217	$1,778	$9,996,205
Hoag Memorial Hospital Presbyterian	2007	William Afable	$665,643	$222,034	$887,677	461	$1,926	$123,282,951
Hoag Memorial Hospital Presbyterian*	2007	Peter Foulke (2)	$2,375,373	$23,970	$2,399,343	461	$5,204	123282951
John Muir Health*	2008	J. Kendall Anderson (3)	$744,994	$6,709,341	$7,454,335	655	$11,381	$53,491,728
Kaiser Northern California	2008	Gregory Adams	$822,710	$161,813	$984,523	System		NA
Kaiser Southern California	2008	Benjamin Chu	$919,490	$184,781	$1,104,271	System		NA

Hospital Name	Year of Tax Return	Name of CEO/Highest Paid Executive	Base Salary	Additional Compensation	Total Compensation	Number of Hospital Beds	Total Compensation Per Bed	Hospital's Net Income For Year Reported
Lodi Memorial Hospital	2008	Joseph P. Harrington	$349,661	$16,116	$365,777	180	$2,032	($1,669,825)
Loma Linda University Medical Center	2008	Ruthita Fike	$610,116	$336,085	$946,201	799	$1,184	($20,802,000)
Long Beach Memorial Medical Center	2007	Terry Belmont	$593,085	$27,776	$620,861	462	$1,344	$68,690,266
Lucile Salter Packard Children's Hospital	2007	Christopher Dawes	$814,600	$46,490	$861,090	264	$3,262	$114,362,080
Madera Community Hospital	2007	John Frye	$230,317	$9,600	$239,917	106	$2,263	$1,751,122
Marin General Hospital	2008	David Bradley	$517,786	$191,697	$709,483	235	$3,019	$21,662,608
Mark Twain St. Joseph's Hospital	2007	Feliciano Jiron	$182,600	$87,287	$269,887	48	$5,623	$818,283
Marshall Medical Center	2007	James Whipple	$407,331	$22,810	$430,141	105	$4,097	$6,154,015
Memorial Hospital of Los Banos	2008	Richard Liszewski	$232,280	$98,098	$330,378	48	$6,883	$865,320
Methodist Hospital of Southern California	2008	Dennis Lee	$625,793	$27,883	$653,076	460	$1,420	($15,313,957)
Mills-Peninsula Health Services	2008	Robert Merwin	$608,742	$304,150	$912,892	403	$2,265	$72,994,660
Motion Picture and Television Fund	2008	David Tillman	$462,010	$466,852	$928,862	412	$2,255	($57,248,970)
Novato Genera Hospital	2008	David Bradley	$517,786	$191,697	$709,483	47	$15,095	$6,659,706
Orange Coast Memorial Medical Center	2007	Marcia Manker	$441,804	$68,936	$510,740	224	$2,280	$13,316,519
Oroville Hospital	2007	Robert Wentz	$385,282	$14,247	$399,489	153	$2,611	$1,550,166
Paradise Valley Hospital*	2008	Alan Soderblom	$304,073	$162,765	$466,838	301	$1,551	$300,082
Parkview Community Hospital	2008	Douglas Drumwright	$539,284	$0	$539,284	193	$2,794	$1,447,986
Pomona Valley Hospital Medical Center	2008	Richard Yochum	$645,306	$285,866	$931,172	453	$2,056	$21,423,811
Presbyterian Intercommunity Hospital	2007	James West	$854,177	$192,948	$1,047,125	454	$2,306	$51,630,294
Providence Holy Cross Medical Center	2008	Larry Bowe	$413,035	$46,794	$459,829	254	$1,810	$21,649,152
Providence Little Company of Mary San Pedro	2008	Nancy Carlson	$400,027	$67,352	$467,379	356	$1,314	($9,407,202)
Providence Little Company of Mary Torrance	2008	Michael Hunn	$424,899	$45,023	$469,922	408	$1,152	($7,606,273)
Providence Saint Joseph Medical Center	2008	Barry Wolfman	$491,868	$22,156	$514,024	389	$1,321	($764,367)
Queen of the Valley Hospital	2007	Dennis Sisto	$664,992	$92,041	$757,033	191	$3,964	$26,087,571
Rady Childrens Hospital San Diego	2007	Kathleen Dooley-Sellick	$776,964	$201,621	$978,585	313	$3,126	$52,701,145
Redlands Community Hospital	2007	James Holmes	$739,441	$43,637	$783,078	176	$4,449	$5,154,839
Redwood Memorial Hospital	2007	Joseph Mark	$520,693	$166,873	$687,566	35	$19,655	$6,958,254
Rideout Memorial	2007	Theresa Hamilton	$311,545	$26,972	$338,517	281	$1,205	$16,034,548
Ridgecrest Regional Hospital	2008	David Mechtenberg	$241,441	$5,555	$246,996	74	$3,338	$3,683,031
Saddleback Memorial Medical Center	2007	Stephen Geidt	$412,768	$63,990	$476,758	325	$1,467	$13,512,911
San Antonio Community Hospital	2008	Steven Moreau	$609,482	$28,806	$638,288	279	$2,288	($959,870)
San Gorgonio Memorial Hospital	2007	Two Interim CEOs	$239,698	$0	$239,698	77	$3,113	($3,043,866)
San Joaquin Community Hospital	2008	Robert Beehler	$314,809	$88,965	$403,774	299	$1,350	$10,686,273
Santa Barbara Cottage Hospital	2008	Ronald Werft	$848,826	$546,946	$1,395,772	408	$3,421	($94,973,039)
Santa Rosa Memorial Hospital	2007	George Perez	$689,023	$32,491	$721,514	333	$2,167	$16,872,879
Scripps Health	2007	Chris Van Gorder	$1,240,126	$425,319	$1,665,445	System		$10,291,596
Sequoia Hospital	2007	Glenna Vaskelis	$169,789	$34,698	$204,487	421	$486	$30,930,126
Seton Medical Center	2007	Bernadette Smith	$391,995	$1,023,163	$1,414,498	478	$2,959	$7,717,806
Sharp Chula Vista Medical Center	2007	Christopher Boyd	$430,005	$55,774	$485,779	330	$1,472	$14,914,986
Sharp Coronado Hospital	2007	Marcia Hall	$288,868	$80,522	$369,390	204	$1,811	($819,263)
Sharp Grossmont Hospital	2007	Michele Tarbet	$460,428	$99,840	$560,268	481	$1,165	$13,571,880
Sharp Mary Birch Hospital	2007	Mary Henrikson	$272,940	$78,242	$351,182	169	$2,078	$41,330,180
Sharp Memorial Hospital	2007	Tim Smith	$442,121	$44,739	$486,860	521	$934	$15,783,902
Sharp Mesa Vista	2007	Kathleen Lencioni	$266,377	$67,805	$334,182	149	$2,243	$1,512,874

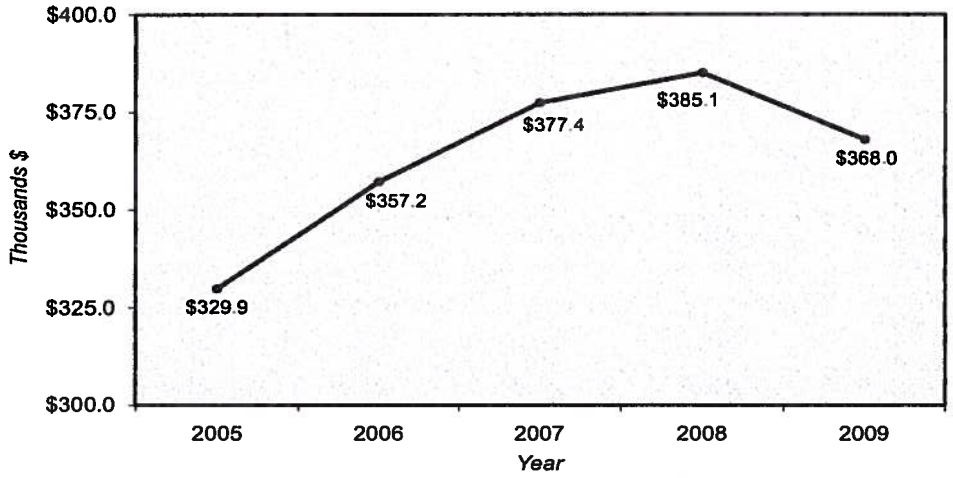
Hospital Name	Year of Tax Return	Name of CEO/Highest Paid Executive	Base Salary	Additional Compensation	Total Compensation	Number of Hospital Beds	Total Compensation Per Bed	Hospital's Net Income For Year Reported
Sierra Nevada Memorial Hospital	Fiscal 2008	Katherine Medeiros	$262,810	$122,826	$385,636	121	$3,187	$5,977,698
Simi Valley Hospital	2008	Darwin Remboldt	$288,275	$397,175	$685,450	201	$3,410	($7,134,612)
South Coast Medical Center	2007	Bruce Christian	$316,778	$94,816	$411,594	208	$1,979	($6,450,301)
St. Agnes Medical Center	2007	Matthew Abraham	$578,408	$770,210	$1,348,618	436	$3,093	$110,164,524
St. Francis Memorial Hospital	Fiscal 2008	Tom Hennessey	$334,188	$253,056	$587,244	356	$1,650	($9,125,303)
St. John's Health Center	2007	Lou Lazatin	$559,098	$120,320	$679,418	334	$2,034	$1,132,170
St. Joseph Hospital – Eureka	2007	Joe Mark	$520,693	$166,873	$687,566	161	$4,270	$3,069,624
St. Joseph Hospital – Orange	2007	Larry Ainsworth	$889,718	$88,531	$978,249	412	$2,374	$55,369,062
St. Jude Medical Center	2007	Lee Penrose	$473,241	$60,588	$533,829	359	$1,487	$65,804,456
St. Louise Regional Medical Center	2007	Joanne Allen	$351,377	$35,325	$386,702	93	$4,158	$1,349,944
St. Mary Medical Center – Apple Valley	2007	Jason Barker	$468,729	$26,113	$494,842	186	$2,660	$14,343,098
St. Rose Hospital	2007	Michael Mahoney	$291,082	$11,821	$302,903	163	$1,858	($1,561,875)
St. Vincent Medical Center	2007	Catherine Fickes	$420,641	$19,633	$440,274	347	$1,269	($10,053,991)
Stanford Hospital & Clinics	2007	Martha Marsh	$1,540,209	$38,443	$1,578,652	613	$2,575	$224,404,727
Sutter Amador Hospital	2008	Anne Platt	$262,172	$104,303	$366,475	66	$5,553	$10,142,285
Sutter Coast Hospital	2008	John Menaugh	$306,123	$149,306	$455,429	59	$7,719	$1,243,353
Sutter Delta Medical Center	2008	Gary Rapaport	$324,578	$146,847	$471,425	145	$3,251	($4,086,671)
Sutter Lakeside Hospital	2008	Kelly Mather/Avery Schlesenberg	$467,453	$56,843	$524,296	49	$10,700	($3,777,027)
Sutter Maternity and Surgery Center of Santa Cr	2008	Larry de Ghetaldi*	$470,077	$200,542	$670,619	30	$22,354	$11,633,982
Sutter Medical Center – Sacramento	2008	Thomas Gagen	$609,491	$346,436	$955,927	734	$1,302	$92,728,136
Sutter Medical Center of Santa Rosa	2008	Mike Cohill	$528,028	$488,941	$1,016,969	135	$7,533	($21,276,105)
Sutter Roseville Medical Center	2008	Patrick Brady	$601,785	$229,755	$831,540	326	$2,551	$59,855,984
Sutter Solano Medical Center	2008	Theresa Glubka	$288,046	$158,352	$446,398	111	$4,022	($4,641,387)
Sutter Tracy Community Hospital	2008	David Thompson	$248,845	$190,621	$439,466	82	$5,359	$15,510,558
Torrance Memorial Medical Center	2008	Craig Leach	$402,701	$286,943	$689,644	401	$1,720	($21,000,672)
Ukiah Valley Medical Center	2008	Terry Burns	$274,048	$375,816	$649,864	78	$8,332	$2,324,465
Valley Presbyterian Hospital	2007	Albert Greene	$646,150	$7,800	$653,950	348	$1,879	($1,589,700)
Verdugo Hills Hospital	2008	Leonard LaBella	$262,075	$17,488	$279,563	158	$1,769	($2,570,340)
Victor Valley Community Hospital	2007	Margaret Peterson	$335,188	$3,509	$338,697	106	$3,195	$110,600
White Memorial Medical Center	2008	Beth Zachary	$406,764	$269,757	$676,521	353	$1,916	$11,216,226
(1) Was paid as an independent contractor								
(2) Compensation reflects exit/retirement package, making him hospital's highest-paid executive in 2007								
(3) Compensation reflects lump sum retirement pay of $5.3 million								

Charity Care Provided During Year Reported
$634,592
$5,635,963
$1,898,691
$2,567,818
$92,335
$1,674,386
$23,973
$31,840
$13,715,516
$7,242,680
$12,222
$631,705
$2,214,975
$1,507,984
$741,713
$28,758,370
$10,579,112
$333,153
$1,667,816
$17,350,484
$9,231,538
$8,883,226
$58,552,629
$1,129,103
$5,559,065
$38,706,795
$939,927
$10,204,896
$9,941,508
$1,924,293
$4,333,417
$3,016,777
$0
$28,960,115
$85,472
$579,541
$3,758,940
$2,206,970
$1,045,217
$6,523,602
6523602
$4,982,340
NA
NA

Charity Care Provided During Year Reported
$2,408,906
$16,077,324
$11,855,052
$4,159,652
$1,102,321
$5,337,114
$350,022
$1,631,564
$1,924,018
$1,962,844
$5,963,563
$875,526
$1,258,123
$194,011
$949,423
$3,239,387
$1,718,406
$7,047,545
$1,326,602
$10,478,043
$1,469,521
$1,805,628
$2,153,018
$1,155,070
$1,366,169
$289,142
$515,560
$3,191,304
$765,726
$2,160,417
$1,503,564
$197,189
$769,282
$4,201,219
$3,458,252
$38,558,945
$1,221,193
$780,015
$7,284,232
$1,360,754
$11,480,642
$1,527,104
$7,595,606
$796,972

Charity Care Provided During Year Reported
$1,050,882
$894,925
$1,259,145
$3,602,395
$4,755,514
$1,916,237
$2,004,737
$6,177,123
$2,099,562
$671,595
$2,276,870
$3,246,254
$22,483
$10,960,231
$1,172,908
$1,925,112
$3,770,477
$871,109
$740,320
$11,124,349
$2,323,052
$8,364,784
$4,131,783
$1,931,808
$2,902,831
$1,106,337
$2,515,979
$52,861
$1,231,504
$10,377,525

Average Base Salary Trends



Annual Base Salary & Annual Total Compensation

	# OF ORGS.	# OF INC.	AVG. BASE SALARY	AVG. TOTAL COMP.	MEDIAN	WEIGHTED AVG. BASE SALARY	WEIGHTED AVG. TOTAL COMP.
All Employers	253	253	$368.0	$432.3	$316.5	$368.0	$432.3
BY ORGANIZATION REVENUE (MILLIONS)							
Up to 20.0	45	45	$302.8	$352.0	$251.1	$302.8	$352.0
20.0 up to 75.0	76	76	$298.8	$347.6	$271.6	$298.8	$347.6
75.0 up to 300.0	55	55	$368.5	$436.4	$361.6	$368.5	$436.4
300.0 up to 1000.0	43	43	$454.5	$519.7	$380.9	$454.5	$519.7
1000.0 up to 3000.0	16	16	$539.9	$665.6	$543.3	$539.9	$665.6
3000.0 and Up	5	5	$802.5	$1065.4	$936.0	$802.5	$1065.4
BY ORGANIZATION SIZE							
Up to 100	29	29	$302.0	$358.1	$276.2	$302.0	$358.1
101 to 200	52	52	$300.5	$343.2	$273.4	$300.5	$343.2
201 to 500	68	68	$319.7	$387.4	$297.2	$319.7	$387.4
501 to 1000	48	48	$376.3	$425.3	$354.3	$376.3	$425.3
1001 to 5000	45	45	$470.0	$553.3	$425.9	$470.0	$553.3
Over 5000	11	11	$706.9	$863.0	$778.3	$706.9	$863.0
BY INDUSTRY							
Banking and Finance	52	52	$369.9	$416.7	$328.2	$369.9	$416.7
Healthcare	34	34	$382.4	$406.7	$319.3	$382.4	$406.7
Hospitality	17	17	$412.2	$546.0	$330.0	$412.2	$546.0
Insurance	43	43	$406.8	$468.1	$356.1	$406.8	$468.1
Manufacturing	23	23	$359.0	$428.5	$300.7	$359.0	$428.5
Not-For-Profit	25	25	$303.4	$337.0	$264.5	$303.4	$337.0
Services	26	26	$350.1	$492.6	$301.3	$350.1	$492.6
Utilities	33	33	$346.3	$405.6	$315.7	$346.3	$405.6

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Executive Incentives

% OF ORGS WITH EMPLOYMENT CONTRACT	AVG. LENGTH OF CONTRACT	% WITH TERMINATION AGREEMENT
33.3	2.9	67.9

PERQUISITES (% OFFERING)	
Annual Physical Exam	13.1
Car Allowance	34.0
Club Membership(s)	15.2
Company Car	27.0
Housing Allowance	8.1
Spouse Travel Allowance	10.1
Supplemental Disability Program	23.0
Supplemental Executive Retirement Plan	16.2
Supplemental Medical Coverage	21.2
Supplemental Life Insurance	14.1
Voluntary Deferred Compensation Program	28.6
% Do Not Offer Perquisites for this Position	10.3

LONG-TERM INCENTIVES (LTI) (% OFFERING)	
Incentive Stock Options - Non-Qualified	6.1
Incentive Stock Options - Qualified	4.1
Long-Term Cash	3.1
Performance Share Plans	7.1
Performance Unit Plans	3.1
Phantom Stock - Appreciation Only	1.0
Phantom Stock - Full Value	0.0
Restricted Stock/Restricted Stock Units	5.1
Stock Appreciation Rights	1.0
% Do Not Offer LTI for this Position	38.4

% OF ORGS WITH STOCK GUIDELINES
15.2

SHORT-TERM INCENTIVES				
% NOT ELIGIBLE	AVG. THRESHOLD %	AVG. TARGET %	AVG. MAXIMUM %	AVG. ANNUAL INCENTIVE ($)
36.7	—	30.0	50.8	205942

SHORT-TERM INCENTIVES (% OFFERING)	
EVA (Economic Value-Added)	4.1
Personal Performance	33.0
Profits	24.7
Return on Assets	9.4
Return on Equity	5.2
Return on Sales	5.2
Unit Performance	8.2
% with None Offered for this Position	18.6

REWARD SYSTEMS (% OFFERING)	
Bonus	51.5
Deferred Profit Sharing	6.2
Incentive Pay	16.5
Key Contributor	6.2
Non-Deferred Profit Sharing	3.1
% None Offered	0.0

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Date: October 27, 2010

To: Board of Directors

Re: Administrative Pension Plan Oversight Committee (APPOC) Report

Members: Mike McCormick, Chair; David Neapolitan, CFO; Deborah Stebbins, CEO; Phyllis Weiss, HR Director; Karen Hopkins, Benefits Coordinator

The APPOC met on Wednesday, 10/20/10 and covered the following topics:

Review of the Diversified investment options' performance
401[a] Employer contribution plan & 457[b] Employee contribution plan
Review of the HighMark investment options' performance
ECHO 403[b] (Frozen) Plan

The committee feels that the current investment options are appropriate and meeting current goals. We are adopting a formal investment policy that will assist in measuring future success against our established goals.

Current status of the two active plans:

401[a] **Employer** contribution plan (covers all non-represented employees and those in Local #6-X-ray and Local #29-Lab):

Number of participants:	198
Contribution rate:	6%
Total Plan assets:	$2.6M as of 12/31/09
	$3.2M as of 10/25/10

- Recommendation by the APPOC to approve a supplemental good-faith PPA/HEART amendment
- Recommendation by the APPOC to approve an additional amendment adopting the provisions of the Emergency Stabilization Act of 2008
  - Both of these amendments are required to be adopted in order to meet Federal Compliance Standards
  - Both amendments are listed on the Consent Agenda for approval by the board.

457[b] **Employee** Deferred Compensation plan (all employees eligible to participate):

Number of participants:	378 (approximately 60% of employee population)
Avg. employee contribution:	$5,468/yr
Total Plan assets:	$26.7M as of 12/31/09
	$28.5M as of 10/25/10

- We are considering an amendment that would allow participants to designate their elective deferral contributions as ROTH contributions and convert plan amounts that are distributable as an eligible rollover distribution to ROTH contributions within the plan as soon as more information is available. This amendment can be adopted any time after January 1, 2011.

Current status of the ECHO 403[b] (Frozen) Plan:

ECHO Plan:

Number of participants:	116 as of 7/1/10
Total Plan assets:	$1.6M as of 7/1/10

Actuarial report as of July 1, 2009: for the plan year ending 6/30/10, the Hospital made contributions of **$168,000** against the plan's Annual Required Contribution (ARC) of **$118,361**. Summary of Actuarial report included.

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

Administrative Pension Plan Oversight Committee (APPOC) Report Continued:

Current status of Union sponsored plans:

These plans are subject to the Pension Protection Act of 2006 which measures their ability to fund their respective plans, expressed in terms of:

- **Green** (meets funding requirements)
- **Yellow** (in cautionary status) or
- **Red** (critical status - does not meet funding requirements – recovery plan must be in place).

Steelworker's Pension Plan (covers Registered Nurses)

This plan continues to be in a "**green**" status for 2010.
The contribution rate for Nurses 7.5% of wages earned
Note: this amount has been capped in the new contract (no increase).
Annual contributions are approximately $755K

SEIU-UHW-West (covers service workers and LVN's/C.N.A.'s)

This plan is in a "**red**" status for 2010.
The Recovery Plan included requiring the Hospital to pay a 10% penalty in order to subsidize unfunded liability.
Contribution rate, effective 6/10, is $1.30/hour
Annual contributions are approximately $253K plus the 10% subsidy.

United H.E.R.E. Local #2850 (covers cooks pension only)

This plan has been in a "**green**" status in the past.
We are waiting for the current status.
Contribution rate is $120.00/mo
Annual contributions are approximately $4,400.00

Stationary Engineers Local 39 Pension Trust (covers engineers only)

This plan was placed in a "**red**" status.
The recovery plan included reduction of benefits for participants retiring after a certain date in 2008 and, effective August 1, 2010, allocating a portion of the contributions received towards their unfunded liability.
This recovery plan did not result in any costs to the Hospital.
Contribution rate is $6.46/hour (equals approx. 16% contribution)
Annual contributions are approximately $64K

Submitted by: Phyllis Weiss, Director
Human Resources Dept.

Actuarial Valuation Report
As of July 1, 2009

Alameda Hospital
Pension Plan

ALTMAN & CRONIN
BENEFIT CONSULTANTS, LLC
100 Pine Street, Suite 1500
San Francisco, CA 94111

1. Summary

1.1 Highlights

This report has been prepared by Altman & Cronin Benefit Consultants, LLC for Alameda Hospital to:

- present the results of the valuation of the Alameda Hospital Pension Plan as of July 1, 2009;
- provide to the plan sponsor the annual required contribution under the Plan for the plan year ending June 30, 2010; and
- provide reporting and disclosure information for financial statements, government agencies and other interested parties.

Contributions

The following summarizes important contribution information.

	Plan Year Ending June 30, 2010	Plan Year Ending June 30, 2009
Annual Required Contribution (ARC)	$118,361	$128,149
Actual contribution made	$168,000	$128,149

For the plan year ended June 30, 2010, the Hospital made contributions of $168,000 to the plan, while the plan's Annual Required Contribution (ARC) is $118,361.

GASB Pension Cost

The following summarizes important accounting cost information.

	Fiscal Year Ending June 30, 2010	Fiscal Year Ending June 30, 2009
Annual Pension Cost (APC)	$123,739	$133,220

Because the Hospital's annual pension cost of $123,739 is less than the actual contributions of $168,000, the Hospital's net pension asset will increase to $160,630 at June 30, 2010.

1.2 Summary of Principal Valuation Results

A summary of principal valuation results from the current valuation follows.

	Actuarial Valuation as of July 1, 2009	July 1, 2008
Summary of Costs		
Normal cost	$0	$0
Annual Required Contribution (ARC)	118,361	128,149
Normal cost as % of covered payroll	N/A	N/A
Annual required contribution as % of covered payroll	N/A	N/A
GASB annual pension cost	123,739	133,220
Assets and Actuarial Present Values		
Market value of assets	$1,499,904	$1,370,353
Actuarial value of assets	1,499,904	1,370,353
Actuarial accrued liability	2,671,515	2,700,503
Unfunded actuarial accrued liability	1,171,611	1,330,153
Summary of Data		
Number of participants in valuation		
Active participants	91	95
Terminated with deferred benefits	35	35
Retirees and beneficiaries	0	0
Total	**126**	**130**
Active Participant Statistics		
Total compensation	N/A	N/A
Average compensation	N/A	N/A
Average age	52.0	51.3
Average credited service	11.4	11.8

Hospital Reorganization as Healthcare District

On November 1, 2002, Alameda Hospital reorganized into a governmental entity known as the City of Alameda Healthcare District (doing business as Alameda Hospital). Since ERISA does not apply to governmental plans, this valuation does not comply with the minimum funding requirements of ERISA. Furthermore, because the Hospital is a governmental entity, it must account for the pension plan on its books under Governmental Accounting Standards Board (GASB) Statements No. 25 and 27. Therefore, as part of this report, we have included the disclosure information required under GASB No. 27.

Assumption and Method Changes

There have been no assumption or method changes since the prior valuation.

Contributions and Funded Status

For the 2009/2010 plan year, the Hospital's Annual Required Contribution (ARC) is $118,361. For the 2008/2009 plan year, the Hospital's Annual Required Contribution (ARC) was $128,149.

The plan's funded status on the accrued liability basis has increased from 50.7% as of July 1, 2008 to 56.1% as of July 1, 2009. The increase from July 1, 2008 to July 1, 2009 was primarily the result of strong asset performance during the 2008/2009 plan year, as well as the Hospital's monthly contributions.

1.3 Certification

We have prepared an actuarial valuation of the Alameda Hospital Pension Plan as of July 1, 2009 for the plan year ending June 30, 2010. The results of the valuation are set forth in this report.

The valuation is based on employee and financial data which were provided by the company and are summarized in this report.

All costs, liabilities and other factors under the Plan were determined in accordance with generally accepted actuarial principles and procedures, in accordance with the provisions of current federal statutes and regulations, using an actuarial cost method which we believe is appropriate. In our opinion, the actuarial assumptions are reasonable and represent our best estimate of the anticipated experience under the Plan. This report fully and fairly discloses the actuarial position of the Plan on an ongoing basis.

We are available to answer any questions on the material contained in the report, or to provide explanations or further details.

Thomas E. Gibbs, Jr., FSA
EA # 08-5726

09/02/2010
Date

Scott H. Leu, ASA
EA # 08-6706

9/2/2010
Date