Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

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

Monday, November 10, 2008

***CLOSED SESSION – 5:00 p.m. OPEN SESSION –7:30 p.m.**

Location:

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

Office of the Clerk: (510) 814-4001

Regular Meeting

Members of the public who wish to comment on agenda items will be given an opportunity before or during the consideration of each agenda item. Those wishing to comment must complete a speaker card indicating the agenda item that they wish to address.

I. Call to Order — Jordan Battani

II. Roll Call — Kristen Thorson

III. General Public Comments

IV. Closed Session **(Expected to start at approximately 5:00 p.m. and expected to last 2.5 hours)**

1.	Discussion of Report Involving Trade Secrets	H & S Code Sec. 32106
2.	Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions	Gov't Code Sec. 54957.6
3.	Consultation with Legal Counsel Regarding Pending Litigation	Gov't Code Sec. 54956.9(a)

4. Approval of Closed Session Minutes – October 6, 2008

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

6. Quality Improvement Committee Report (QIC) — H & S Code Sec. 32155

7. Public Employee Performance Evaluation — Gov't Code Sec 54957
   Title: Chief Executive Officer

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

1. Announcements from Closed Session — Jordan Battani

VI. Consent Agenda

1. Approval of October 6, 2008 Minutes **ACTION ITEM** [enclosure]

2. Approval of Revisions to Compliance Program Document and Approval of Administrative Policy No. 43 **ACTION ITEM** [enclosure]

3. Approval of Acquisition of Health Line Systems Inc. ECHO Software **ACTION ITEM** [enclosure]

4. Authorization to Execute Contract for Avega – Alliance Decision Support System **ACTION ITEM** [enclosure]

VII. Regular Agenda

1. Governance Institute Presentation — Mitch Rodgers, Governance Institute

2. Finance and Management Committee Report

   - Acceptance of September 2008 Financial Statements — David A. Neapolitan
     ACTION ITEM [enclosure]

- Pension Committee Report — Deborah E. Stebbins, David Neapolitan

  - ❖ Pension Committee Minutes of October 29, 2008 [enclosure]
  - ❖ Approval of Investment Guidelines for Alameda Hospital Pension Plan **ACTION ITEM** [enclosure]
  - ❖ Approval of Recommendation to move Pension Investments from Stable Value Fund to Balanced Income Portfolio **ACTION ITEM** [enclosure]

3. Strategic Planning and Community Relations Committee Report — Robert Bonta

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

   - Affirmative Action Plan Update
   - Statutory Restrictions on Contracts for Health Care Districts [enclosure -for information only]

5. Medical Staff President Report — Steve Lowery, MD

6. General Public Comments

7. Board Comments

8. Adjournment

The next regularly scheduled board meeting will be on Monday, December 1, 2008.
Closed Session will begin at 6:00 p.m. Open Session will follow at approximately 7:30 p.m.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors
October 6, 2008

Directors Present:
Robert Bonta
Jeptha Boone, MD
Robert Deutsch, MD
Steve Wasson

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

Medical Staff Present:
Steve Lowery, M.D.

Legal Counsel Present:
Thomas Driscoll, Esq.

Excused:
Jordan Battani

Submitted by: Kristen Thorson

Topic	Discussion	Action / Follow-Up
1. Call to Order	1st Vice President, Robert Deutsch, MD called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 5:50 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors was present.	
3. General Public Comments	None at this time.	
4. Closed Session	At 5:51 p.m. the meeting adjourned Executive Closed Session.	
5. Reconvene to Public Session & Adjournment	Robert Deutsch, MD reconvened the meeting into public session at 7:40 p.m. and made the following closed session announcements.	
6. Closed Session Announcements	**[1] Minutes** **[2] Quality Improvement Committee** **[3] Medical Executive Committee Report and Approval of Credentialing Recommendations**	[1] The Closed Session Minutes for the September 8, 2008 meeting were approved. [2] The Quality Improvement Committee Report for August was accepted as presented. [3] Medical Executive Committee Report and Approval of

Topic	Discussion	Action / Follow-Up
		Credentialing Recommendations were approved as presented.

Initial Appointment:

Name	Specialty	Affiliation
o Gary Clark, MD	General Surgery	Kaiser
o Aaron Kaplan, MD	Radiology	BIC
o Joan King-Angel, MD	Internal Medicine/Geriatrics	Kaiser
o Amardeep Mangat, DO	Internal Medicine/Hospitalist	AIM
o Maria Milller-Millitante, DO	Internal Medicine/Hospitalist	AIM
o Ashish Patel, MD	General Surgery	Kaiser
o Pushpasree Sajja, MD	Internal Medicine/Hospitalist	AIM
o Adam Schlifke, MD	Anesthesiology	Kaiser
o Jason Skalet, MD	Ophthalmology	Kaiser
o Mitzi Williams, DPM	Podiatry	Kaiser

Reappointments – Medical Staff

Name	Specialty	Status	Appointment Period End
o Raymond Gardner, MD	Ophthalmology	Courtesy	09/30/10
o Jon Greif, MD	Breast Surgery	Courtesy	06/30/09
o James Kong, MD	Allergy/Immunology Internal Medicine	Active	07/31/09
o Steve Lowery, MD	Pulmonary Medicine Critical Care Medicine	Active	09/30/10
o Lamont Paxton, MD	Vascular Surgery	Courtesy	09/30/10
o Jason Pollard, DPM	Podiatry	Courtesy	04/30/09
o Alice Reier, MD	Hematology/Oncology	Courtesy	09/30/09
o Michael Silpa, MD	Gastroenterology	Active	09/30/10
o Htay Win, MD	Internal Medicine	Courtesy	04/30/10

Initial appointment – Allied Health Professional

Name	Specialty	Appointment Period End
o Carlos Torres-Roig, CRNA	Nurse Anesthetist	09/30/10

Proctoring:

Name	Specialty
o Adam Schlifke, MD	Anesthesiology

Resignations:

Name	Specialty
o Charlie Chu, MD	Internal Medicine
o Samuel Ko, MD	Internal Medicine, Hospitalist
o Karen Rowley, MD	Pathology
o Michel Zakari, MD	Internal Medicine, Hospitalist

7. Consent Agenda	**[1] Approval of September 9, 2008 Minutes** **[2] Biennial Review and Approval of City of Alameda Health Care District Conflict of Interest Code #2008-0Y**	Item [3] was removed from the consent calendar for discussion. Dr. Boone moved to approve the balance of the consent calendar (Items 1 & 2). Director Bonta seconded the motion. The motion

Topic	Discussion	Action / Follow-Up
		carried unanimously.
	[3] Approval for the formation of a Pension Committee and Reallocation of Fund from Fixed Income to Balanced Portfolio The Board of Directors expressed concern over moving funds from fixed income to a balanced portfolio with the volatility in the market these days. The formation of the Pension committee would provide overall guidance and oversight to the pension funds but would not make specific decisions on such as picking what funds to invest in. Ms. Stebbins suggested that the Pension Committee meet with the prospective fund manager to discuss their recommendation to move to a balanced portfolio and will bring back to their recommendation to the Board of Directors at the November meeting. Currently the pension fund is funded as mandated by law. Steve Wasson suggested that guidelines/standards be set up to guide the fund such as ERISA (Employee Retirement Income Security Act). The Board also suggested that certain equities be avoided (e.g. tobacco) in an investment portfolio.	The Board agreed that a pension committee should be formed and that there would be some overlap with the Finance and Management Committee. Steve Wasson agreed to chair the committee and suggested that the committee meet at least quarterly. The Board agreed not to move any money from the fixed fund to a balance portfolio until the action could be reviewed by the Pension Committee.
8. Regular Agenda	**[1]Finance and Management Committee Report** *Acceptance of the August 2008 Financial Statements* CFO David Neapolitan presented the August 2008 Financial Statements noting the following statistics for the month. Average daily census of 61.9 versus 63.2 budgeted. Acute average daily census was 29.3 versus 30.1 budgeted. Sub-Acute average daily census was 32.6 versus 33.1 budgeted. Total gross patient revenue greater than budget by $89,438. Inpatient revenue was less than budget by $219,811 or 1.8%. Outpatient revenue was greater than budget by $309,249 or 3.3% Surgery cases were 448 versus 437 budgeted Total patient days were below budget by 134 days at 2,100. The Acute Average Length of Stay was slightly above budget at 4.13 for the month. Emergency Room Visits continued to drop below budget for the month at 1,336 versus a budget of 1,436. Overall the total profit for the month was $21,686	Director Boone moved to accept the August 2008 Financial Statements as presented. Director Wasson seconded the motion, the motion carried unanimously.

Topic	Discussion	Action / Follow-Up
	bringing the YTD profit of $78,961. *Fiscal Year (FY) 2008 Audit Presentation* Rick Jackson from TCA Partners presented the Audited financial statements to the Board of Directors. The Audit was also presented to the Finance and Management Committee and that committee has recommended approval by the Board of Directors. Rick Jackson explained that Board Report is a by-product of the actual audit. If certain issues arose during the audit they would be disclosed to the Board Report. There were no issues and stated that there was a clean set of books. The Management Discussion and Analysis is a description of what has happened over the last fiscal year. In addition, page 5 of the Audit is the opinion letter that states a clean opinion for the financial audit. Mr. Jackson stated that it was a pleasure working with David Neapolitan and the staff at Alameda Hospital. *Acceptance of FY 2008 Audit* **[3] Information Systems Overview Presentation** Robert Lundy-Paine, Director of Information Systems presented an overview of his department and reviewed the many initiatives that the department is currently working on. His report included: ▪ Information Systems Staff and Responsibilities ▪ Physical Infrastructure General Overview ▪ Hospital software ▪ A sampling of completed projects ▪ Future Project List The Board thanked Mr. Lundy-Paine for his work with staff and physicians. **[4] Strategic Planning and Community Relations Report** Rob Bonta reported that the next meeting of the Strategic Planning and Community Relations Committee would be held on Tuesday, October 21, 2008 at 7:30 a.m. The committee will continue discussion and review the draft Strategic Plan.	Steve Wasson made a motion to accept the FY 2008 Audited Financial Statements. Jeptha Boone, MD seconded the motion. The motion carried unanimously.

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<tr><th>Topic</th><th>Discussion</th><th>Action / Follow-Up</th></tr>
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Chief Executive Officer's Report
Deborah E. Stebbins reported on the September monthly statistics:

Statistics:

	August	August Budget	July Actual
Average Daily Census	82.43	82.07	82.90
Patient Days	2,473	2,462	2,259
ER Visits	1,360	1,546	1,336
OP Registrations	2,528	2,562	2,441
Total Surgeries	453	390	448

Ms. Stebbins reported that the annual Health Fair will be held on October 18, 2008 from 9:00 a.m. - 12:30 p.m.

[5] Medical Staff President Report
Medical Staff President, Steve Lowery, MD requested approval of the proposed revision to Article 1, Section B, Admission Exceptions, of the Medical Staff Rules and Regulations.

</td><td>Jeptha Boone, MD moved to approve the revision to the Medical Staff Rules and Regulations. Rob Bonta Seconded the motion. The motion carried unanimously.</td></tr>
<tr><td>8. General Public Comments</td><td>None at this time.</td><td></td></tr>
<tr><td>10. Board Comments</td><td>None at this time.</td><td></td></tr>
<tr><td>11. Adjournment</td><td></td><td>A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 9:15 p.m.</td></tr>
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Attest: _____ _____

Jordan Battani — President

Robert Bonta — Secretary

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: October 29, 2008

TO: City of Alameda Health Care District Board of Directors

FROM: David Neapolitan, CFO
Joyce Walker, Director of Budget and Compliance

SUBJECT: Approval of Revisions to Compliance Program Document and Administrative Policy No. 53

In February of 2005, President Bush signed into law the Deficit Reduction Act (DFR), which requires specified changes to Medicaid law. One of those changes is the requirement for employee education regarding false claims recovery.

Section 6032 of the DRA requires any entity that receives or makes annual payments under the Medi-Cal program of at least five million dollars, as a condition of receiving such payments, to have established written policies and procedures regarding the Federal and State False Claims Act for their employees, agents and contractors.

To comply with this requirement, Alameda Hospital Management has prepared Administrative Policy No. 53 – *Education Concerning False Claims Liability, Anti-Retaliation Protections and Detecting and Responding to Fraud, Waste and Abuse*. Additionally, the Compliance Program document has also been reviewed and revised to include references to the above mentioned policy, as well as to update the document to reflect our current compliance activity.

It is the intent of Management to include the revised Compliance Document and the related Administrative Policy in all hospital and medical staff orientation packets and Mandatory Annual Training (MAT).

It is the recommendation of Management that the District Board approve the revised Compliance Program document for Alameda Hospital and Administrative Policy No. 53.

COMPLIANCE PROGRAM
FOR
ALAMEDA HOSPITAL

September 2008

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City of Alameda Health Care District
2070 Clinton Avenue
Alameda, California 94501
510-522-3700

INTRODUCTION

Each employee, contractor, and member of the medical staff of the City of Alameda Health Care District, dba Alameda Hospital ("the Hospital") must recognize that he or she has assumed compliance responsibilities by joining the Hospital's staff. This document describes the principal elements of those responsibilities. The Hospital is committed to assuring full compliance with the law in all of its operations, as well as providing the best possible care to our patients.

COMPLYING WITH THE HOSPITAL'S STANDARDS OF CONDUCT

Each employee, contractor, and member of the medical staff is responsible for ensuring that his or her conduct conforms to the Hospital's Standards of Conduct, as well as any other Hospital or payor policy and any applicable Federal and state statute, regulation, and rule.

All Hospital employees, contractors, and members of the medical staff must follow the Standards of Conduct. Any violation of the Standards by any employee, manager, officer, or independent contractor is a serious matter that may result in formal discipline, up to and including termination. These Standards of Conduct do not constitute an employment contract or other contractual relationship. You should not interpret any of these standards as a promise of continued employment.

If you have a question as to whether or not a procedure or action conforms to the Standards of Conduct, you should speak with your immediate supervisor. Members of the medical staff may pose questions to the President of the Medical Staff. If you do not feel comfortable discussing the matter with these individuals, or if you have discussed the matter with these individuals and you are still unsure as to the appropriate conduct, you should contact the Hospital's Compliance Officer, Joyce Walker. If you do not feel comfortable contacting the Compliance Officer, you may contact any of the other members of the Compliance Committee, including Kristy Lugert, Phyllis Weiss, Janet Dike, Robert Lundy-Paine, Kerry Easthope, Leon Dalva, Anthony Corica and Mary Bond. A list of the Compliance Committee members' telephone numbers is attached as Exhibit 1. The President of the Board of Trustees and the President of the Medical Staff may serve as ad hoc members of the Compliance Committee. Alternatively, you can call the compliance hotline (510-814-4361) and leave a voicemail message. If you wish, your call to the hotline may be made anonymously, or you may identify yourself but ask that your identity remain confidential to the extent possible as the Hospital seeks to resolve the compliance issue that you have identified.

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REPORTING VIOLATIONS OF THE STANDARDS OF CONDUCT

It is the responsibility of each employee, contractor, and member of the medical staff to report any violations of the Standards of Conduct. This obligation may be satisfied in several ways. You can report the violation to your supervisor. You can call the compliance hotline (510-

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814-4361) and leave a voicemail message. If you are a member of the medical staff, you can report violations to the President of the Medical Staff. You may also send a memorandum to the Compliance Officer or another member of the Compliance Committee. All communications to the Compliance Officer will be kept strictly confidential to the fullest extent possible, as consistent with any reporting requirements or other obligations or needs of the Hospital. Issues may be raised anonymously.

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The position of compliance officer was created to allow any employee, contractor, or member of the medical staff with a regulatory or other compliance question to obtain the appropriate information. The Compliance Officer will be able to answer questions about the Standards of Conduct and resolve disputed interpretations. Acting in cooperation with the other members of the Compliance Committee, the Compliance Officer will take any necessary action to investigate a complaint and take appropriate remedial action. The Board of Directors will exercise supervision over the Compliance Committee and the compliance officer, as necessary. The Hospital's compliance program has been issued at the direction of and under the authority of the Board of Directors.

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No retaliatory action will be taken or will be permitted by the Hospital against any individual or entity that reports any suspected violations of the Standards of Conduct in good faith. Please refer to City of Alameda Hospital Administrative Policy No. 53 for additional information regarding False Claims Liability, Anti-Retaliation Protections and Detecting and Responding to Fraud, Waste and Abuse.

STANDARDS OF CONDUCT

The Hospital will furnish treatment in accordance with all pertinent federal and state laws. The Hospital will take reasonable steps to ensure that its employees, contractors, and members of the medical staff act in conformity with relevant laws and regulations. The following are the Standards of Conduct that the Hospital has adopted:[1]

General Matters

1. All employees, contractors, and members of the medical staff must cooperate fully and completely with any compliance program, policy or initiative instituted by the Hospital.

2. All employees, contractors, and members of the medical staff must fully and completely comply with the Hospital's policies and procedures.

3 All treatment recommended and provided by the Hospital will be medically necessary. All lengths of stay ("LOS") shall be determined in accordance with the medical needs of the patient. LOS shall not be extended or limited, except as appropriate under the circumstances.

[1]The responsibilities of the Hospital's employees and the members of the staff are not limited to those enumerated in the Standards of Conduct.

4. The Hospital will not over-utilize services or under-utilize services in treating its patients.

5. All Hospital records and documents are of a highly confidential nature. They shall not be disclosed to anyone not employed by or affiliated with the Hospital without the written permission of the relevant patient or his or her legal guardian, except as otherwise provided for under the Hospital's policies and as permitted by law.

6. The Hospital will not pay any person or any entity for patient referrals. Except for certain items or services of nominal value, the Hospital will not offer any item or service or any financial inducement, or gift to prospective patients or others in order to encourage patients to undergo treatment at the Hospital.

7. Except for the occasional modest expressions of gratitude from patients, employees and members of the staff should refuse gifts, loans or anything of substantial value offered by outside individuals or companies. Employees and members of the medical staff may accept items or services of nominal value, which cannot exceed $50 per gift, up to a maximum of $300 per year, if (a) the entity providing the gift makes it available to all other similarly situated individuals and (b) the gift is not linked in any way to any referrals of either patients or business.

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8. No property belonging to the Hospital (including documents or copies of documents) is to be removed from the Hospital without the permission of the Hospital.

9. Except as expressly permitted in writing or by law, no employee, contractor, or member of the medical staff may use or disclose to any person any trade secrets or other confidential or proprietary information belonging to the Hospital, including, but not limited to, records and files, patient lists, referral information, marketing materials, business records, financial documents, and any other papers, records, and documents the disclosure of which might adversely affect the Hospital.

10. All employees, contractors, and members of the medical staff of the Hospital shall report any actual or suspected violation of the Hospital's compliance program by any person associated with the Hospital to the Compliance Officer, to one of the other members of the Compliance Committee, or to the President of the Medical Staff. The President of the Medical Staff shall provide the information that he or she obtains to the Compliance Officer.

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11. Any employee, contractor, or member of the medical staff of the Hospital must immediately notify the Compliance Officer or the President of the Medical Staff in writing if he or she is charged, investigated or convicted in connection with any alleged criminal offense related to the provision of medical care, involving an allegation of moral turpitude, or related to any alleged fraudulent act or omission. The President of the Medical Staff shall provide the information that he or she obtains to the Compliance Officer.

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12. Any employee, contractor, or member of the medical staff of the Hospital must immediately notify the Compliance Officer or the President of the Medical Staff if he or she is excluded, suspended, debarred, or removed from any government health care program or otherwise precluded from participating in federal or state programs. The President of the Medical Staff shall provide the information that he or she obtains to the Compliance Officer.

13. No employee of the Hospital will bill any patient or any third party payor for any services rendered in connection with his or her employment by the Hospital. If any employee receives any fees or charges for services performed during his or her employment by the Hospital, the employee shall remit such payment to the Hospital promptly.

14. Upon separation, no employee, contractor, or member of the medical staff may take or retain any of the Hospital's papers, patient lists, fee books, patient records, files, or other documents, or copies of any such materials.

15. Upon separation, any employee will be provided the opportunity to have an exit interview and will provide complete and accurate information to the Hospital in connection with that interview. The exit interviews shall be conducted by the Director of the Human Resources Department or his designee.

16. The Hospital will respond to all governmental inquiries as required by law.

17. Any information provided by the Hospital in responding to any governmental, payor, or patient inquiries shall be as accurate as possible.

18. Every significant contact with a payor or government entity in which the Hospital receives coverage or other advice that the Hospital relies upon in submitting claims or taking other actions should be documented with a completed form like the one attached as Exhibit 2. A copy of any such forms should be sent to the Compliance Officer.

19. A bound copy of the compliance program document shall be maintained by each department and as well as at the work stations of each senior manager and each billing department, business office, and medical records department employee. It is the responsibility of the Compliance Officer to audit compliance with this requirement on a sample basis annually.

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Discharge, Transfer and Emergency Presentations

1. Whenever a patient is discharged from the Hospital to a sub-acute care provider such as a skilled nursing facility, home health agency, or rehabilitation care provider, or requires durable medical equipment for which Medicare or Medi-Cal benefits are available, the Hospital shall honor the patients' choice of providers.

2. For anyone presenting to the Emergency Department, the Hospital shall provide an appropriate medical screening examination to determine whether or not an emergency medical condition exists. There shall be no exceptions to this established policy of the Hospital. If an emergency medical condition exists, the Hospital shall admit the patient or arrange for an appropriate transfer.

Contracts With Physicians and Suppliers

1. The Hospital will not pay any person or any entity for patient referrals, whether directly or indirectly.

2. All contracts with physicians furnishing personal services or equipment to the Hospital shall: (a) be in writing and signed by the parties, (b) reflect the fair market value of the items and services furnished, and (c) specify the items or services to be furnished, and will otherwise comply with the safe harbor provisions under the Anti-Kickback Statute, the exceptions under the Stark law, and any and all other applicable federal or state laws.

3. All lease agreements between the Hospital and any individual or entity in a position to refer patients to the Hospital or to generate other business between the parties shall: (a) be in writing and signed by the parties, (b) shall have a term of at least one year, (c) be commercially reasonable, (d) state the full rental amount, which shall reflect fair market value, and (e) not take into account the value or volume of referrals or other business generated between the parties.

Patient Charts and Billing

1. All billing and patient records will be accurate, complete, and as detailed as required by the applicable government or other payor. Patient records will be organized in a manner to facilitate easy retrieval.

2. All billing and patient records should accurately document the service provided, the charges, the identity of the provider, the date of service, the place of service, and the identity of the patient.

3. All charts for outpatient or physicians' services shall meet the documentation standards required for the type and level of service provided and billed.

4. The employees and members of the staff of the Hospital shall take all reasonable steps to ensure that claims for reimbursement submitted to any federally-funded health care program or other payor are appropriately documented, accurate, and properly reflect the services actually rendered.

5. Claim forms will be submitted in a timely manner taking all reasonable steps to ensure the accuracy of the date of service, the nature of the service, and all other information, including the signatures used.

6. The Hospital will provide appropriate training and supplemental information on coding to the admitting staff and the billing staff. The Hospital, its employees, and members of the staff shall select the most appropriate CPT, ICD-9, revenue and DRG codes in describing procedures performed and other services provided, regardless of the impact upon payment. Compensation to billing department employees or to any billing consultants shall not provide any financial incentive to code claims improperly.

7. Any requests for information from a state or federal agency, a carrier, fiscal intermediary, or other third party payor, other than a routine request, shall be provided to the Compliance Officer. Any response to such a request shall be documented by maintaining a copy of such response, complete with copies of any attachments or exhibits or a list of the documents provided.

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8. The Hospital will bill for medically necessary services in accordance with federal and state statutes, regulations, and payor requirements. This shall include the proper bundling of services when required by the payor.

9. Any discounts received from suppliers shall be disclosed on the Hospital's cost reports through listings of net costs or as otherwise required and appropriate.

10. Under the supervision of the Compliance Officer, a sample of medical records and corresponding bills for services will be periodically reviewed for compliance with the Hospital's billing policies and with Federal requirements. If any of these reviews identify possible instances of noncompliance, the Compliance Committee shall take all appropriate steps to address any such instances.

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Collection of Co-Payments and Deductibles
And Refunds of Overpayments

1. It is the policy of the Hospital to make a reasonable and good faith effort to collect any co-payments and/or deductibles owed to it, unless such co-payment or deductible is waived in accordance with Hospital policy based on a good faith determination of the patient's financial need.

2. The Hospital shall waive Medicare and Medi-Cal co-payments or deductibles only in cases of financial need. In such cases, supporting documentation shall be retained in the patient's billing file.

3. The Hospital will refund any payor overpayments in a timely fashion, and will make every reasonable effort to clear any overpayments in a timely fashion.

4. A review of the patient accounts for credit balances will take place at the end of each quarter.

THE HOSPITAL'S ETHICS PROCESS

THE COMPLIANCE COMMITTEE

The Hospital's Compliance Committee shall be primarily responsible for the compliance activities of the Hospital. If a Committee member is involved personally and directly in any allegation that is raised, he or she will abstain from any consideration of any such allegation. If all of the Committee's members are involved personally and directly in any allegation, the Hospital's Board and attorneys will be notified and informed of the nature of the allegation. The Hospital's Board and attorneys will then be responsible for undertaking any investigation and corrective action involving any such allegation.

If the Compliance Officer disagrees with any decision or other action taken by the Compliance Committee, the Compliance Officer will be given an opportunity to address the members of the Hospital's Board of Directors with respect to the dispute. This opportunity shall be provided to the Compliance Officer within a reasonable period of time from the date that the request is made, as determined by an analysis of all relevant circumstances.

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A. INVESTIGATIVE PROTOCOL

A primary duty of the Compliance Committee shall be to facilitate reports of possible misconduct from the Hospital's employees and members of the medical staff. The Compliance Committee shall ensure that every report, whether written or oral, that is received shall be reviewed and evaluated by the Compliance Committee.

The Committee may determine that a report does not warrant investigation. If the Committee concludes, based upon its initial review of a report, that an investigation is warranted, the Committee may ask the Hospital's attorneys to conduct the investigation or it may conduct the investigation itself. Any investigation shall be completed in a timely fashion.

At the conclusion of any investigation, a privileged and confidential report shall be written by or to the Hospital's attorneys containing a summary of the reported allegation, the steps taken to investigate the report, the investigative findings, and the recommendations, if any, for corrective action. After consultation with the Hospital's attorneys, the Compliance Committee shall act on the report in a timely fashion. The Compliance Committee's actions may include a corrective action plan, refunds of any documented overpayments, or voluntary disclosure to government agencies, as appropriate and required. The Compliance Committee may request advice of counsel to determine the extent of any potential liability and to plan the appropriate response.

B. AUDIT PROTOCOL

The Compliance Officer, in consultation with the Compliance Committee, shall institute a plan for periodic internal audits of certain facets of the Hospital's operations. The Compliance Officer shall select an appropriate auditor. The Compliance Officer and the Compliance Committee may retain outside counsel and other consultants with expertise, as necessary and appropriate under the circumstances. The Compliance Officer and the Compliance Committee shall determine the frequency with which each area shall be audited, and whether any additional areas need to be audited.

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C. COMPLIANCE TRAINING

As part of its compliance program, the Hospital shall provide periodic training for its employees. Members of the medical staff shall also be invited to all appropriate sessions, and will be strongly encouraged to attend. The focus of the training shall be the Standards of Conduct and the way in which the employee disciplinary system will be used to enforce the compliance program. Each employee that is required to attend a compliance training session shall be required to sign an attendance sheet establishing attendance at the training session. It is the responsibility of the Compliance Committee to integrate new regulations and legal developments affecting the Hospital's operations into its compliance training.

The Compliance Officer is obligated to ensure that each new employee or member of the medical staff receives a copy of the compliance program and acknowledges receipt of that program in writing. With the Director of the Human Resources Department, the Compliance Officer is responsible for training all new employees regarding the requirements of this program and related policies, and emphasizing its importance to the Hospital. The Compliance Officer may delegate this responsibility to other persons, as appropriate.

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Annually, the members of the medical staff shall receive a memo from the Compliance Officer regarding key compliance issues pertinent to hospital operations and current activities of governmental regulatory agencies.

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D. IMPLEMENTING OBLIGATIONS UNDER NEW STATUTES AND REGULATIONS

The Compliance Officers has the obligation to disseminate new and relevant information to the appropriate Hospital personnel, including staff physicians. Normally, this will be accomplished either through memoranda or through distribution of copies of relevant statutes, regulations, or decisions. The Compliance Officer should also be prepared when necessary to conduct in-service training or have in-service training conducted, if extensive and complicated changes must be communicated or if important new procedures must be developed as a result of any statutory or regulatory development.

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E. EXIT INTERVIEWS

Any employee terminating employment with the hospital will be provided the opportunity to have an exit interview and shall be scheduled to meet with the Director of the Human Resources or his designee to discuss their work experience at Alameda Hospital. Included within this meeting will be a discussion of the Compliance Program and the Standards of Conduct.

F. ANNUAL REPORT

The Compliance Officer shall prepare, in consultation with outside counsel, an annual report of compliance activities for presentation to the Compliance Committee and to the Board of Directors. The report shall include a summary of all relevant information, including any recommendations the Compliance Officer may have regarding improvements in the Hospital's compliance practices or in the compliance training provided to employees and members of the staff.

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In the annual report, the Compliance Officers shall indicate whether:

(1) the Standards of Conduct have been circulated to all current employees and members of the staff, except for contractors who do not provide at least $25,000 in health care items and services on an annual basis, unless the contractor is physician-owned or controlled;

(2) all reports and inquiries received by the Compliance Officer have been investigated and resolved;

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(3) all employees have attended any mandatory training sessions;

(4) disciplinary procedures related to compliance issues have been reviewed for consistency and effectiveness; and

(5) whether appropriate steps have been taken to distribute information regarding new federal and state laws, regulations, and significant decisions to appropriate Hospital staff.

G. EXERCISING DUE DILIGENCE IN SELECTING EMPLOYEES

The Hospital is committed to preventing the delegation of discretionary authority to any employee, contractor, or member of the medical staff who has a discoverable propensity to engage in illegal activity. This goal will be accomplished in the following manner:

1. Prospective Employees and Members of the Medical Staff

The Hospital will carefully evaluate all prospective employees or members of the medical staff. The Hospital's application process will be designed to elicit relevant information that can assist in this inquiry. The application form will include a question as to whether the individual is excluded, suspended, or debarred, or has any other limitation with respect to his/her ability to fully participate in federal employment or contracting, and a statement that this would be grounds to deny employment. The application form will also contain an acknowledgment by the applicant that the information in the application will be subject to verification, that the verification process may continue after the employee or member of the medical staff is hired or engaged, and that any false statements or material omissions are grounds for dismissal.

The Hospital will determine if any prospective employee (or an employee of a registry employed by the Hospital) or member of the medical staff has been excluded from participation in federally-funded health care programs by reviewing the Office of the Inspector General's and the General Services Administration's Lists of Excluded Persons. If a person has been excluded, the Hospital will, after consultation with legal counsel, take such action as is appropriate or is required by law under the circumstances. In cases involving the medical staff, such action shall be taken only after consultation with the President of the Medical Staff and, as necessary or appropriate, with the Medical Executive Committee and the Board of Directors.

If applicable, the Hospital shall also query the National Practitioner Data Bank and any state licensing boards. For any position that requires significant involvement in billing and coding responsibilities, the Compliance Officers, acting through the director of the Human Resources Department, shall require appropriate background checks.

2. Existing Employees and Members of the Medical Staff

The Hospital will also monitor the activities of its current employees and members of the medical staff for potential compliance problems. The obligation imposed on employees and members of the medical staff by the compliance program to report suspected misconduct is one significant device for alerting the Compliance Officer to potentially harmful employee and medical staff conduct. The Hospital's commitment to periodic compliance audits is another important check.

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3. Independent Contractors or Vendors

The Hospital will also monitor the contracts that it enters into to provide items and services that may be paid for in whole or in part with funds received from the Medicare or Medi-Cal programs (or other federal healthcare programs). Before entering into any new contract, or renewing any existing contract, the Hospital will determine if any independent contractor has been excluded from participating in these programs, has been listed as being debarred or otherwise ineligible for participating in federally funded health care programs, or has been convicted of any crimes related to health care. The Hospital will also periodically check its existing contractors for eligibility status, and may take such action as is necessary to meet its legal requirements in the event that an existing contractor is determined to be ineligible for federal healthcare program participation.

The Hospital will, after consultation with legal counsel, take such action as is appropriate or is required by law under the circumstances in these cases. In cases involving the medical staff, such action shall be taken only after consultation with the President of the Medical Staff and, as necessary or appropriate, with the Medical Executive Committee and the Board of Directors. The mechanisms discussed above in connection with prospective employees and members of the medical staff will be used in connection with independent contractors where contracts involve the provision of health care items or services in the amount of $25,000 or more per annum or that are physician-owned or controlled.

4. Annual Reviews

The mechanisms discussed above with respect to the screening of employees, contractors, and members of the medical staff shall be repeated annually for (1) all members of the medical staff and (2) all contractors whose contracts involve the provision of more than $25,000 in health care items or services on an annual basis, or the contract involves billing, coding, reimbursement, or patient care services; or the contract is with an entity that is physician-owned or controlled.

H. DISCIPLINARY ACTIONS

It shall be the responsibility of the Compliance Committee to ensure that any employee, contractor, or member of the medical staff found to have violated the Standards of Conduct is disciplined in an appropriate, measured, and consistent fashion. The Compliance Committee shall review all significant disciplinary decisions involving compliance issues quarterly to ensure that this standard has been met.

All managers and supervisors should make consistent and serious attempts to identify any misconduct committed by employees or others that they supervise. Managers may be subject to discipline for failure to detect compliance violations that occur to the extent that the manager is negligent in this duty. If a manager or supervisor, through negligence, carelessness, or inattention facilitates or prolongs misconduct, then an appropriate penalty commensurate with the seriousness of the offense will be imposed.

The Hospital recognizes that different categories of culpability may exist (i.e., simple negligence, gross negligence, or willful conduct) and this will be taken into consideration when determining the appropriate discipline. Depending on the circumstances, certain offenses may

be sufficient to justify disciplinary action, up to and including immediate termination of employment or staff membership, including:

(1) violation of any federal or state statute;

(2) failure to report conduct by a Hospital employee, staff member, or contractor that a reasonable person under the circumstances should have known was criminal or a violation of law;

(3) failure to report a violation of the Standards of Conduct by any Hospital employee, staff member, or contractor that a reasonable person under the circumstances should have known violated the Standards;

(4) willfully providing materially false information to the Hospital, its attorneys, a government agency, or other person in connection with any matter related to the Hospital or the provision of any health care service or item; and

(5) knowingly or willfully obstructing any government investigation or audit.

An employee or member of the medical staff whose conduct would otherwise justify termination may have a lesser discipline imposed if the employee or member of the medical staff reported his or her own violation, whether or not the report constitutes the Hospital's first awareness of the violation and the employee's or member of the medical staff's involvement, or if the employee or member of the staff provided full and complete cooperation during the investigation of the violation.

RESPONDING TO INVESTIGATIONS

If any investigators or auditors make unscheduled visits, the Compliance Officer, in consultation with outside counsel, shall be the sole point of official contact and communication. However, nothing in this policy is designed to preclude employees or members of the medical staff from communicating appropriately with law enforcement officials, if they so desire. The Compliance Officer can provide further information as to what should be done, consistent with the law, in the event that investigators or auditors contact you.

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City of Alameda Health Care District Policy No. 5		
Action	**Date**	**By:**
Created:	07/1998	Law Firm of Arent Fox Kintner Plotkin & Kahn
Approvals:	08/98	Legal Counsel (Foley & Lardner)
Reviewed/Revised	01/01	Leadership Quality Council
	12/03	MEC
	04/06	District Board
Reviewed/Revised		MEC/District Board

COMPLIANCE COMMITTEE

NAME	TITLE	TELEPHONE
Ms. Joyce Walker Compliance Officer	Director of Budget and Compliance	814-4003
Ms. Kristy Lugert	Director of Health Information Management	814-4039
Ms. Phyllis Weiss	Director of Human Resources	814-4027
Mr. Anthony Corica	Director of Physician Relations	814-4081
Ms. Janet Dike	Director of Quality Resource Management	814-4036
Mr. Robert Lundy-Paine	Director of Information Systems	814-4311
Ms. Mary Bond	Executive Director of Nursing Services	814-4032
Mr. Leon Dalva	Director of Revenue Cycle	814-4323
Mr. Kerry Easthope	Associate Administrator	814-4000

The President of the Board of Trustees and the President of the Medical Staff may serve as ad hoc members of the Compliance Committee

VERIFICATION CORRESPONDENCE

<Addressee>

Dear_____:

On_____,at_____am/pm, I spoke to you regarding a question concerning_____ _____. You informed me that _____ _____. I intend to act in reliance on the information that you have provided to me. Based on the information that you provided, it is my understanding that the guidance that you provided is in accordance with the applicable rules and policies governing_____. If this is not, in fact, correct, please write to me immediately to clarify the situation.

Thank you for your kind attention to this matter,

Sincerely,

_____

Cc: Joyce Walker

Exhibit 2

CITY OF ALAMEDA HEALTH CARE DISTRICT
ADMINISTRATIVE POLICY NO. 53

TITLE: Education Concerning False Claims Liability, Anti-Retaliation Protections, and Detecting and Responding to Fraud, Waste and Abuse

PURPOSE: To provide information about the role of certain federal and state laws in preventing and detecting fraud, waste and abuse in federal health care programs.

SCOPE: Hospital-wide (including employees, contractors, and agents of Alameda Hospital

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POLICY:

It is the policy of Alameda Hospital to provide health care services in a manner that complies with applicable federal and state laws and that meets the high standards of business and professional ethics. To further this policy, and to comply with Section 6032 of the Deficit Reduction Act of 2005, Alameda Hospital provides the following information about its policies and procedures and the role of certain federal and state laws in preventing and detecting fraud, waste, and abuse in federal health care programs:

Summary of Federal and State Laws: The following is a summary of the Federal False Claims Act, the Program Fraud Civil Remedies Act, and the California False Claims Act, and their role in preventing and detecting fraud, waste and abuse in federal health care programs.

Federal False Claims Act; Title 31, United States Code, Chapter 37

The federal False Claims Act imposes liability on any person or entity who:

- Knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program;
- Knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program; or
- Conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid.
- "Knowingly" means:
    - Having actual knowledge that the information on the claim is false;
    - Acting in deliberate ignorance of whether the claim is true or false; or
    - Acting in reckless disregard of whether the claim is true or false.

A person or entity found liable under the False Claims Act is, generally, subject to a civil penalty of not less than $5,000 and not more that $10,000, plus 3 times the amount of damages that the Government sustains because of the illegal act. In health care cases, the amount of damages sustained is amount paid for each claim that is filed that is determined to be false.

Anyone may bring a *qui tam* action under the False Claims Act in the name of the United States. The case is initiated by filing the complaint and all available material evidence under

seal with a federal court. The complaint remains under seal for at least 60 days and will not be served on the defendant. During that time, the Government investigates the complaint. The Government may, and often does, obtain additional investigation time by showing good cause. After expiration of the review and investigation period, the Government may elect to pursue the case in its own name or decide not to pursue the case. If the Government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

If the Government proceeds with the case, the person who filed the action will receive between 15% and 25% of any recovery, depending upon the contribution of that person to the prosecution of the case. If the Government does not proceed with the case, the person who filed the action will be entitled to between 25% and 30% of any recovery, plus reasonable expenses and attorneys' fees and costs.

Program Fraud Civil Remedies Act, Title 31 United States Code, Chapter 38

The Program Fraud and Civil Remedies Act (PFCRA) creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that my be imposed under the False Claims Act.

The PFCRA imposes liability on people or entities that file a claim that they know or have reason to know:

- Is false, fictitious, or fraudulent;
- Includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
- Includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
- Is for payment for property or services not provided as claimed.

A violation of this section of the PFCRA is punishable by a $5,000 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid.

In addition, a person or entity violates the PFCRA if they submit a written statement that they know or should know:

- Asserts a material fact that is false, fictitious or fraudulent; or
- Omits a material fact that they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy.

A violation of this section of the PFCRA carries a civil penalty of up to $5,000 in addition to any other remedy allowed under other laws.

CITY OF ALAMEDA HEALTH CARE DISTRICT
ADMINISTRATIVE POLICY NO. 53

California False Claims Act, California Government Code, Chapters 12650 - 12655:

The California False Claims Act imposes liability on any person who:

- Knowingly presents or causes to be presented to an officer or employee of the state or of any political subdivision thereof, a false claim for payment or approval;

- Knowingly makes, uses, or causes to be made or used a false record or statement to get a false claim paid or approved by the state or by any political subdivision;

- Conspired to defraud the state or any political subdivision by getting a false claim allowed or paid by the state or by any political subdivision; or

- Is a beneficiary of an inadvertent submission of a false claim to the state or political subdivision, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the state or the political subdivision within a reasonable time after discovery of the false claim.

Any person who commits any of the above shall be liable to the state or the political subdivision for three times the amount of damages which the state or the political subdivision sustains because of the act. The person shall also be liable to the state or to the political subdivision for the costs of a civil action brought to recover any of those penalties or damages, and may be liable to the state or political subdivision for a civil penalty of up to $10,000 for each false claim.

A person may bring a *qui tam* civil action under the California False Claims Act in the name of the person and either the State of California or for a political subdivision by filing a compliant in superior court in camera. The complaint may remain under seal for up to 60 days and will not be served on the defendant. On the same day, the qui tam plaintiff shall serve by mail the Attorney General with a copy of the complaint and a written disclosure of substantially all material evidence and information the person possesses. Within the 60 day period, the Attorney General will conduct an investigation, and will notify the court that he will either elect to proceed with the action, in which case the seal will be lifted, or decline to take over the action, in which case the seal will be lifted and the qui tam plaintiff shall have the right to conduct the action.

If the state of political subdivision proceeds with an action brought by a qui tam plaintiff, the qui tam plaintiff shall, receive at least 15% but not more than 33% of the proceeds of the action or settlement of the claim, depending upon the contribution of that person to the prosecution of the action. If the state or political subdivision does not proceed with an action, the qui tam plaintiff shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages of behalf of the state. This amount shall not be less than 25% and not more than 50% of the proceeds of the action or settlement.

Alameda Hospital's Policies and Procedures for Detecting and Preventing Fraud:

Within its Compliance Plan Document, Alameda Hospital has identified Standards of Conduct with which each employee (including Management), contractor, and member of the medical staff is expected to be familiar. The Hospital will take reasonable steps to ensure that these

Standards of Conduct are followed. In general, the standards can be grouped into the following categories:

- Patient rights and confidentiality of all records and documentation;
- Discharges, transfers and emergency presentations;
- Proper financial recording, including medical records and billings, collections of co-payments and deductibles, and refunds of overpayments by patients and payers;
- Gifts, gratuities, kickbacks and referrals;
- Protection of organizational assets;
- Periodic audits of billings, records, and other hospital procedures.

A copy of the compliance plan is provided to each employee upon hire, to each member of the medical staff at the time of appointment, and to each contractor that provides at least $25,000 in goods and/or services. The document is also located in the Administrative Policy and Procedure Manual in each department.

A compliance hotline has been established which can be used by anyone to report a potential violation of the Standards of Conduct. The compliance officer, or any member of the compliance committee will be able to answer questions about the compliance plan or the Standards of Conduct.

Anti-Retaliation Protections:

Individuals within an organization who observe activities or behavior that may violate the law in some manner and who report their observations either to management or to governmental agencies are provided protections under certain laws.

For example, both the Federal False Claims Act and the California False Claims Act include protections for people who file *qui tam* lawsuits as described above. The False Claims Act states that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of a *qui tam* action is entitled to recover damages. He or she is entitled to "all relief necessary to make the employee whole," including reinstatement with the same seniority status, twice the amount of back pay (plus interest), and compensation for any other damages the employee suffered as a result of the discrimination. The employee also can be awarded litigation costs and reasonable attorneys' fees.

Role of False Claims Laws:

The false claims laws discussed above are an important part of preventing and detecting fraud, waste and abuse in federal and state health care programs because they provide governmental agencies the authority to seek out, investigate and prosecute fraudulent activities. Enforcement activities take place in the criminal, civil and administrative arenas. This provides a broad spectrum of remedies to battle these problems.

CITY OF ALAMEDA HEALTH CARE DISTRICT
ADMINISTRATIVE POLICY NO. 53

Anti-retaliation protections for individuals who make good faith reports of waste, fraud and abuse encourage reporting and provide broader opportunities to prosecute violators. Statutory provisions, such as the anti-retaliation provisions of the federal and state False Claims Acts, create reasonable incentives for this purpose. Employment protections create a level of security employees need in order to help in prosecuting these cases.

City of Alameda Health Care District Policy No. 53	
Required Committees:	Management Team

Policy must be reviewed by all committees listed above before approval by the Administration or District Board

	Date:	**By:**
Created:	10/08	Finance
Approvals:	11/08	Administration
	11/08	District Board

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: October 29, 2008

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

FROM: Deborah E. Stebbins, CEO

SUBJECT: Approval of Acquisition of Health Line System's Inc. ECHO Software

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Hospital Administration hereby requests that the City of Alameda Health Care District, Board of Directors authorize management to proceed with the acquisition of the ECHO software from Health Line Systems Inc. The quoted cost totals $72,400 plus an allowance of $8,000 for Meditech interface and installation expenses. In addition, the annual license and support fees are $14,500.

This new software package will serve two key functions. First, it will replace the existing MEDSTAFF credentialing system that will no longer be supported as of January 1, 2010. Secondly, the software will provide a required new tool to assist the hospital with Joint Commission Accreditation. The software is currently used in over 1,000 hospitals throughout the United States.

In January 2007, the Joint Commission implemented a substantially revised set of credentialing and privileging standards for all accredited hospitals. According to the Joint Commission, these revisions were designed to improve the clarity of the standards as well as to improve their objectivity and validity. Organizations now must:

- Evaluate each practitioner's professional practice.
- Collect data on good performance and not just outlier or trending data
- Use the data to determine the status of each practitioner's privileges.

In addition, the Joint Commission has changed the requirement for how often practitioners must be evaluated. The new standards now require that practitioners' performance be evaluated in an ongoing fashion.

Alameda Hospital received a deficiency in this area during the previous Joint Commission survey in May of 2007. This software tool will assist us in being compliant with these standards. It would be good to get a years or so track record of standards compliance before the next survey.

Date: November 6, 2008

To: City of Alameda Health Care District Board of Directors

From: David A. Neapolitan, Chief Financial Officer

Subject: Authorization to Execute Contract for a Decision Support System

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The purpose of this memorandum is to outline management's evaluation of four potential Decision Support Systems, provide additional details about the capabilities and functionality of the recommended system including contractual terms and to request that the Board authorize the Chief Executive Officer to execute a contract with the recommended vendor.

Background:

In 1999 the organization implemented the Meditech System to serve as the Hospital's primary information system. This system, while a very comprehensive and strong system that delivers core financial and clinical functionality, is a hierarchical based system which has various short comings in its ability to easily conduct programmatic cost analysis, conduct what-if scenarios, development of user friendly budgeting applications and limited ability to create custom reports on the fly. As a result, management started an evaluation of add-on systems that could meet the following key objectives:

- Ability to conduct cost analysis of service line performance down to the practitioner level in order to improve cost effectiveness of services delivered and to ensure that the organization continually and easily evaluates the financial performance of all service lines.
- Ability to analyze managed care contract performance to ensure that accurate payments are received on patient billings, ability to automate the process of following up on underpayments received and to be able to effectively negotiate contract amendments as contracts come up for renewal.
- Ability to develop annual operating and capital budgets via an integrated tool and allow for monthly performance reporting back to management with the ability to access supporting data directly from the Meditech system via the budgeting and reporting tool.
- Identify a system that can easily be integrated with our existing Meditech core system.
- Identify a system that will require minimal capital investment due to limited resources.
- Identify a system that requires minimal reliance on Alameda Hospital Information Technology staff to maintain a new system.

- Identify a system that will require minimal implementation effort due to limited internal staff and that will be easy to use and maintain by primary users of the system.

We identified four (4) systems that we felt could potentially meet the outlined objectives which included:

- MedAssets - Avega - Alliance Decision Support
- Organizational Intelligence
- Medi-Solve
- IPeople

Each of the above listed vendors was invited to demonstrate their respective systems to the Chief Financial Officer, the Director of Budget and the Director of Information Technology. After these evaluations, this team unanimously felt that only one system could fully meet all of the objectives that had been identified. See Exhibit A for a summary of results of these initial demonstrations. This vendor was then invited back to the Hospital to demonstrate their product to a larger group that included the Chief Executive Officer, Associate Administrator, Director of Revenue Cycle, Director of Nursing, Director of Physician Relations, Director of Quality / Case Management, Accounting Manager, and on of the Hospital the Systems Analysts. As a result of that demonstration the entire management team believes that this system would fully meet the stated objectives.

Selected System – MedAssets - Avega – Alliance Decision Support

The Alliance Decision Support System was the only system that met all of our stated objectives through a fully integrated product line that is designed to accelerate decision-making enterprise-wide by integrating clinical, financial and operational information into a common data set for accuracy and ease of use across the organization. This information is intuitively displayed through a newly designed intelligent dashboard with multiple interactive panels to help executive and department level users relate financial outcomes to clinical and operational decisions for business process improvement, margin enhancement and enterprise-wide accountability.

The applications within the Alliance Decision Support System include:

- **Cost Accounting**, a straightforward interface to guide you through the process of developing cost standards, calculating case costs and allocating overhead. This application includes micro costing, open charge codes, RVU, and markup options.
- **Clinical Analytics**, an expansive tool for evaluating product lines, physician treatment protocols and quality of care related data.
- **Contract Management**, a comprehensive tool supports all aspects of the contract process including contract planning, negotiation, expected payment calculations, contract compliance and monitoring.
- **Budgeting**, a paperless process with workflow management tools, allows the organization to streamline the set-up of multiple forecast and spread methods, deploy the budget to multiple end-users and monitor the completion of the budget.

- **Department Performance Reporting**, a dashboard reporting tool provides performance, volume, revenue, expense, and staffing graphs and reports that inform and help drive performance improvement.
- **Key Indicators**, a management dashboard application that provides executives and management decision makers with timely access to organization defined business intelligence, which can help identify emerging trends, measure progress in reaching stated business objectives, and reinforce what is important to the success of the organization.
- **myAlliance®**, a centrally maintained and secure information management and report distribution tool allows reports and information from systems outside of Alliance to be integrated on the desktop of the organizations management team.

Included as Exhibit B is the original proposal that was prepared by MedAssets on August 18, 2008, this proposal provides additional information about MedAssets (Section I), additional detailed information about each of the various applications (Section II) and information about the MedAssets Decision Support ASP Solution (Appendix A). The only significant change to this document which has been a result of continued negotiations with MedAssets is a change to the Alliance Decision Support Pricing (Section III). We have attached Exhibit B to summarize the current pricing options that have been updated as of November 6, 2008.

Recommendation:

Management recommends, subject to management's satisfactory completion of a site visit to the Community Hospital of the Monterey Peninsula (CHOMP) and phone interviews of Huntington Memorial Hospital (Pasadena, CA) and John C. Lincoln Hospital (Phoenix, AZ), that the Board of Directors authorize the execution of the agreement with MedAssets for the implementation of the Avega - Alliance Decision Support System based upon Option 1 as outlined in Exhibit C. We believe that this option provides the most cost effective approach to implementing a fully integrated decision support system to the hospital that will accelerate organization-wide decision making by integrating clinical, financial and operational information.

Exhibit A

Alameda Hospital
Summary of Decision Support Applications

DSS Applications	Cost Accounting	Contract Management	Clinical Analytics	Budgeting	Key Indicators Dashboard	ASP Application
Med Assets - Avega - myAlliance	Yes	Yes	Yes	Yes	Yes	Yes
Organization Intelligence "OI"	Yes	In Development	Yes	Yes	Yes	Yes
IPeople	No	No	Yes	No	Yes	No
Medi-Solve	No	No	Yes	No	Yes	No

MedAssets Proposal To:

ALAMEDA HOSPITAL

MedAssets®
flexible approach. custom solutions.

August 18, 2008

Judy Griffith

Regional Director

MedAssets Revenue Management Solutions

Telephone: (303) 895-6005

Email: jgriffith@medassets.com

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MedAssets®
flexible approach. custom solutions.

Section I. Executive Summary

MedAssets is pleased to provide this proposal to Alameda Hospital for the acquisition and implementation of a Decision Support System.

Our suite of integrated software is widely regarded as the best Decision Support software in the healthcare industry and utilized by more than 600 hospitals, health plans and other provider-based organizations. We have extensive experience in delivering Application Service Provider (ASP) solutions like this project we are proposing for Alameda Hospital, and we are experts at delivering projects on time and within budget. We believe the combination of our software, service approach, experience, and commitment to the financial improvement of our clients uniquely positions MedAssets to satisfy Alameda Hospital's requirements for a Decision Support solution.

Company Overview

MedAssets is headquartered in metro Atlanta, GA with offices in St. Louis, Los Angeles, Nashville, Dallas, Denver, and Mahwah, NJ. With more than 1,500 employees, MedAssets is focused upon improving the financial strength of healthcare providers by implementing integrated supply chain and revenue cycle solutions that help control cost, improve margins and cash flow, increase regulatory compliance, and optimize operational efficiency. As a strategic business partner, MedAssets can replace multiple vendors and decrease supply costs by 3-10%, increase net patient revenue by 1-3%, and deliver additional cash from existing operations. Our customers encompass 115+ healthcare systems and integrated delivery networks, 2,400 Acute Care providers, and 30,000 Alternate Site providers whom we have helped improve their financial health.

In January 2006, MedAssets acquired Avega Health Systems, the leading provider of Business Decision Support solutions for the health care industry. Founded in 1983, Avega continues to set the standard it has maintained for 25 years by maintaining a singular focus on software and services that provide value to our healthcare clients. With over 140 professionals dedicated to our Decision Support and Performance Analytics product line, we remain committed to providing our customers with the best Business Decision Support solution available today.

Our Decision Support clients include integrated delivery networks, children's hospitals, large multi-facility entities, for-profit and not-for-profit, tertiary care centers, rehabilitation centers, teaching organizations and health maintenance organizations. The sizes of these health care organizations range from a single hospital with 59 acute care beds, to a multi-entity enterprise comprised of more than 180 hospitals. They range in complexity as well, from community hospitals to teaching facilities in university settings. It is this breadth of size and depth within our client base that truly sets MedAssets apart as being a scalable solution; in particular, one that best meets the profile of an organization like Alameda Hospital.

MedAssets Decision Support and Performance Analytics

Our proposal includes implementing our Alliance Decision Support® system for Alameda Hospital as your Decision Support system. Alliance is an integrated system comprised of decision support components, enterprise reporting tools, management dashboards and an integrated data warehouse. MedAssets utilizes the industry's most comprehensive data model to integrate financial, budgeting, clinical, administrative, and operational data in a robust business intelligence environment that facilitates decision-making across organizations. The foundation of this warehouse is the MedAssets-

designed consumer-centric data model, which allows all data from multiple hospitals, care delivery settings, even with disparate source systems and coding methodologies, to be integrated into a corporate warehouse. The MedAssets Decision Support solution utilizes Oracle database technology and includes an extensive suite of standards reports. In addition, we have integrated the industry-leading report writer, Crystal Reports XI, into our data model to provide online query and ad-hoc reporting capabilities.

Our proposal includes the following business components within the MedAssets Decision Support and Performance Analytics solution:

- Contract Management includes comprehensive features to support all aspects of the contract process; including contract planning, negotiation, expected payment calculation, compliance, and monitoring.
- Cost Accounting provides a straightforward interface that guides you through the process of developing cost standards, calculating case costs, and allocating overhead. Cost capabilities include micro-costing, open charges codes, RVU, markup and more.
- Clinical Analytics provides key features for evaluating product lines, physician treatment protocols and quality of care.
- Budgeting provides an enterprise-wide, paperless process for budgeting planning allowing you to streamline the set-up of multiple forecasts and spread methods, deploy the budget out to multiple end-users and monitor the completion of the budget through workflow management tools.
- Key Indicators is a management dashboard component designed to provide your executives and management decision makers with timely access to client-defined business intelligence that can help identify emerging trends, measure progress in reaching stated business objectives, and reinforce what is important to the organization.

Project Overview

Our approach to this project will be to work side by side with the Alameda Hospital team to deliver a Decision Support tool that ensures Alameda Hospital recognizes Return on Investment and is poised to continue to improve operational and financial performance through the rollout of the Decision Support solution.

Our project has been organized into two phases, each with a Planning phase and an Implementation phase. The two components are:

- Phase 1: Data Planning and Infrastructure Preparation. This planning phase of this project will develop the overall project plan for the Decision Support System implementation as well as the standardized approach to implementation and reporting. The implementation phase will configure the Alliance software for use at Alameda Hospital.
- Phase 2: Implementation of Alameda Hospital in an ASP configuration. This project will complete the planning and central implementation of the Alliance software for use by Alameda Hospital facilities.

The MedAssets team will manage the overall project. The staffing for the services in our proposal will be delivered entirely by the MedAssets service team in conjunction with designated project staff from Alameda Hospital. Each phase of each project is based on specific deliverables and is monitored and measured via milestone achievements.

When we complete our project with Alameda Hospital you will have the following capabilities:

- Payor contract modeling capabilities and support
- Payor contract performance and compliance monitoring for all Payor contracts modeled

- Service Line Analysis and Management
- Clinical Analysis and Management allowing physician peer comparison, practice pattern analysis and clinician behavior change
- Clinical and Business Process Improvement (workflow improvements in ER and operating room)
- Strategic Business Planning
- Multiple Cost Accounting methodologies
- Budgeting and Financial Modeling
- Consistent data standards, cost and clinical standards, and reporting standards across the enterprise
- Dashboard reporting delivering key business measures to executives and management decision-makers
- Enterprise-wide report distribution and management

Thank you for the opportunity to present our unique products and services to Alameda Hospital. We look forward to the opportunity to present our approach to this important project.

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Section II. Product Overview

Alliance Decision Support®

Alliance Decision Support (Alliance) uses industry-leading Oracle technology and a sophisticated object-oriented data model that includes industry standard reporting tools featuring Crystal Reports. Alliance integrates financial, clinical, and administrative information from disparate systems to support decision-making throughout your organization. With robust data management and reporting capabilities, and easy-to-use tools, Alliance helps you improve clinical performance, control costs, and effectively support your management activities.

Alliance was designed from the ground up to meet the changing needs of healthcare organizations like yours. By choosing to design a new application from scratch, we took advantage of new technology, such as open systems design, object-oriented development, Windows functionality on the client, and complete client/server functionality. By working with our development partners, leading healthcare organizations, we were able to leverage our expertise with their knowledge of cost accounting/decision support system requirements facing healthcare. The result is a system that has proven itself in the market as the leader in decision support systems today.

Alliance's contract modeling methodologies and capabilities are among the most advanced in the industry. In selections specifically for contract management systems, Alliance is consistently a finalist and typically the winner. Currently more than 120 leading healthcare organizations, representing over 600 healthcare entities, have selected Alliance Decision Support as their model of the future.

Consumer-Centric Data Model

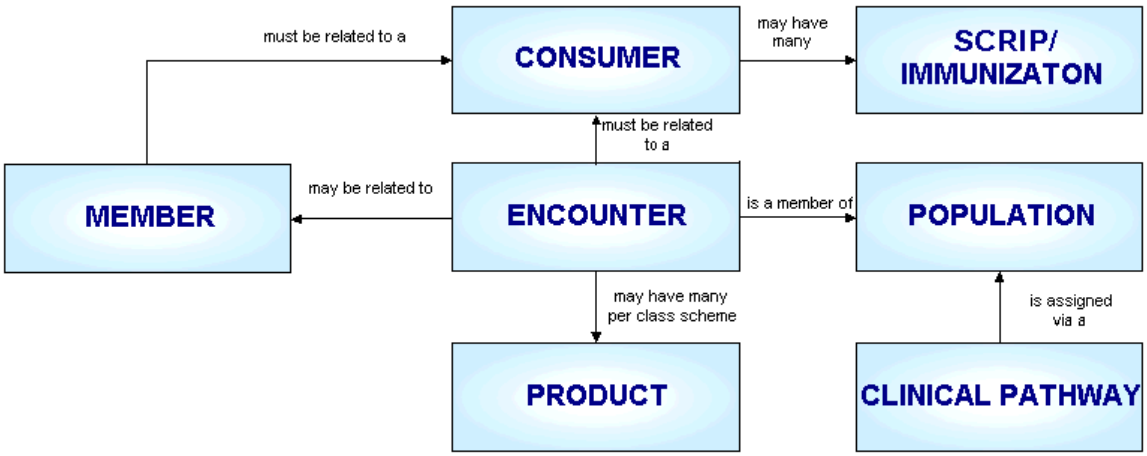
The Alliance data model was designed for the healthcare paradigm of the future - a complex, multi-entity, integrated delivery system. The data model unifies clinical, demographic, membership, and financial data in a single model, and integrates both the health plan and the provider perspectives. We designed the data model utilizing the expertise gained during years of developing DSS systems, in addition to input from large, progressive health care organizations which represent the future of the

health care industry.

This consumer-centric model allows the ability to review all health care services, in the form of encounters or scrip data, delivered to an individual or human being over time. Additional benefits include:

- Foundation for episode groupings and other encounter relationships
- Supports cross-encounter clinical analyses, especially time-based and cross-facility studies
- Historical demographic data supports many types of marketing analyses (e.g. zip code trends)

The consumer-centric model that follows represents a small portion of the much larger, more complex Alliance data model.

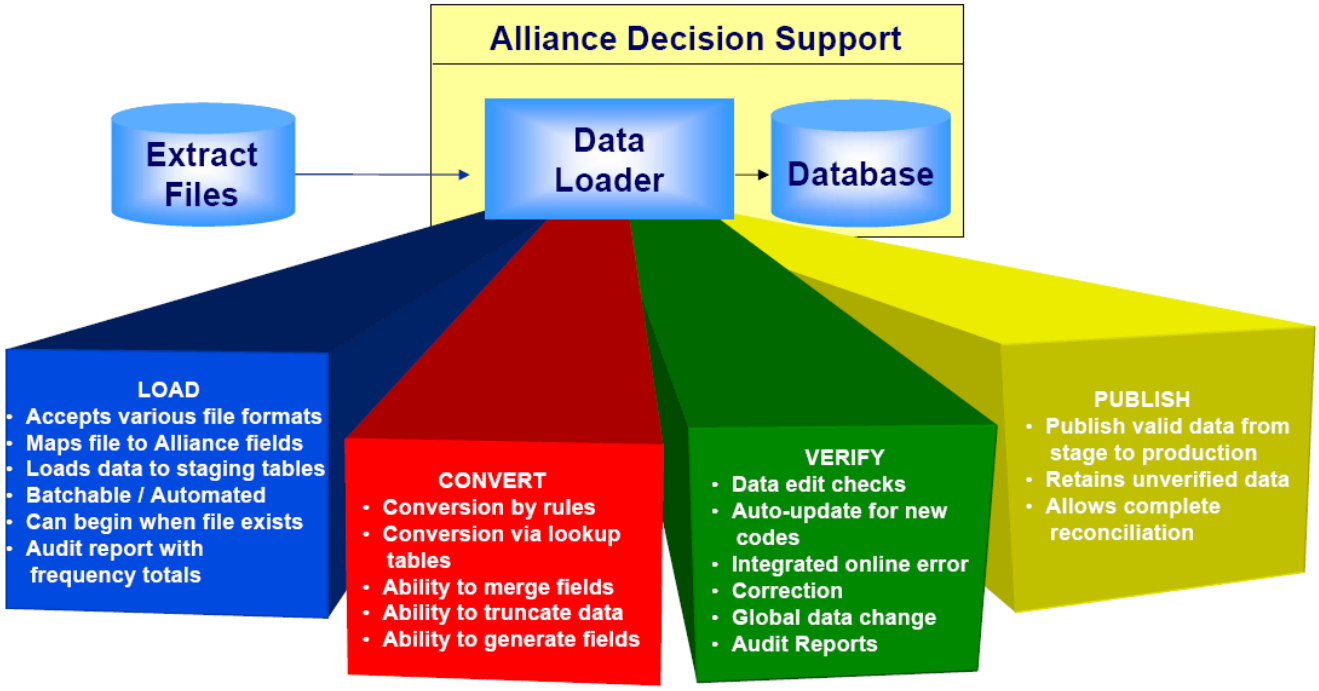


Source Data Extraction/Integration

Avega Health Systems, the Decision Support business unit of MedAssets, has developed and delivered industry-leading business intelligence solutions for the health care industry since its founding in 1983. As a result, we have 25 years of experience receiving data into our application from every major source system. While we do not supply interfaces to legacy systems, we are able to utilize extracts provided by our clients from these systems to facilitate the loading of data into Alliance. We work with our clients during the Data Planning phase of implementation to identify the data sources, data format, and data files required by the application. Alliance then utilizes a highly customizable data loader for data acquisition which enables us to work with your data **regardless of the source system**. Our clients currently interface their data from systems such as:

- Siemens
- Meditech
- McKesson
- Eclipsys
- Lawson
- PeopleSoft
- Cerner
- IDX
- Epic
- QuadraMed
- CPSI
- Self-developed

MedAssets' Alliance Data Loader accepts virtually any file format and offers an easy-to-follow Windows-based Graphical User Interface that guides users through a number of steps, or stages, to ensure that data is loaded in a timely and accurate manner. As long as your organization can extract data from your source systems, Alliance can accept the data.



MedAssets employs a batch processing interface methodology utilizing the Alliance Data Loader. The batch can be configured in a variety of ways to best serve your business needs. For clients who prefer to interface quite often (e.g. daily), the batch monitors a location for the existence of a file and then begins the batch processing. MedAssets has clients who are loading data monthly, weekly, and daily. Also, for the data being loaded back into a source system, clients are able to identify the parameters for the upload (e.g. by patient type, by payer, for a given date range).

On the following pages is an overview of the Alliance components included in our proposal.

Alliance Cost Accounting

To manage costs successfully, you need to have unit costs and resource utilization data at your fingertips. Alliance strengthens your cost development activities by aggregating unit cost data, enabling you to see the entire cost of product lines, populations, contracts, and practitioner groups. You can quickly isolate areas of cost variance, evaluate options for improvement, and focus on monitoring changes and optimizing resources. Alliance Cost Accounting capabilities allow you to:

- Develop costs at the charge item level using RVU, RCC and RCP methodologies or any combination thereof
- Create sophisticated overhead allocation models for indirect costs
- Use fixed and variable cost identification for strategic and financial modeling
- Develop costs for all provider types
- Develop claims costs for payers
- Perform cost analysis and benchmarking

The four major segments of the cost management cycle may be briefly described as follows:

Structure Definition

- Identify all aspects of costs for the enterprise, such as participating entities' accounting structures, healthcare services bought or sold, member populations, and other cost units
- Identify relationships to define revenue flow, expenses for direct/indirect cost determination, and cost aggregation

Cost Drivers

- Identify processes and decisions impacting the cost of services, including practice protocols, new managed care populations, or buying service from outside providers
- Establish planned levels of cost for each cost-driving process and compare the actual cost to the plan

Cost Determination

- Identify unit costs for component services delivered by either internal or external providers according to CPT-4, charge code, or other codified patient care service
- Distribute expenses to cost structures that align the source of expense with the provider services, reflect necessary corporate allocations, and other multi-entity considerations
- Aggregate costs according to enterprise-wide cost structures, such as contracts, populations, inpatient pathway, or primary care practitioners' panel

Cost Management

- Monitor cost performance at all levels of structure, process, or consumer
- Identify areas where financial risk needs to be shifted or managed differently due to poor performance
- Simulate alternatives, such as practice patterns, care delivery setting, contract carve outs, or stop loss clauses, in order to improve performance

Alliance Contract Management

Alliance provides a comprehensive contract management program, from both the provider and payer perspectives. Alliance integrates every aspect of the contract cycle, from planning through payment management. It supports a full scope of contract arrangements and pricing mechanisms, including charge-based pricing, service level pricing, and capitation and stop-loss arrangements. The system can interface with your operational billing process to calculate expected reimbursement and adjust A/R balances at the time of billing. It supports rebills when corrections are made to an original bill. Alliance Decision Support's contract capabilities include:

- Flexible service definitions including carve-outs and populations
- Robust pricing and reimbursement modeling
- Utilization and patient mix analysis
- Actual to expected payment variance reporting and profitability analysis
- Underpayment analysis
- Compliance monitoring
- Net billing
- Unlimited "what-if" capabilities

The main business processes of the contract management cycle, and how Alliance addresses these critical stages, are briefly described as follows.

Contract Planning

Alliance addresses your particular contract planning needs and business initiatives. With Alliance, you can analyze cost and payment information to determine the profitability of a proposal or existing contract. During the contract planning process, Alliance helps you analyze your business to identify what types of new contracts, covered services, and payment methodologies you should pursue. Alliance then facilitates the development of guidelines to use in the negotiation, including break-even points, payment methods, reimbursement levels, and financial targets.

Contract Negotiation

Alliance supports your organization's need to negotiate profitable contracts for both the purchase and sale of services. Cost, quality, and payment information for the entire continuum of care can be integrated to give you a solid understanding of the financial and operational implications of proposed contract terms.

During the negotiation process, Alliance gives you the power to quickly develop and analyze a wide array of contract terms, including capitation and special carve outs. With Alliance Decision Support's powerful modeling tools, you can rapidly iterate through multiple proposals, offers, and counteroffers to determine what terms are best for your organization.

Contract Compliance and Contract Monitoring

Are you getting paid properly? Alliance allows you to review the expected reimbursement against actual payment. With Alliance, you can identify areas of operational improvement and non-compliance with negotiated contract terms, including underpayments and overpayments to other providers. Alliance assists you in developing and implementing strategies for overcoming operational issues and negotiating payment recovery.

Alliance Contract Management Features

Alliance supports all your contract management needs, whether you're buying or selling services. Key features include:

Contract Modeling

Efficient and timely development of contract terms through:

- Easy-to-understand terminology
- User specific, step-by-step prompting
- Folders to organize contract payments
- Unlimited special case payments
  - Stop loss and risk limiters
  - Carve outs
- Contract modeling for virtually all contract terms, including:
  - Comprehensive Discount FFS Payment Terms
  - Capitation (PMPM and Percent of Premium)
  - Carve outs
  - Global Contracts
  - Customized User Formulas
  - Medicare (PPS and APC)
  - APGs
  - Inpatient and Outpatient Medicare
  - Physician Fee Schedule (HCPCS, CPT-4, etc.)

Reporting

Powerful, flexible enterprise-wide reporting through:

- OLAP (On-Line Analytical Processing – optional)
- Menu-driven and "point and click" features
- Standard and customized reporting – defined by the user
- User-specific report library

Accounts Receivable Management
Consistent net revenue/payment calculations through:

- Automated, nightly contractual allowance calculations
- Automated interface to billing system
- Single source calculation engine
- Timely, automated posting of contractual allowances
- Expected to actual reporting
- EORs (Explanation of Reimbursement)

Validation
Analyze and validate risk-based assumptions through:

- Membership trend analysis
- Demographic changes and shifts
- In- and out-of-network usage
- Forecasted vs. actual reporting

Billing Process Integration
Alliance can be integrated with the existing billing processes in your information system environment. This capability provides both your operational and decision support systems with a single source for contract terms and calculations.

Alliance Clinical Analytics

Alliance Decision Support integrates clinical data with financial and administrative data to help you assess the quality and cost of services.

Managing the quality of care is more important than ever. Alliance leads the way in clinical performance measurement and utilization management by supporting your disease and wellness management programs and quickly and accurately identifying areas for improvement. Flexible population definition capabilities help you manage outcomes effectively. You can track both custom and predefined measures, and monitor the value of care over time to enhance the purchase and delivery of services. The system maximizes the use of electronically available data, reducing manual data collection.

Alliance facilitates a wide range of clinical management initiatives, including:

- Resource utilization and cost comparisons
- Pathway development and monitoring
- Peer review and provider profiling
- Preventative Care Monitoring
- Regulatory Compliance

Alliance Budgeting

Alliance Budgeting component is designed to address the complete budget development and financial reporting needs of your organization. Alliance addresses the key need of organizations today: access to an enterprise-wide tool that allows each end-user access to data from their own workstation without having to request reports from a centralized reporting area.

Alliance provides traditional fixed, flexible, and product line budget development capabilities with

complete performance and productivity reporting. Alliance includes multi-year forecasting, balance sheet and cash flow analysis, drill down analysis, report writing and executive information system capabilities.

Alliance is a comprehensive financial application with an underlying multi-dimensional Oracle database that centrally manages large amounts of information from multiple sources. The standard and exception reporting, graphing, rotating and drill down capabilities provide the necessary tools to manipulate and view the data in a variety of formats. These formats include the easy to read and use Alliance graphical user interface, Microsoft Excel, and standard HTML format accessed via any standard web browser. The system allows easy access to the information and has the ability to distribute it electronically, eliminating the need to produce hard copy reports. This technology, combined with a Windows GUI, provides a user-friendly environment with unparalleled flexibility.

Alliance streamlines and improves many processes within your organization, including budget development, performance reporting, financial modeling, capital budgeting and long range planning. Alliance results in faster distribution of information, improved internal communication and analysis, as well as reductions in costs. Staff members at all levels of your organization are empowered with the necessary information to make more timely and informed decisions.

Budget Development Features

Alliance offers distributed budgeting capabilities that allow for a wide variety of budget development techniques to be used to meet the unique needs of different entities or departments within your organization. Information can be entered at any level and updated centrally as appropriate. Some of the budget development features include:

- Supports creation of user defined models and formulas
- "What-If" analysis with unlimited budget scenarios
- Standard and ad hoc budget worksheets
- Support for fixed, flexible and product line budgeting
- Maintains unlimited amount of historical data at user defined levels of detail
- Calculates unlimited amount of budgeted data at user defined levels of detail
- Automated generation of standards based on history
- Wide variety of spread options

Performance Reporting Features

Alliance's financial reporting capabilities combine data from various data sources and distributes information on-line to appropriate end-users. The performance reporting features include:

- Standard reporting and graphing
- Data rotation and drill down capabilities
- Side by side entity (or department) comparisons of actual, budget, flexed budget and "what-if" scenarios
- Exception Reporting
- Includes dollars, FTE's and statistical variance analysis

Productivity Reporting Features

Alliance's productivity reporting allows for analysis of staffing budgets from three sources of variance:

- Planning variance - attributable to the differences in actual volumes compared to those budgeted (similar in concept to a flexible budget)
- Rate variance – attributable to differences in the price per unit (i.e. rate per hour) actually paid

versus budgeted

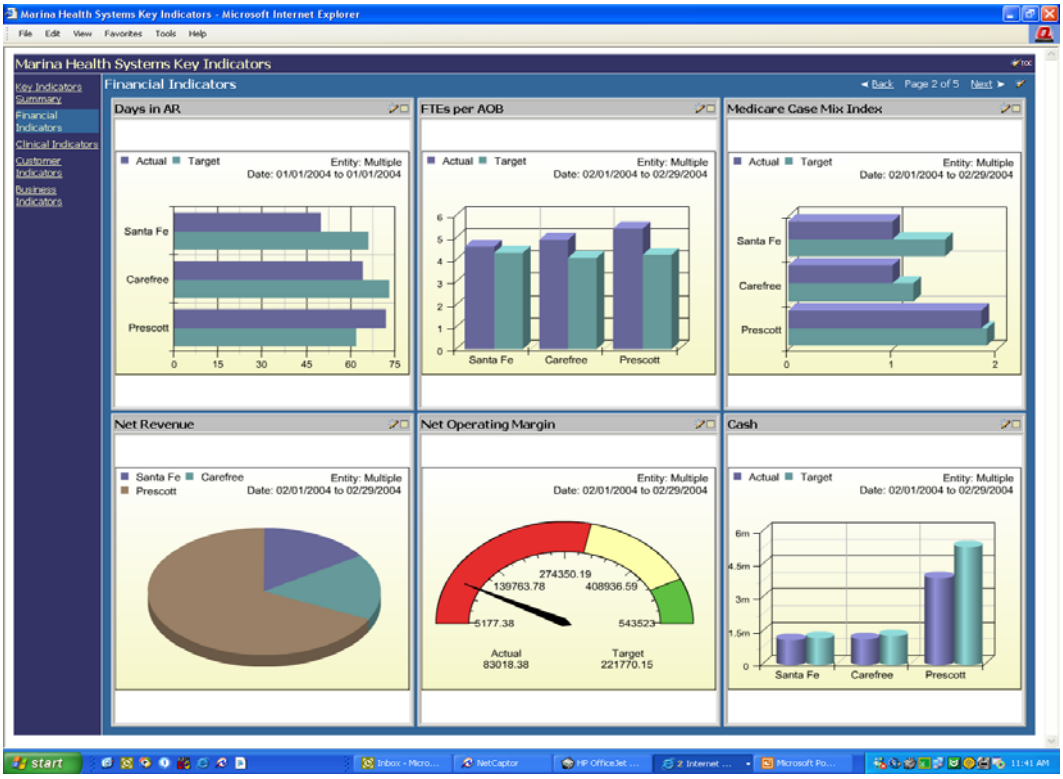
- Efficiency variance – attributable to the differences in the output per unit of labor (i.e., hours per unit of service) actually experienced compared to budget ratio

Alliance supports a fully integrated financial management approach. You can automatically link your budget to other critical processes within Alliance – such as provider resource management, capital budgeting, and long-range planning. As a result, you greatly increase the reliability of your financial models.

Key Indicators

Key Indicators (KI) is a dashboard reporting tool that delivers key business measures to executives and management decision-makers. These key business measures can help identify emerging trends, measure progress in reaching stated business objectives, and reinforce what is important to the business. KI provides browser-based distribution of these key business measures in an "executive dashboard" format, which is easy to use and understand.

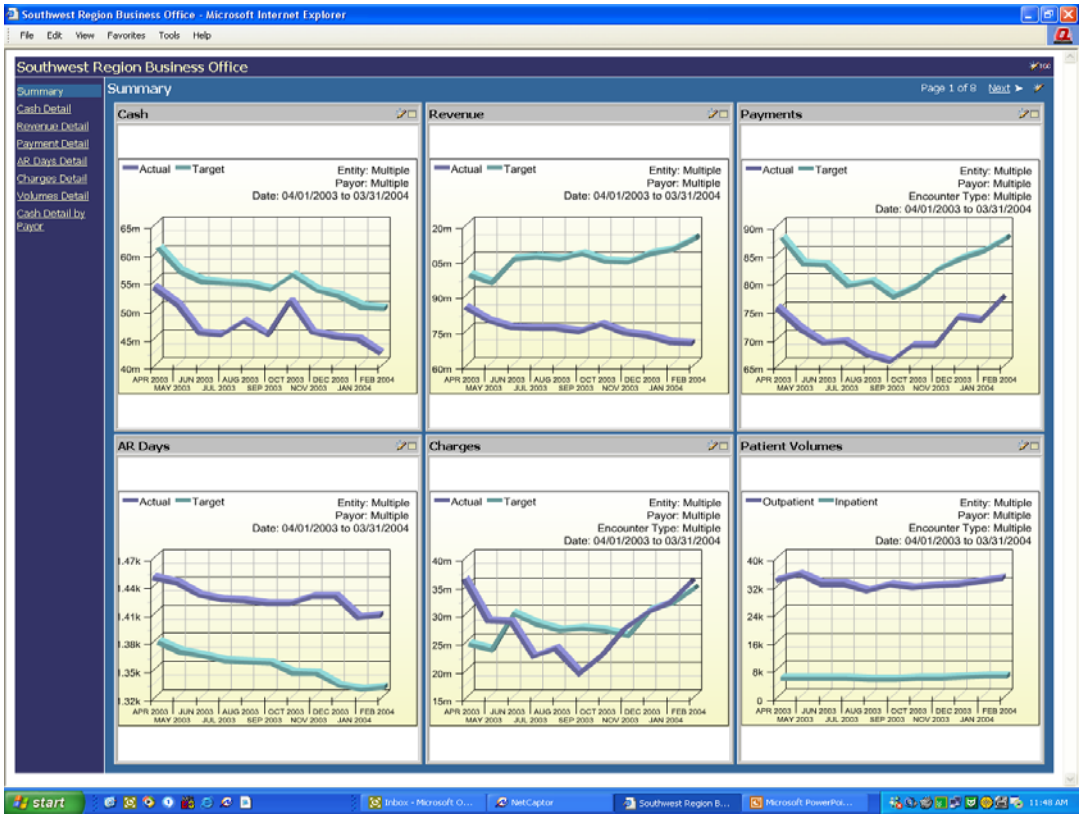
Key Indicators Executive Dashboard – Sample View (1)



KI is designed to provide key business measures at a summary level in a format that suits the individual user. The views are provided in a variety of easy-to-access formats, both graphical and tabular. The information can come from different and unique sources across the enterprise. The KI dashboard can be easily configured for each user's specific view or a general user group default view.

Our flexible design allows a key business measure to be updated on a daily, weekly, monthly, quarterly or yearly basis specific to your organization. KI supports an unlimited number of different client defined business measures that can be tracked and monitored. Each user has the ability to select the subset of indicators that they deem most relevant, and save them as their default view.

Key Indicators Executive Dashboard – Sample View (2)



The ability to display and compare business measures without regard for their source systems is a primary advantage of Key Indicators.

Standard features include:

- Unlimited number of client defined business measures.
- Dashboard views can be customized by users and for user groups.
- Multiple graph types.
- Flexible drill down capability.
- Define both Targets and Thresholds.
- Data sources from the entire Client enterprise.
- Integrate source systems to KI database via automated data loading or through form based entry screen.
- Role based security by user, by indicators and by indicator dimensions.
- Briefing book organizational structure.
- Administration & configuration is designed for ease of maintenance

Section III. Cost Proposal

The following pages outline our detailed cost proposal for Alameda Hospital.

A. Pricing Assumptions

1. **Pricing quoted is valid until October 18, 2008.**
2. The following facilities have been included in this proposal:
   - Alameda Hospital – Alameda, CA
3. Application License Fee that enables Alameda Hospital access one or more components of the Alliance Decision Support suite. The License Fee is based upon the annual operating expenses of Alameda Hospital, estimated to be $50.7 million. The License Fee provides for licensing of the Alliance components listed on the respective pricing tables.
4. Third Party products are incorporated into our software and require a minimum number of Named User licenses.
5. MedAssets staff will serve in a project management advisory role guiding Alameda Hospital through the implementation process. Detailed deliverables for the implementation and technical installation are available upon request and will be included in the contract.
6. Interfaces do not require licensing, as MedAssets is reliant on the source system vendor and Alameda Hospital for supplying extract files in the preferred formats. Our Alliance Data Loader is included.
7. Training is provided through attendance at MedAssets' University training courses. These courses are conducted either in El Segundo, CA or Nashville, TN. Selected components of MedAssets' training are web based. The certifications included in this proposal are:

University Certifications	Number of Certifications
Cost Development	2
Contract Development	2
Report Authoring	2
Budget Development (Models and Solves)	2
Alliance Administrator	2
Alliance Data Load and Reconciliation	2

8. Maintenance Fees for the application and third party products are included. These fees provide for telephone support from our central support team in El Segundo, CA and for ongoing enhancement and revision to the software. These fees are subject to an annual increase.

B. Alliance Decision Support Pricing

The following pricing is based upon a 60-month agreement.

ONE TIME COSTS	ASP
License Fees: Alliance Decision Support ▪ Cost Accounting ▪ Contract Management ▪ Clinical Analytics ▪ Budgeting ▪ Key Indicators Dashboard Integrated Third Party Software	Included in ASP Monthly Fee
Training for two people	Included in ASP Monthly Fee
Technical Installation	Included in ASP Monthly Fee
Implementation Services (21) (2)	Included in ASP Monthly Fee
TOTAL ONE TIME COSTS	**$ 0**
RECURRING COSTS	
ASP Monthly Fee (3) ▪ **$ 5,015** / month (includes cost for one additional person for training at Avega's University)	$60,180
Application and Third Party Maintenance Fees(4)	Included in ASP Monthly Fee
TOTAL YEAR 1 COST	**$60,180**
TOTAL ESTIMATED YEAR 2 COST	**$53,739**

(1) *Implementation Services fees are based upon our current understanding of client needs and are subject to change pending a Needs Assessment exercise.*

(2) *Does not include Out of Pocket expenses. Pricing is fixed fee for the scope outlined.*

(3) *ASP Services are described in **Appendix A**. ASP fees are based upon our current understanding of current and planned licensing, number of users, and patient data levels. In the event the number of patient encounters increases beyond the planned amount for growth, the monthly ASP fees shall be subject to increase to satisfy any additional disk space requirements.*

(4) *Maintenance Fees are subject to annual increases in subsequent years of the agreement.*

Appendix A. MedAssets Decision Support ASP Solution

What are the benefits of an ASP solution?

Under an ASP arrangement, MedAssets will be responsible for purchasing, configuring and operating the hardware for our Alliance application. The application is housed at MedAssets' data center while your end-users connect via a high-speed Internet based Virtual Private Network (VPN).

The result? Your staff is able to focus more time on mission critical tasks such as loading data, performing cost and contract updates, developing your budget, and generating and distributing reports. The remote location of the hardware in MedAssets' data center is virtually transparent to your end-users. With ASP, you can experience:

- Reduced Up-Front Investment - No up-front capital expenditure and low cost operating expense, we offer our ASP clients high value and high performance for a good price. ASP fees are spread over a period of 3 to 5 years. ASP arrangements allow MedAssets to spread software and technology investment over a large client base, allowing for economies of scale for MedAssets and reduced fees for our clients. MedAssets does this by managing cost and availability aggressively using virtualization technologies from both IBM and VMware.
- Minimized IS Department Resource Requirements - Guaranteed "up-time." Your IS staff is able to focus on 24X7 mission critical systems.
- MedAssets manages all aspects of your server hardware in our data center, ensuring you stay current on the latest hardware/software platforms.
- MedAssets performs system and application upgrades, backups and restores, as well as all administrative Oracle database tasks.
- Reductions in recruiting, retaining, and retraining IS personnel needed to perform support and maintenance functions.
- Shorter implementation cycles compared to typical Turn-Key rollout of new technology.
- To system users, the ASP solution will be seamless – it will look and feel like the system hardware is operating next door.
- Outsourcing Services - MedAssets' decades of expertise in the decision support market means that you can also rely upon us to handle on-going maintenance of your data loading, cost calculations, contract model calculations, and other analytical tasks; all at a fraction of the cost of hiring an analyst.

What hardware and technology do we need to run an ASP?

MedAssets purchases the hardware for you, configures and installs the application on the server, and maintains the hardware for the life of the arrangement. Your users connect via a high-speed Internet based Virtual Private Network (VPN). The setup is relatively easy and our technical service consultants can get you up and running in minimal time. Most ASP clients are able to utilize existing PCs, and require only Windows XP and Internet Explorer 6 installed on the client. Our next release will also support Windows Vista and Internet Explorer 7, in addition to XP and IE6.

How long does implementation take?

You can be up and running in as little as three months! MedAssets' baseline decision support implementation services include project planning and management, and preliminary data loading and reconciliation.

How soon can I expect to experience ROI?

Clients using MedAssets decision support experience payback within 3-4 years through a traditional Turn-Key system purchase – and in even less time under an ASP arrangement!

What does ASP support encompass?

MedAssets' client support and infrastructure teams develop and nurture a great professional working relationship with our ASP clients through personal contact. For reliability and dependability, multiple levels of hardware redundancy have been engineered into the data center we currently operate in El Segundo, California providing our clients with their data and functionality needs. Mission-critical business applications and information is regularly backed up and stored off-site by a provider of these services. This provider hosts the applications and information on secure enterprise class hardware.

What is MedAssets' redundancy plan?

We have fully redundant servers in the event of a hardware failure, connected to the ASP Storage Area Network (ASP) using IBM DS4000 arrays. At the storage level we have disk redundancy via our RAID 1 configuration in the ASP SAN that precludes the loss of data by a failure in an individual disk. We also have multiple servers supporting the ASP, as such a complete server failure results in our switching the storage LUNs to an alternate server, and restoring complete functionality on this different server while the primary is unavailable. The ASP hosting facility has two connections to the Internet: a 6 Mbps ATM circuit as our primary, and a 1.544 Mbps T1 as our backup. Additionally we have redundant VPN concentrators configured to automatically make use of the multiple connections.

What is MedAssets' backup and recovery plan?

We perform nightly backups of all ASP customers. We perform hot backups of our Oracle systems, which leaves the system fully available to our customers, 24x7. All data is backed up via our enterprise tape-backup solution, and copies of media are stored off-site at a secured location.

What is MedAssets' disaster recovery plan?

In the event of a complete site failure, the off-site tape media will be used to restore the customer data to our datacenter in Cape Girardeau, MO. The customer downtime would be a maximum of one week.

What are the connection requirements?

We require an Internet connection for the site-to-site VPN connection established between the customer site and the MedAssets ASP. The bandwidth requirements are minimal, as we make extensive use of terminal server technology to minimize the traffic passing across the VPN connection to our client. With our implementation only screen updates are passed rather than the full data stream, dramatically reducing the Internet connectivity requirement.

We've found that the typical use pattern by our customers consumes approximately 100Kbps worth of bandwidth. There are exceptions to this for the uploading of load files, or downloading of extracted reports, but these generally occur once a month, and can be deprioritized at the network level if there is network congestion.

Additional Information about the MedAssets ASP Hosting Center?

Our Service Level standard for our ASP customers is 98% unplanned availability. By this measure, every outage we take for maintenance or fault resolution, counts against the availability metrics. We do

not have standard maintenance windows where the users are forced to be out of the system that do not impact our availability numbers.

We maintain our hosting facility on a secured floor of a building that has a 24x7 security detail. Additionally, the datacenter is internally restricted to employees directly supporting the facility.

We have provisioned extensive internal data security controls. Every customer has a dedicated VLAN for their access servers separated by a firewall from other customers, and every database runs separately and is also protected by a firewall to ensure no customer has any access to another customer's data.

The ASP data network is restricted from access by the rest of MedAssets, with the exception of the Support organization directly responsible for resolving customer issues. Every internal account request is individually tracked for access; as such access to the customer data is restricted to Service and Client Support personnel directly working on the individual customer's implementation and problem resolutions.

Additionally, as a result of our hosting multiple customers in our facility, we have made many system optimizations that many of our clients choose not to do for financial or support reasons that produce dramatically increased performance in our application. Given the relative complexity and cost of providing this solution in-house, the ASP offers optimal performance for the Alliance application suite, while eliminating the requirements to maintain skill sets for Oracle administration and optimization in house.

- Identify a system that will require minimal implementation effort due to limited internal staff and that will be easy to use and maintain by primary users of the system.

We identified four (4) systems that we felt could potentially meet the outlined objectives which included:

- MedAssets - Avega - Alliance Decision Support
- Organizational Intelligence
- Medi-Solve
- IPeople

Each of the above listed vendors was invited to demonstrate their respective systems to the Chief Financial Officer, the Director of Budget and the Director of Information Technology. After these evaluations, this team unanimously felt that only one system could fully meet all of the objectives that had been identified. See Exhibit A for a summary of results of these initial demonstrations. This vendor was then invited back to the Hospital to demonstrate their product to a larger group that included the Chief Executive Officer, Associate Administrator, Director of Revenue Cycle, Director of Nursing, Director of Physician Relations, Director of Quality / Case Management, Accounting Manager, and on of the Hospital the Systems Analysts. As a result of that demonstration the entire management team believes that this system would fully meet the stated objectives.

Selected System – MedAssets - Avega – Alliance Decision Support

The Alliance Decision Support System was the only system that met all of our stated objectives through a fully integrated product line that is designed to accelerate decision-making enterprise-wide by integrating clinical, financial and operational information into a common data set for accuracy and ease of use across the organization. This information is intuitively displayed through a newly designed intelligent dashboard with multiple interactive panels to help executive and department level users relate financial outcomes to clinical and operational decisions for business process improvement, margin enhancement and enterprise-wide accountability.

The applications within the Alliance Decision Support System include:

- **Cost Accounting**, a straightforward interface to guide you through the process of developing cost standards, calculating case costs and allocating overhead. This application includes micro costing, open charge codes, RVU, and markup options.
- **Clinical Analytics**, an expansive tool for evaluating product lines, physician treatment protocols and quality of care related data.
- **Contract Management**, a comprehensive tool supports all aspects of the contract process including contract planning, negotiation, expected payment calculations, contract compliance and monitoring.
- **Budgeting**, a paperless process with workflow management tools, allows the organization to streamline the set-up of multiple forecast and spread methods, deploy the budget to multiple end-users and monitor the completion of the budget.

- **Department Performance Reporting**, a dashboard reporting tool provides performance, volume, revenue, expense, and staffing graphs and reports that inform and help drive performance improvement.
- **Key Indicators**, a management dashboard application that provides executives and management decision makers with timely access to organization defined business intelligence, which can help identify emerging trends, measure progress in reaching stated business objectives, and reinforce what is important to the success of the organization.
- **myAlliance®**, a centrally maintained and secure information management and report distribution tool allows reports and information from systems outside of Alliance to be integrated on the desktop of the organizations management team.

Included as Exhibit B is the original proposal that was prepared by MedAssets on August 18, 2008, this proposal provides additional information about MedAssets (Section I), additional detailed information about each of the various applications (Section II) and information about the MedAssets Decision Support ASP Solution (Appendix A). The only significant change to this document which has been a result of continued negotiations with MedAssets is a change to the Alliance Decision Support Pricing (Section III). We have attached Exhibit B to summarize the current pricing options that have been updated as of November 6, 2008.

Recommendation:

Management recommends, subject to management's satisfactory completion of a site visit to the Community Hospital of the Monterey Peninsula (CHOMP) and phone interviews of Huntington Memorial Hospital (Pasadena, CA) and John C. Lincoln Hospital (Phoenix, AZ), that the Board of Directors authorize the execution of the agreement with MedAssets for the implementation of the Avega - Alliance Decision Support System based upon Option 1 as outlined in Exhibit C. We believe that this option provides the most cost effective approach to implementing a fully integrated decision support system to the hospital that will accelerate organization-wide decision making by integrating clinical, financial and operational information.

Exhibit C

Alameda Hospital
Comparison of Pricing for MedAssets - Avega - myAlliance System

	Option 1	Option 2	Option 3
Acquisition Approach	Application Service Provider (ASP)		Turn-Key
Term	60 Months	36 Months	
ONE TIME COSTS			
Hardware Costs	Included in ASP Monthly Fee		TBD
License Fees:	Included in ASP Monthly Fee		$ 105,000
Alliance Decision Support			
Cost Accounting	Included in ASP Monthly Fee		
Contract Management	Included in ASP Monthly Fee		
Clinical Analytics	Included in ASP Monthly Fee		
Budgeting	Included in ASP Monthly Fee		
Key Indicators Dashboard	Included in ASP Monthly Fee		
Integrated Third Party Software	Included in ASP Monthly Fee		39,450
Training for two (2) individuals each module	Included in ASP Monthly Fee		18,000
Technical Installation[7]	Included in ASP Monthly Fee		5,600
Implementation Services[1][2]	Included in ASP Monthly Fee		153,300
TOTAL ONE TIME COSTS	$ -	$ -	$ 321,350
RECURRING COSTS			
ASP Monthly Fee	$ 4,265	$ 8,689	N/A
ASP Annual Fee	$ 51,180	$ 104,268	N/A
Application and Third Party Maintenance Fees	Included in ASP Monthly Fee		35,879
TOTAL RECURRING COSTS	$ 51,180	$ 104,268	$ 35,879
TOTAL COST - YEAR 1	$ 51,180	$ 104,268	$ 357,229
TOTAL ESTIMATED COST - YEAR 2[5]	52,971	107,917	37,135
TOTAL ESTIMATED COST - YEAR 3	54,825	111,694	38,435
TOTAL ESTIMATED COST - YEAR 4	56,744	115,603	39,780
TOTAL ESTIMATED COST - YEAR 5	58,730	119,649	41,172
TOTAL PROJECT COST	$ 274,450	$ 559,131 [6]	$ 513,751

(1) Implementation Service fees are based upon current understanding of client needs and are subject to change pending a Needs Assessment analysis.

(2) Does not include out of pocket expenses. Pricing is fixed fee for the scope outlined.

(3) ASP fees are based upon current understanding of current and planned licensing, number of users, and patient data levels. In the event the number of patient encounters increases beyond the planned amount for growth, the monthly ASP fees shall be subject to increase to satisfy any additional disk space requirements.

(4) Maintenance fees are subject to annual increases in subsequent years of the agreement.

(5) Estimated cost in years 2 -5 based upon an annual CPI Increase of an estimated rate of 3.5%

(6) Assumes continued use of application for additional two years.

(7) Technical installation services for turn-key environment is based upon a standard hardware configuration pending a formal needs assessment. Changes to the configuration (addition of test or failover environments, for example) may result in additional fees.

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED

FINANCIAL STATEMENTS

FOR THE

PERIOD ENDING

09/30/08

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

ALAMEDA HOSPITAL
City of Alameda Health Care District
September 30, 2008

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ALAMEDA HOSPITAL

September 30, 2008

The management of the Alameda Hospital (the Hospital) has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending September 30, 2008 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of September 30, 2008

- Total assets on the balance sheet increased by $34,290 from the prior month as a result of an increase of $657,615 of cash and cash equivalents, the net fixed assets increased by $81,983 and $125,792 of other assets offset by a decrease of $855,002 in net patient accounts receivable.

- Total cash and cash equivalents for September increased by $657,615 and reflect 14.8 days of cash on hand compared to 10.0 in the prior month. The increase in cash and cash equivalents was primarily the result of the receipt of payment from the State of California on September 29th for outstanding claims that had been held pending resolution of the budget.

- Net patient accounts receivable decreased in September by $855,002 compared to an increase of $1,695,765 in August. Accounts receivable days were 58 compared to 61 in the prior month primarily as a result of the payment of just over $1 million from Medi-Cal for claims that had not been processed for payment pending approval of the State's 2008/2009 operating budget. An additional $588K was received during the first week of October Medi-Cal which will decrease the outstanding accounts receivable balance further.

- Total net fixed assets increased by $81,983 as a result of the purchase of major movable equipment totaling $150,429, the increase in construction in progress (CIP) projects totaling $55,041 offset by the current month's depreciation expense of $124,590. The most significant purchase in the major movable equipment area was the purchase of a Johnson and Johnson Sterilization System in surgery that made up $127,000 of this category. In the CIP category the majority of the purchases related to the time and attendance software project ($28,102) and the pharmacy project ($26,138).

- Other current assets increased by $125,792 primarily as a result of increased amounts due from Kaiser for greater operating room utilization ($85,476) during the month of September and net increases in prepaid expenses of $32,706. This increase was primarily the result of the payment of the facilities annual license fee to the Department of Public Health.

- Total liabilities increased by $6,965 compared to a decrease of $563,305 in the prior month. This slight increase was the result several factors that included increases of $310,519 in accounts payable and accrued expenses and $246,157 in payroll and benefit related accruals offset by decreases of $477,000 in other liabilities and $86,523 in loan and capitalized lease obligation payments.

- Accounts payable at September 30th was $5,219,780, which represents an increase of $310,519 from the prior month. As a result, days in accounts payable increased to 85 compared to prior month which was at 79. This increase was necessitated by the delays in the receipt of payment from the State of California for services provided to Medi-Cal beneficiaries.

- Combined gross revenue was greater than budget by $80,799 or 0.4%. Net patient revenue was better than budgeted by $152,744 or 3.1%. The total patient days were 2,469 and included 620 patient days from the South Shore facility as compared to the prior month's total patient days of 2,234 (315 South Shore days included) and the prior year's 1,972 total patient days. Inpatient revenue, excluding South Shore, was only slightly greater than budgeted by 0.6% while outpatient revenue, excluding South Shore, was also only slightly greater than budgeted by 0.1%. The combined average revenue per adjusted patient day, excluding South Shore, was $6,345 compared to a budgeted amount of $6,389. The average daily acute care census was 28.8 compared to a budget of 27.9 and

29.3 in the prior month; the average daily Sub-Acute census was 32.8 versus a budget of 33.2 and 32.6 in the prior month and the newly added South Shore unit had an average daily census of 20.7 versus a budget and prior month census of 21.0, respectively.

- ER visits were 1,360 or 6.6% less than the budgeted 1,456 visits. ER visits were also lower than the prior year's September visits of 1,430 or 4.9%.

- Total surgery cases were 16.2% greater than budget, with Kaiser surgical cases making up 324 or 71.5% of the total cases. The mix of Kaiser eye cases continues to account for 49% of the Kaiser volume.

- Combined excess revenue over expense (profit) for September was $12,427 versus a combined budgeted excess of expenses over revenue (loss) of $94,978. This brings the year-to-date excess of revenues over expenses (profit) to $91,388 or 144.6% better than budget. In looking at the Hospital only performance, excess revenue over expense (profit) is $ 5,923 and $106,045 or 105.8% and 154.6% favorable to the operating budget for the month and first quarter ending September 30, 2008, respectively.

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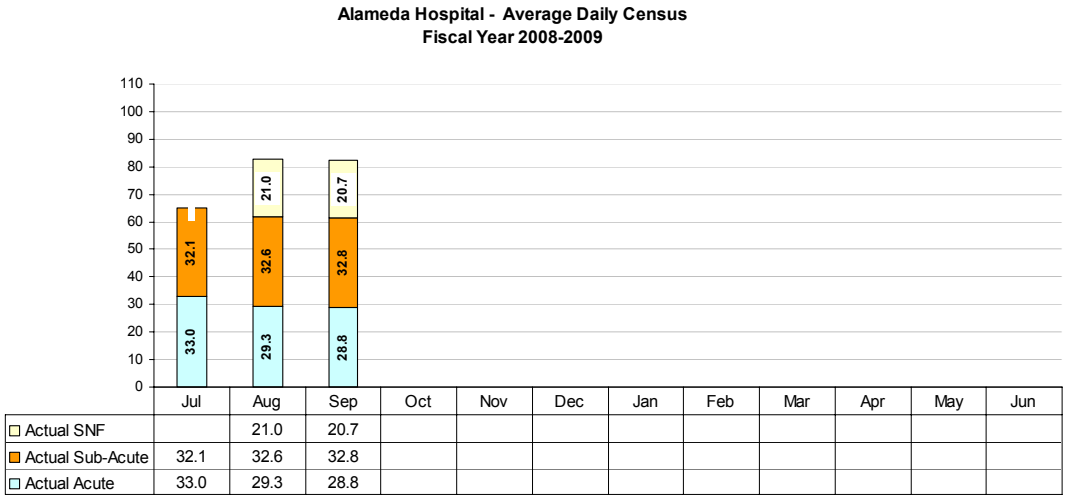
Volumes

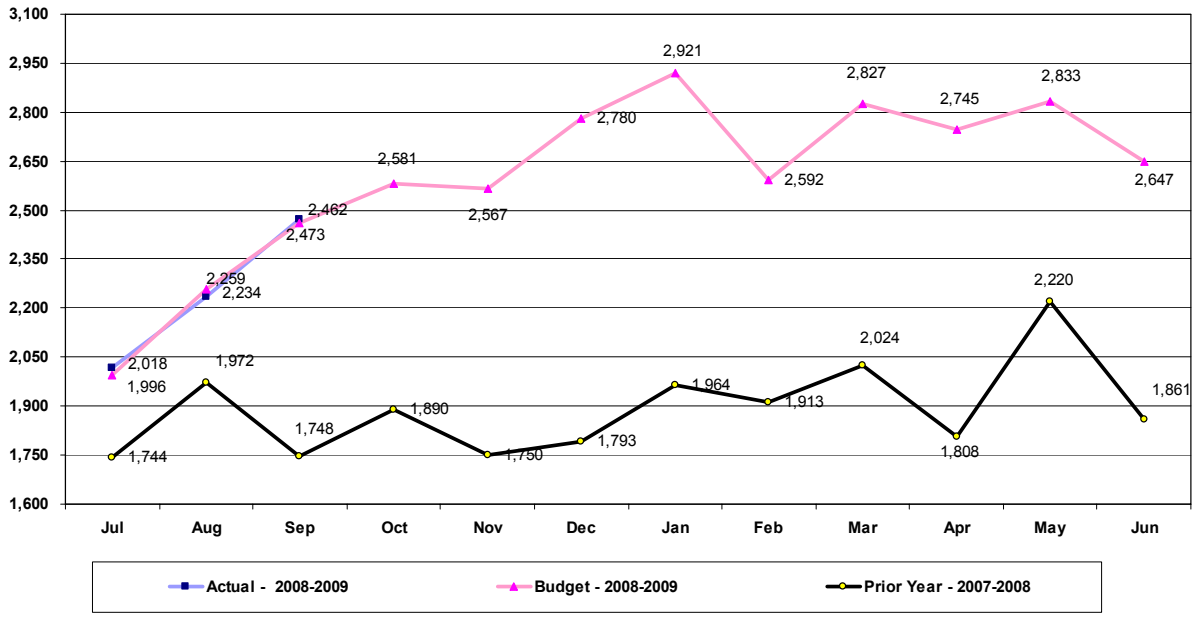
Overall actual daily census was 82.3 versus a budget of 82.1. Acute average daily census was 28.8 versus a budget of 27.9, Sub-Acute average daily census was 32.8 versus a budget of 33.2 and the South Shore unit had an average daily census of 20.7 versus a budget of 21.0.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Actual SNF		21.0	20.7									
Actual Sub-Acute	32.1	32.6	32.8									
Actual Acute	33.0	29.3	28.8									

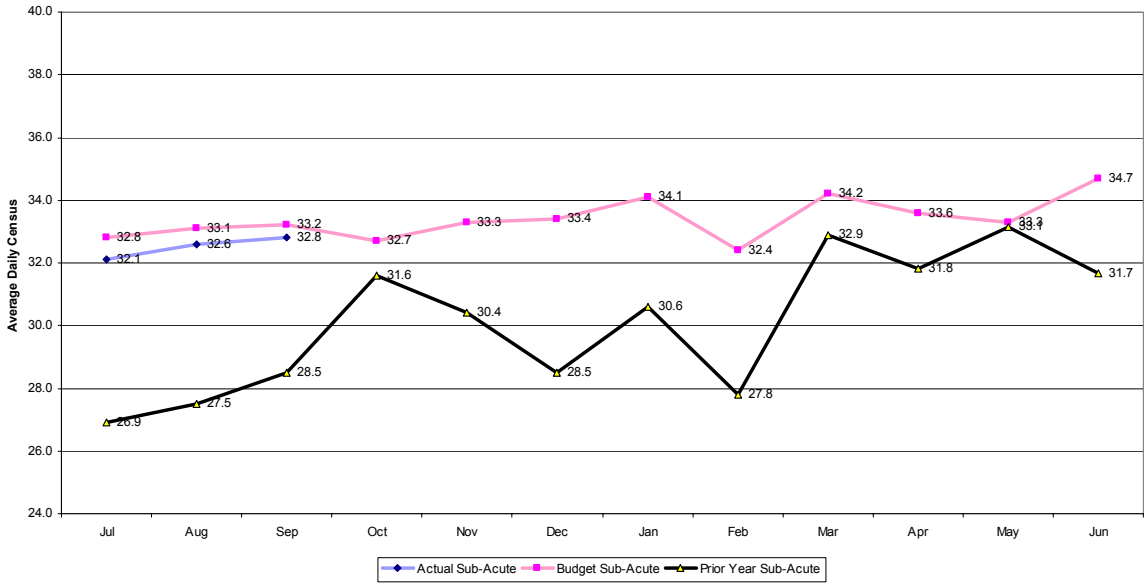
Actual	65.1	82.9	82.3									
Budget	64.4	83.2	82.1									

Total patient days in September were 0.3% greater than budget and 5.8% better than the prior year after removing the South Shore patient days from the current year total patient day count. The following graph shows the total patient days for the month of September including South Shore.

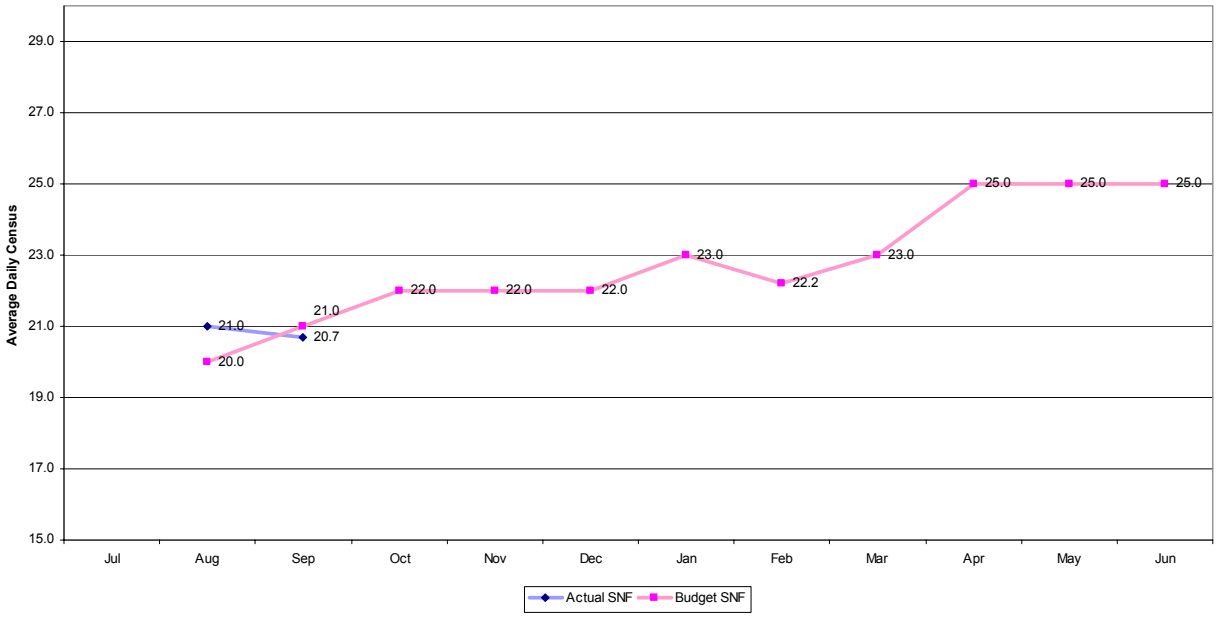


Acute care patient days were 3.2% (27 days) greater than budgeted and 2.9% (24 days) greater than the prior year. The acute average length of stay in September returned to the budgeted and prior year norm of 4.00.

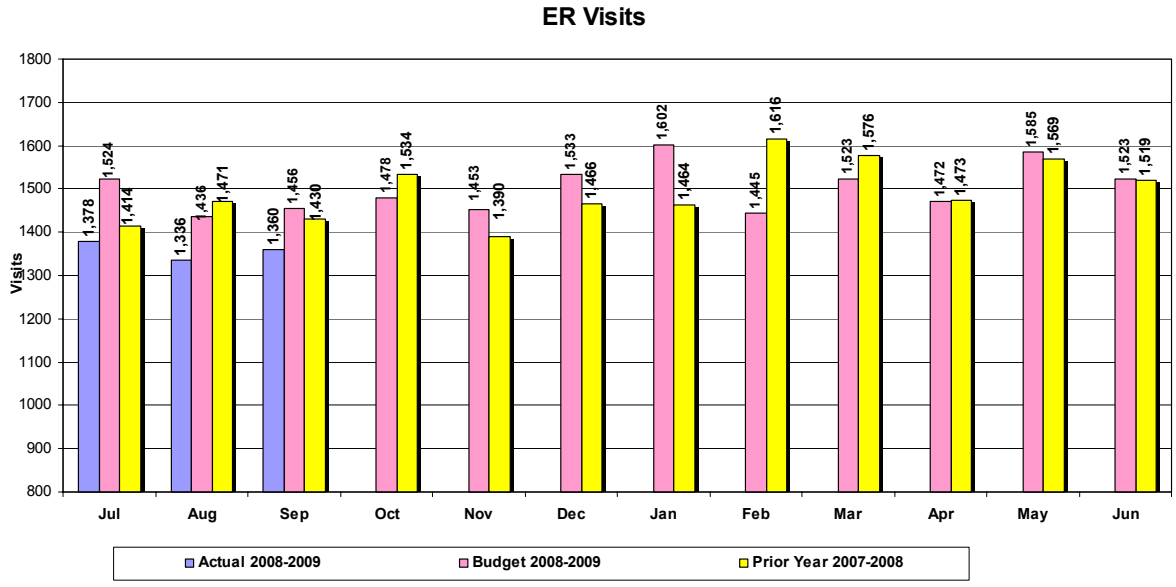
Sub-Acute patient days were 1.0% less than budget and 15.1% greater than the prior year. The following graph shows the Sub-Acute programs average daily census.



Skilled Nursing Unit (South Shore) patient days were 1.6% less than budgeted for the month of September and are 0.5% greater than budget for the first two months of operations. The following graph shows the Skilled Nursing Unit average daily census as compared to budget by month.

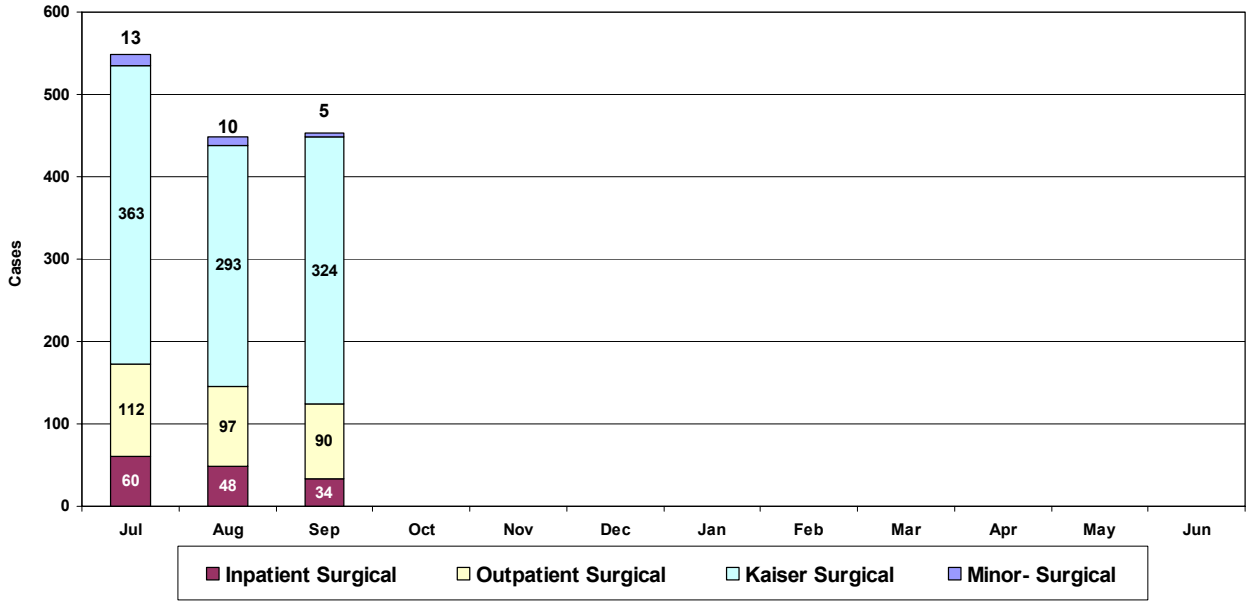


September ER visits were 6.6% less than budgeted and 4.9% less than the prior year.



Surgery cases were 453 versus the 390 budgeted and 407 in the prior year. However, out of the total surgical cases in September, Kaiser again dominates the payor mix with 324 or 71.5% of the total surgical cases. As a result of this increase in volume, our reimbursement for Kaiser Outpatient cases in September decreased to 18.8% as compared to 21.6% of gross charges in August. Kaiser continues to state that they remain committed to a review, in the near future, of a possible adjustment to the terms of our contract in order to compensate the hospital for their consistently higher than projected volumes.

Surgical Cases

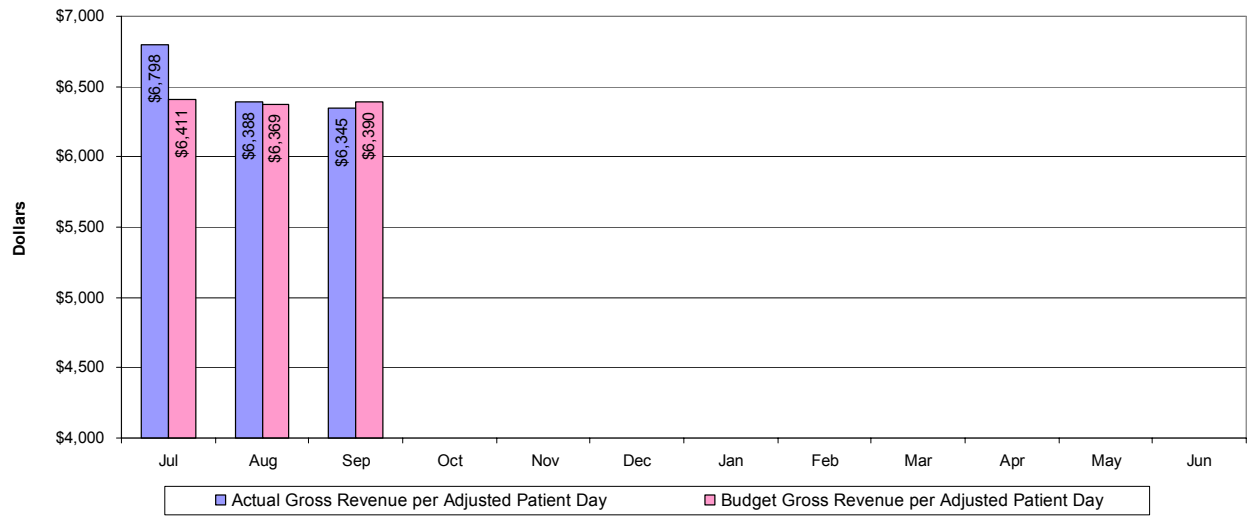


Income Statement – Hospital Only

Gross Patient Charges

Gross charges in September were slightly greater than budget by $38,573, and was comprised of favorable variances in both inpatient and outpatient gross revenues of $26,205 and $12,368, respectively. On an adjusted patient day basis total patient revenue was $6,345 versus the budgeted $6,389 or a 0.7% unfavorable variance from budget.

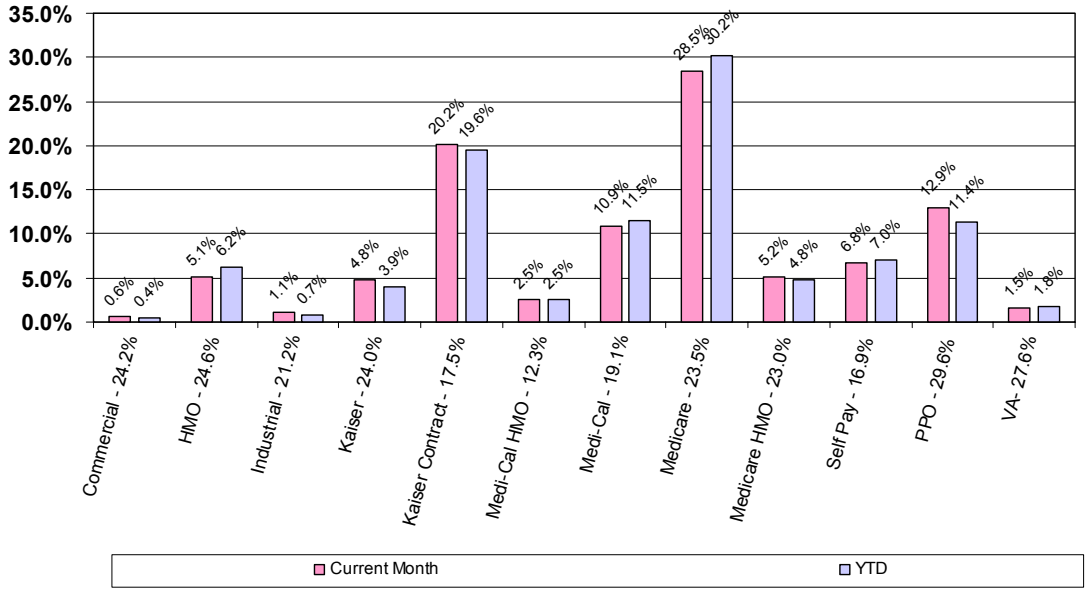
Alameda Hospital
Gross Revenue per Adjusted Patient Day
Fiscal Year 2008-2009



Payor Mix

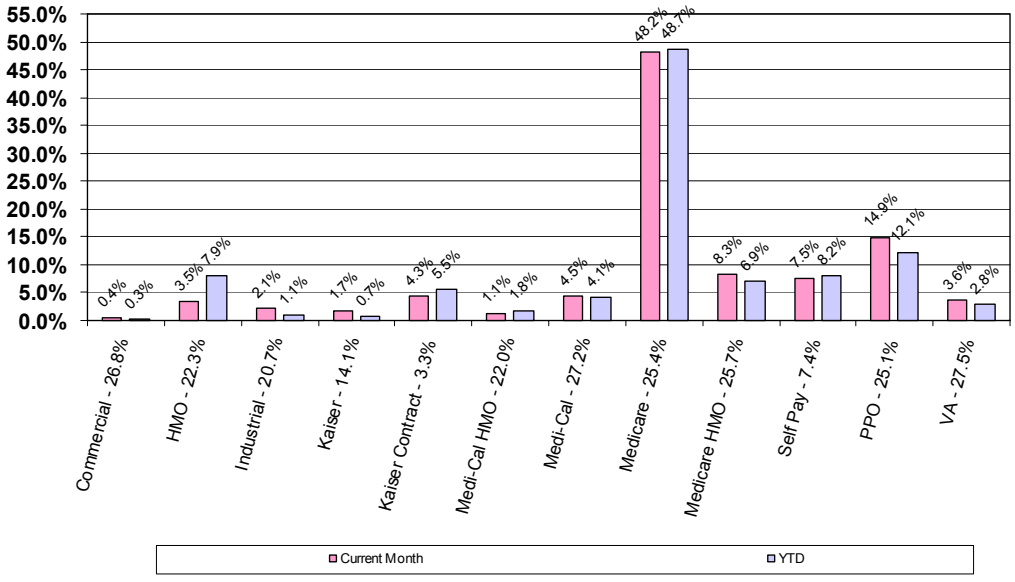
Medicare continues to hold the top payor position with total gross revenue representing 28.5% and 30.2% for the current month and year to date, respectively of our total gross patient charges with Kaiser as the second largest source of gross patient revenues at 25.0% and 23.5% for the current month and year to date, respectively. The graph below shows the percentage of revenues generated by each of the major payors as well as the current months expected reimbursement for each.

Combined Payor Mix



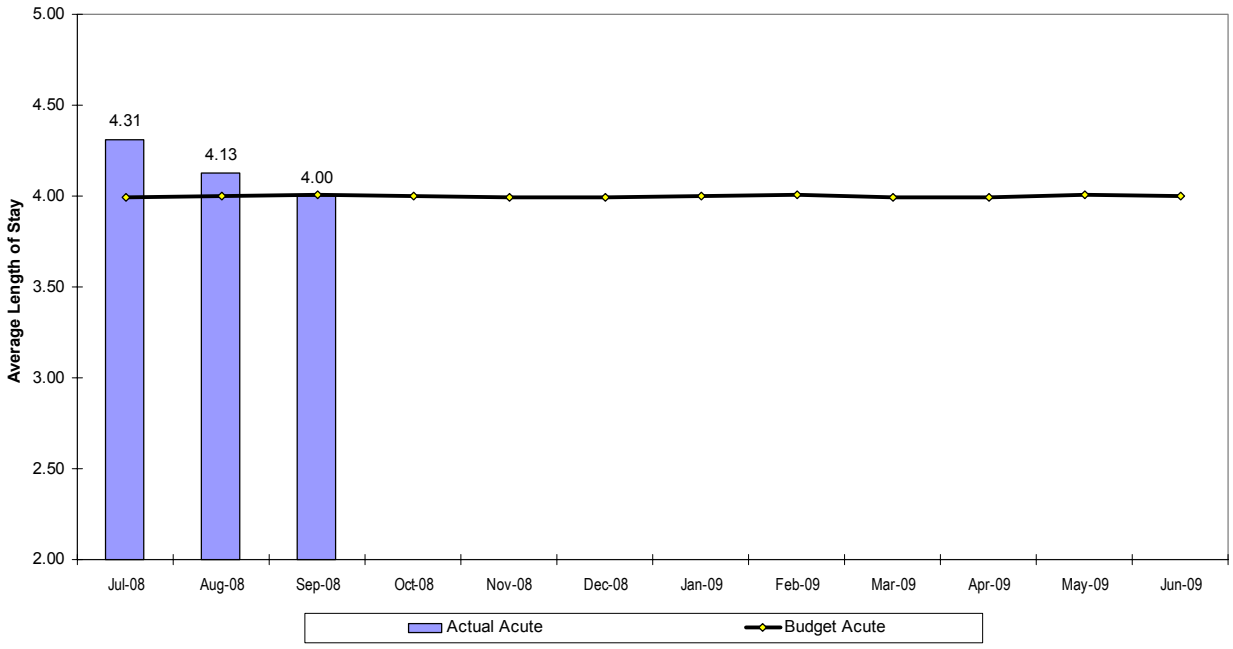
On the Hospital's inpatient acute side, 48.2% and 48.7% for the current month and year to date, respectively of the total gross revenue was generated by Medicare patients. Expected reimbursement for inpatient Medicare cases has been estimated to be 25.4% based upon September, discharges which are slightly lower than the 25.8% reimbursement level experienced in August. In September there was only one case that hit outlier thresholds. The Medicare case mix index for September was 1.3712 versus August's 1.2815.

Inpatient Acute Care Payor Mix



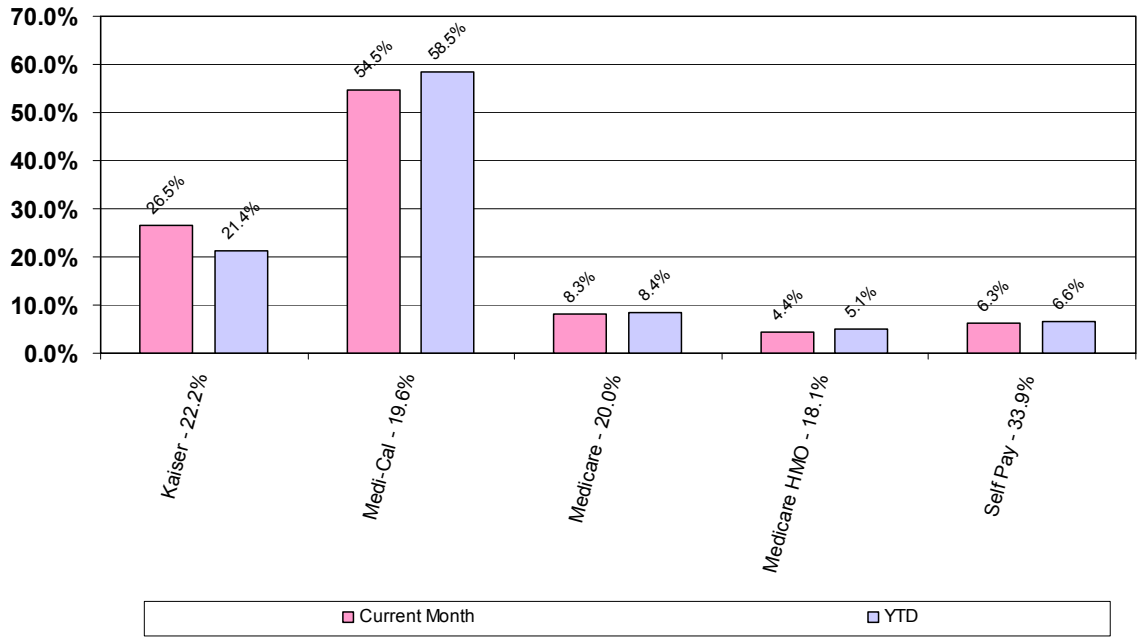
The average length of stay for the inpatient acute care units decreased to the budgeted level of 4.00.

Average Length of Stay



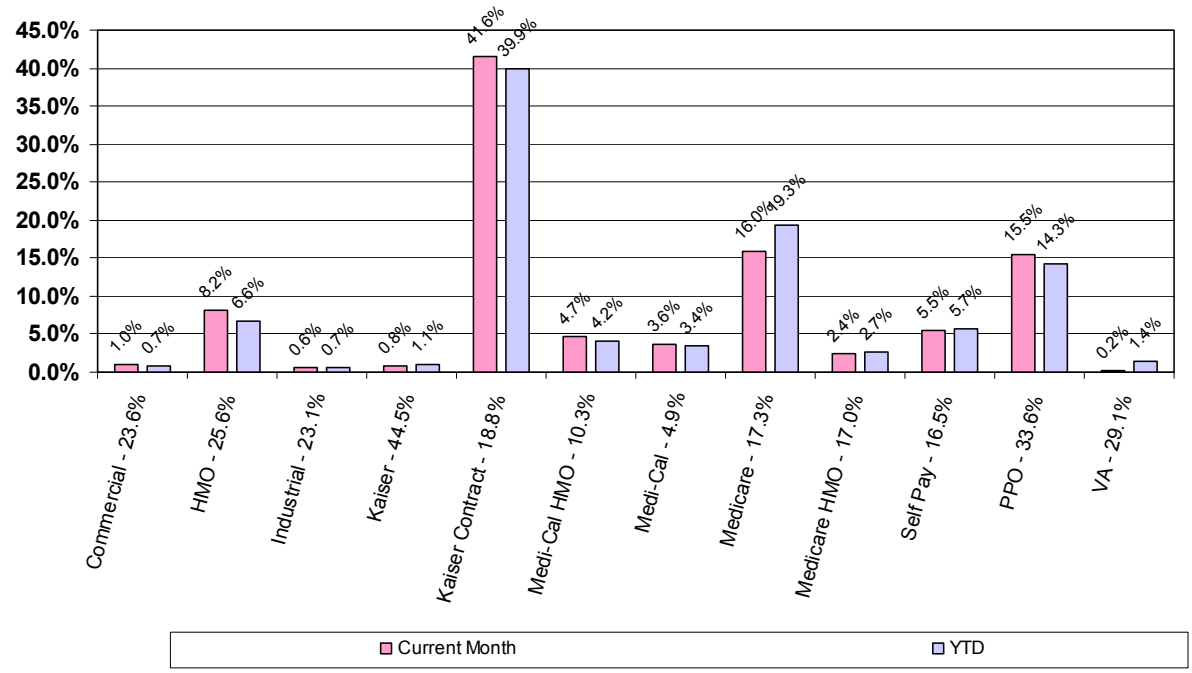
In September, 54.5% of the Sub-Acute programs gross revenue was from Medi-Cal beneficiaries followed by 26.5% from Kaiser and 8.3% from Medicare as is seen in the graph below.

Inpatient Sub-Acute Care Payor Mix



The outpatient gross revenue payor mix for September was comprised of 42.4% Kaiser, 16.0% Medicare, 15.5% PPO and 8.2% HMO and is shown on the following graph.

Outpatient Services Payor Mix



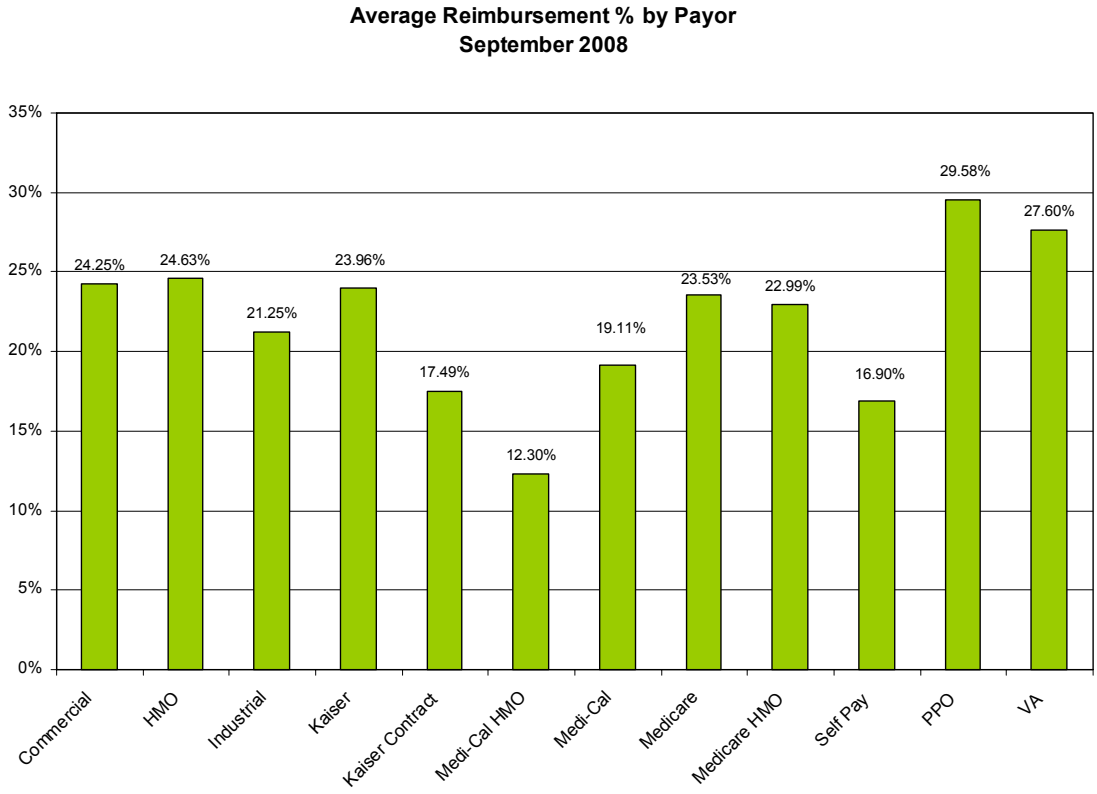
Deductions From Revenue

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

In the month of September contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 76.13% versus the budgeted 76.97%. In September there were again no DRG "take backs" associated with the Recovery Audit Contractor (RAC) project. However, the new National Recovery Audit program is to be phased in state-by-state starting in the fall of 2008. A new RAC contractor has been selected by CMS for California, HealthDataInsights, Inc., with California RAC audits slated to resume in March of 2009.

Net Patient Service Revenue

Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the actual anticipated cash payments the Hospital is to receive for the services provided. The graph on the following page shows the level of estimated reimbursement that the Hospital has experienced during the current month of fiscal year 2009 by major payor category.

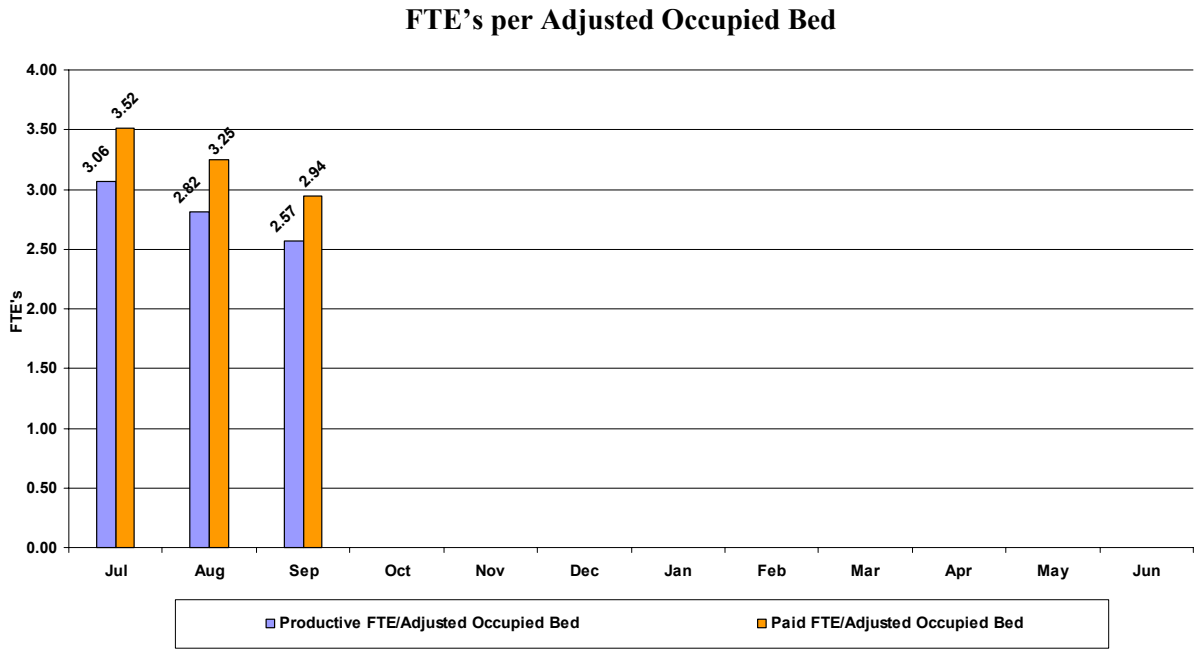


Total Operating Expenses

Total operating expenses were greater than the fixed budget by $68,546 or 1.3%. This unfavorable variance resulted in expenses per adjusted patient day of $1,670 compared to a budget of $1,663 or 0.4% favorable to the volume adjusted budget. The following discusses the significant areas that make up the variance from the fixed operating budget.

Salary and Registry Expenses

Salary and registry costs combined were greater than budgeted by $56,764, with the majority of the unfavorable variance ($110,377) in the registry category while salary costs were favorable to budget by $53,613. The salary and registry costs per adjusted patient day were $899 versus the budgeted $889 resulting in an unfavorable variance of $10 per adjusted patient day for the month. However, on a year-to-date basis the hospital is $40,382 and $20 per adjusted patient day favorable to budget. Combined productive FTE's per adjusted occupied bed was 2.57 in September versus the budgeted 2.94. The graph on the following page shows the combined (Hospital including South Shore) productive and paid FTE's per adjusted occupied bed for FY 2009.



Benefits
For the month of September benefit costs were favorable to budget by $66,331 and was the result of lower than budgeted amounts for vacation accruals, $65,436.

Supplies
Supply costs were $48,108 unfavorable to budget in September. This variance from the fixed operating budget was the result of greater than budgeted costs for surgical supplies of $46,955 and was primarily driven by the increase in surgical volumes that occurred in September that exceeded budgeted volumes by 16.2%.

Rents and Leases
This category was unfavorable to budget by $10,727 primarily as a result of the under accrual in August of the lease costs associated with the Cardinal Pyxis machines ($6,000).

Insurance
Insurance costs continue to be under budget as result of the favorable experience in our professional liability insurance program. We expect that for FY 2009 a savings of approximately 25% will be achieved in professional liability insurance rates over that of the prior year due to improved loss experience. In addition, in October we received our annual dividend credit totaling $45K from Beta's 63% increase in dividend rates which resulted from our improved loss ratio and the length of time that we have been insured by Beta.

Other Operating Expenses
This category exceeded the fixed operating budget by $12,728 in the month of September as a result of the following:

- Three staff members from HR/PR were sent to Boston, MA for training on the Meditech system, cost $3,100.
- Final training and travel expenses related to the Achieve Mentors mentoring program of $6,900 were incurred in September.
- Training for emergency room physicians and other physicians on the use of the portable ultrasound equipment totaling $2,600.

Balance Sheet

Patient Accounts Receivable

Gross patient accounts receivable decreased by $3,654,918 from the prior month and the gross days in receivables decreased to 58 compared to 61 in the prior month. Both decreases are primarily attributable to the resolution of the State's 2008/2009 operating budget at the end of September.

Liabilities

Total Current and Long Term Liabilities at September 30, 2008 were $20,002,742 versus $19,995,777 in the prior month, an increase of $6,965. This slight increase was the result several factors that included increases of $310,519 in accounts payable and accrued expenses and $235,354 in payroll and benefit related accruals offset by decreases of $477,000 in other liabilities and $86,523 in loan ($20,017) and capitalized lease obligation payments ($66,506).

- Increase in accounts payable and accrued expenses primarily resulted from the slow down in payments from the Medi-Cal program that delayed approximately $1.6 million in cash payments until the last days of September and the first week of October.
- Payroll and benefit related accruals increased as a result of additional wage and tax accruals that occurred in September due to the timing of biweekly payrolls which resulted in a net increase of two days payroll that was required to be accrued at September 30, 2008 totaling $160,860. In addition, accruals for registry costs totaling $135,948 were recorded in September. These increases were offset by decreases in required time off accruals of $69,300.
- Other liabilities decreased by $477,000 as a result of the 1/12 amortization of the FY 2009 parcel tax revenues which became earned income in the month of September.

ALAMEDA HOSPITAL
Balance Sheet
September 30, 2008

	September 30, 2008	August 31, 2008	Audited June 30, 2008
Assets			
Current assets:			
Cash and cash equivalents	$ 2,626,970	$ 1,969,355	$ 4,520,157
Net Accounts Receivable	8,654,711	9,509,713	7,944,522
Net Accounts Receivable %	20.33%	20.57%	20.17%
Inventories	1,054,838	1,055,919	1,048,503
Est.Third-party payer settlement receivable	283,250	273,165	245,115
Other assets	6,970,839	6,845,047	7,270,116
Total Current Assets	19,590,608	19,653,199	21,028,413
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate	638,057	623,159	602,817
Total fixed assets, net of accumulated depreciation	7,314,979	7,232,996	7,450,244
Total Assets	$ 27,543,644	$ 27,509,354	$ 29,081,474
Liabilities and Net Assets			
Current Liabilities:			
Accounts payable and accrued expenses	5,219,780	4,909,261	5,423,290
Loans Payable	2,358,135	2,378,152	2,400,000
Payroll and benefit related accruals	5,052,225	4,816,871	4,099,642
Est.Third-party payer settlement payable	1,893,006	1,893,006	1,893,006
Other liabilities	5,160,860	5,637,860	7,351,860
Total Current Liabilities	19,684,006	19,635,150	21,167,798
Long-Term Liabilities:			
Long-term pension liabilities	(33,737)	(58,352)	(65,212)
Long-term IBNR reserves	120,000	120,000	120,000
Capitalized Lease payable	232,473	298,979	425,862
Total Long-Term Liabilities	318,736	360,627	480,650
Total Liabilities	20,002,742	19,995,777	21,648,448
Net Assets			
Unrestricted Funds	6,921,594	6,909,168	6,830,209
Restricted Funds	619,307	604,409	602,817
Net Assets	7,540,902	7,513,577	7,433,026
Total Liabilities and Net Assets	$ 27,543,644	$ 27,509,354	$ 29,081,474

ALAMEDA HOSPITAL - COMBINED
Summary Statement of Revenues, Expenses
For the Three Months Ended September 30, 2008

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	Budget	Variance	Var %	Jul 07	Actual	Budget	Variance	Var %	FY07
Operating revenues:										
IP Revenue	$ 12,155,429	$ 12,086,998	$ 68,431	0.6%	$ 10,827,038	$ 38,352,638	$ 37,530,560	$ 822,078	2.2%	$ 34,118,410
OP Revenue	9,046,908	9,034,540	12,368	0.1%	7,934,857	29,252,468	27,190,257	2,062,211	7.6%	25,508,819
Total revenue	$ 21,202,337	$ 21,121,538	$ 80,799	0.4%	$ 18,761,895	$ 67,605,106	$ 64,720,817	$ 2,884,289	4.5%	$ 59,627,230
Less: Deductions from Revenue	(15,010,243)	(15,189,782)	179,539	1.2%	(14,205,829)	(49,409,667)	(47,249,359)	(2,160,308)	-4.6%	(45,467,966)
Bad Debt	(971,695)	(874,525)	(97,169)	-11.1%	(2,872)	(2,471,041)	(2,223,937)	(247,104)	-11.1%	(559,074)
Charity	(103,943)	(93,548)	(10,394)	-11.1%	(189,214)	(259,797)	(233,818)	(25,980)	-11.1%	(282,291)
Net patient service revenue	$ 5,116,457	$ 4,963,683	$ 152,774	3.1%	$ 4,363,980	$ 15,464,601	$ 15,013,704	$ 450,897	3.0%	$ 13,317,898
	24.13%	23.50%			23.26%	22.87%	23.20%			22.34%
Other revenue	10,419	10,040	379	3.8%	8,322	32,811	30,120	2,691	8.9%	34,808
Total operating revenues	$ 5,126,877	$ 4,973,723	$ 153,154	3.1%	$ 4,372,302	$ 15,497,412	$ 15,043,824	$ 453,588	3.0%	$ 13,352,706
Operating expenses:										
Salaries	$ 2,825,277	$ 2,885,784	$ 60,507	2.1%	$ 2,580,200	$ 8,351,852	$ 8,661,723	$ 309,871	3.6%	$ 8,021,913
Registry	221,759	111,382	(110,377)	-99.1%	106,285	599,651	344,192	(255,459)	-74.2%	397,448
Benefits	774,452	870,561	96,109	11.0%	571,732	2,539,761	2,583,978	44,217	1.7%	1,767,398
Professional Fees	288,447	282,408	(6,039)	-2.1%	306,282	954,744	845,851	(108,893)	-12.9%	964,883
Supplies	754,847	705,732	(49,115)	-7.0%	698,312	2,286,967	2,183,483	(103,484)	-4.7%	2,188,852
Purchase Services	354,775	345,299	(9,476)	-2.7%	307,184	1,036,474	1,033,635	(2,839)	-0.3%	911,897
Rents and Leases	65,672	54,926	(10,746)	-19.6%	44,748	180,662	152,998	(27,664)	-18.1%	144,193
Utilities and Telephone	66,717	73,473	6,756	9.2%	57,998	214,970	220,857	5,887	2.7%	193,026
Insurance	47,267	57,538	10,271	17.9%	59,408	139,953	178,918	38,965	21.8%	178,136
Interest Expense	12,938	12,132	(806)	-6.6%	9,764	39,234	36,395	(2,839)	-7.8%	30,212
Depreciation and amortization	124,590	113,449	(11,141)	-9.8%	166,740	371,374	338,818	(32,556)	-9.6%	500,689
Other Operating Expenses	79,165	66,230	(12,935)	-19.5%	44,882	196,646	198,648	2,002	1.0%	113,134
Total operating expenses	$ 5,615,906	$ 5,578,914	$ (36,992)	-0.7%	$ 4,953,535	$ 16,912,288	$ 16,779,496	$ (132,792)	-0.8%	$ 15,411,782
Operating gain (loss)	$ (489,030)	$ (605,191)	$ 116,161	19.2%	$ (581,233)	$ (1,414,876)	$ (1,735,672)	$ 320,796	18.5%	$ (2,059,076)
Non-operating revenues (expenses):	$ 501,457	$ 510,213	$ (8,756)	-1.7%	$ 513,427	$ 1,506,265	$ 1,530,639	$ (24,374)	-1.6%	$ 1,559,294
Excess of revenues over expenses	12,427	(94,978)	107,405	113.1%	(67,806)	91,388	(205,033)	296,421	144.6%	(499,782)

ALAMEDA HOSPITAL - HOSPITAL ONLY
Summary Statement of Revenues, Expenses
For the Three Months Ended September 30, 2008

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	Budget	Variance	Var %	Jul 07	Actual	Budget	Variance	Var %	FY07
Operating revenues:										
IP Revenue	$ 11,732,814	$ 11,706,609	$ 26,205	0.2%	$ 10,827,038	$ 37,709,232	$ 36,978,525	$ 730,707	2.0%	$ 34,118,410
OP Revenue	9,046,908	9,034,540	12,368	0.1%	7,934,857	29,252,468	27,180,766	2,071,702	7.6%	25,508,819
Total revenue	$ 20,779,722	$ 20,741,149	$ 38,573	0.2%	$ 18,761,895	$ 66,961,700	$ 64,159,291	$ 2,802,409	4.4%	$ 59,627,230
Less: Deductions from Revenue	(14,743,215)	(14,996,902)	253,687	1.7%	(14,205,829)	(48,999,414)	(46,964,632)	(2,034,782)	-4.3%	(45,467,966)
Bad Debt	(971,695)	(874,525)	(97,169)	-11.1%	(2,872)	(2,471,041)	(2,223,937)	(247,104)	-11.1%	(559,074)
Charity	(103,943)	(93,548)	(10,394)	-11.1%	(189,214)	(259,797)	(233,818)	(25,980)	-11.1%	(282,291)
Net patient service revenue	$ 4,960,870	$ 4,776,174	$ 184,696	3.9%	$ 4,363,980	$ 15,231,448	$ 14,736,905	$ 494,543	3.4%	$ 13,317,898
	23.87%	23.03%			23.26%	22.75%	22.97%			22.34%
Other revenue	10,419	10,040	379	3.8%	8,322	32,811	30,120	2,691	8.9%	34,808
Total operating revenues	$ 4,971,289	$ 4,786,214	$ 185,075	3.9%	$ 4,372,302	$ 15,264,260	$ 14,767,025	$ 497,235	3.4%	$ 13,352,706
Operating expenses:										
Salaries	$ 2,722,591	$ 2,776,204	$ 53,613	1.9%	$ 2,580,200	$ 8,202,512	$ 8,498,353	$ 295,841	3.5%	$ 8,021,913
Registry	221,759	111,382	(110,377)	-99.1%	106,285	599,651	344,192	(255,459)	-74.2%	397,448
Benefits	771,310	837,641	66,331	7.9%	571,732	2,531,360	2,535,259	3,899	0.2%	1,767,398
Professional Fees	271,509	269,006	(2,503)	-0.9%	306,282	907,880	807,019	(100,861)	-12.5%	964,883
Supplies	743,845	695,737	(48,108)	-6.9%	698,312	2,269,706	2,168,728	(100,978)	-4.7%	2,188,852
Purchase Services	351,844	343,819	(8,025)	-2.3%	307,184	1,029,737	1,031,450	1,713	0.2%	911,897
Rents and Leases	57,921	47,194	(10,727)	-22.7%	44,748	169,536	141,583	(27,953)	-19.7%	144,193
Utilities and Telephone	65,332	70,927	5,595	7.9%	57,998	212,417	217,099	4,682	2.2%	193,026
Insurance	46,258	56,684	10,426	18.4%	59,408	138,514	177,657	39,143	22.0%	178,136
Interest Expense	12,938	12,132	(806)	-6.6%	9,764	39,234	36,395	(2,839)	-7.8%	30,212
Depreciation and amortization	123,684	112,447	(11,237)	-10.0%	166,740	370,006	337,338	(32,668)	-9.7%	500,689
Other Operating Expenses	77,832	65,104	(12,728)	-19.6%	44,882	193,926	196,985	3,059	1.6%	113,134
Total operating expenses	$ 5,466,823	$ 5,398,277	$ (68,546)	-1.3%	$ 4,953,535	$ 16,664,479	$ 16,492,058	$ (172,421)	-1.0%	$ 15,411,782
Operating gain (loss)	$ (495,534)	$ (612,063)	$ 116,529	19.0%	$ (581,233)	$ (1,400,220)	$ (1,725,033)	$ 324,813	18.8%	$ (2,059,076)
Non-operating revenues (expenses):	$ 501,457	$ 510,213	$ (8,756)	-1.7%	$ 513,427	$ 1,506,265	$ 1,530,639	$ (24,374)	-1.6%	$ 1,559,294
Excess of revenues over expenses	5,923	(101,850)	107,773	105.8%	(67,806)	106,045	(194,394)	300,439	154.6%	(499,782)

ALAMEDA HOSPITAL - SOUTH SHORE ONLY
Summary Statement of Revenues, Expenses
For the Three Months Ended September 30, 2008

	Current Month - Fixed Budget					Year to Date - Fixed Budget				
	Actual	Budget	Variance	Var %	Jul 07	Actual	Budget	Variance	Var %	FY07
Operating revenues:										
IP Revenue	$ 422,616	$ 380,389	$ 42,227	11.1%	$ -	$ 643,406	$ 552,035	$ 91,371	16.6%	$ -
OP Revenue	-	-	-	0.0%	-	-	9,491	(9,491)	-100.0%	-
Total revenue	$ 422,616	$ 380,389	$ 42,227	11.1%	$ -	$ 643,406	$ 561,526	$ 81,880	14.6%	$ -
Less: Deductions from Revenue	(267,028)	(192,880)	(74,148)	-38.4%	-	(410,253)	(284,727)	(125,526)	-44.1%	-
Bad Debt	-	-	-	0.0%	-	-	-	-	0.0%	-
Charity	-	-	-	0.0%	-	-	-	-	0.0%	-
Net patient service revenue	$ 155,588	$ 187,509	$ (31,921)	-17.0%	$ -	$ 233,153	$ 276,799	$ (43,646)	-15.8%	$ -
	36.82%	49.29%			0.00%	36.24%	49.29%			0.00%
Other revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total operating revenues	$ 155,588	$ 187,509	$ (31,921)	-17.0%	$ -	$ 233,153	$ 276,799	$ (43,646)	-15.8%	$ -
Operating expenses:										
Salaries	$ 102,686	$ 109,580	$ 6,894	6.3%	$ -	$ 149,340	$ 163,370	$ 14,030	8.6%	$ -
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	3,142	32,920	29,778	90.5%	-	8,401	48,719	40,318	82.8%	-
Professional Fees	16,938	13,402	(3,536)	-26.4%	-	46,864	38,832	(8,032)	-20.7%	-
Supplies	11,002	9,995	(1,007)	-10.1%	-	17,261	14,755	(2,506)	-17.0%	-
Purchase Services	2,931	1,480	(1,451)	-98.0%	-	6,737	2,185	(4,552)	-208.3%	-
Rents and Leases	7,751	7,732	(19)	-0.2%	-	11,126	11,415	289	2.5%	-
Utilities and Telephone	1,385	2,546	1,161	45.6%	-	2,553	3,758	1,205	32.1%	-
Insurance	1,009	854	(155)	-18.1%	-	1,439	1,261	(178)	-14.1%	-
Interest Expense	-	-	-	0.0%	-	-	-	-	0.0%	-
Depreciation and amortization	906	1,002	96	9.6%	-	1,368	1,480	112	7.6%	-
Other Operating Expenses	1,333	1,126	(207)	-18.4%	-	2,720	1,663	(1,057)	-63.6%	-
Total operating expenses	$ 149,083	$ 180,637	$ 31,554	17.5%	$ -	$ 247,809	$ 287,438	$ 39,629	13.8%	$ -
Operating gain (loss)	$ 6,505	$ 6,872	$ (367)	-5.3%	$ -	$ (14,656)	$ (10,639)	$ (4,017)	-37.8%	$ -
Non-operating revenues (expenses):	$ -	$ -	$ -	0.0%	$ -	$ -	$ -	$ -	0.0%	$ -
Excess of revenues over expenses	6,505	6,872	(367)	-5.3%	-	(14,656)	(10,639)	(4,017)	-37.8%	-

ALAMEDA HOSPITAL - COMBINED
Summary Statement of Revenues, Expenses
For the Three Months Ended September 30, 2008

	Current Month - Per Adjusted Patient Day					Year to Date - Per Adjusted Patient Day				
	Actual	Budget	Variance	Var %	July 07	Actual	Budget	Variance	Var %	FY07
Operating revenues:										
IP Revenue	$ 2,822	$ 2,810	$ 12	0.4%	$ 3,574	$ 3,235	$ 3,240	$ (5)	-0.2%	$ 3,573
OP Revenue	2,101	2,100	1	0.0%	2,620	2,468	2,347	121	5.2%	2,671
Total revenue	$ 4,923	$ 4,910	$ 13	0.3%	$ 6,194	$ 5,703	$ 5,587	$ 116	2.1%	$ 6,244
Less: Deductions from Revenue	(3,485)	(3,531)	46	1.3%	(4,690)	(4,168)	(4,079)	(89)	-2.2%	(4,762)
Bad Debt	(226)	(203)	(23)	-11.3%	(1)	(208)	(192)	(16)	-8.3%	(59)
Charity	(24)	(22)	(2)	-9.1%	(62)	(22)	(20)	(2)	-10.0%	(30)
Net patient service revenue	$ 1,188	$ 1,154	$ 34	2.9%	$ 1,441	$ 1,305	$ 1,296	$ 9	0.7%	$ 1,393
	24.13%	23.50%			23.26%	22.88%	23.20%			22.31%
Other revenue	2	2	-	0.0%	3	3	3	-	0.0%	4
Total operating revenues	$ 1,190	$ 1,156	$ 34	2.9%	$ 1,444	$ 1,308	$ 1,299	$ 9	0.7%	$ 1,397
Operating expenses:										
Salaries	$ 656	$ 671	$ 15	2.2%	$ 852	$ 705	$ 748	$ 43	5.7%	$ 840
Registry	51	26	(25)	-96.2%	35	51	30	(21)	-70.0%	42
Benefits	180	202	22	10.9%	189	214	223	9	4.0%	185
Professional Fees	67	66	(1)	-1.5%	101	81	73	(8)	-11.0%	101
Supplies	175	164	(11)	-6.7%	231	193	189	(4)	-2.1%	229
Purchase Services	82	80	(2)	-2.5%	101	87	89	2	2.2%	95
Rents and Leases	15	13	(2)	-15.4%	15	15	13	(2)	-15.4%	15
Utilities and Telephone	15	17	2	11.8%	19	18	19	1	5.3%	20
Insurance	11	13	2	15.4%	20	12	15	3	20.0%	19
Interest Expense	3	3	-	0.0%	3	3	3	-	0.0%	3
Depreciation and amortization	29	26	(3)	-11.5%	55	31	29	(2)	-6.9%	52
Other Operating Expenses	18	15	(3)	-20.0%	15	17	17	-	0.0%	12
Total operating expenses	$ 1,302	$ 1,296	$ (6)	-0.5%	$ 1,636	$ 1,427	$ 1,448	$ 21	1.5%	$ 1,613
Operating gain (loss)	$ (112)	$ (140)	$ 28	20.0%	$ (192)	$ (119)	$ (149)	$ 30	20.1%	$ (216)
Non-operating revenues (expenses):	$ 116	$ 119	$ (3)	-2.5%	$ 170	$ 127	$ 132	$ (5)	-3.8%	$ 163
Excess of revenues over expenses	4	(21)	25	119.0%	(22)	8	(17)	25	147.1%	(53)

ALAMEDA HOSPITAL - HOSPITAL ONLY
Summary Statement of Revenues, Expenses
For the Three Months Ended September 30, 2008

	Current Month - Per Adjusted Patient Day					Year to Date - Per Adjusted Patient Day				
	Actual	Budget	Variance	Var %	July 07	Actual	Budget	Variance	Var %	FY07
Operating revenues:										
IP Revenue	$ 3,583	$ 3,606	$ (23)	-0.6%	$ 3,574	$ 3,680	$ 3,683	$ (3)	-0.1%	$ 3,573
OP Revenue	2,762	2,783	(21)	-0.8%	2,620	2,855	2,707	148	5.5%	2,671
Total revenue	$ 6,345	$ 6,389	$ (44)	-0.7%	$ 6,194	$ 6,535	$ 6,390	$ 145	2.3%	$ 6,244
Less: Deductions from Revenue	(4,502)	(4,620)	118	2.6%	(4,690)	(4,782)	(4,677)	(105)	-2.2%	(4,762)
Bad Debt	(297)	(269)	(28)	-10.4%	(1)	(241)	(221)	(20)	-9.0%	(59)
Charity	(32)	(29)	(3)	-10.3%	(62)	(25)	(23)	(2)	-8.7%	(30)
Net patient service revenue	$ 1,514	$ 1,471	$ 43	2.9%	$ 1,441	$ 1,487	$ 1,469	$ 18	1.2%	$ 1,393
	23.86%	23.02%			23.26%	22.75%	22.99%			22.31%
Other revenue	3	3	-	0.0%	3	3	3	-	0.0%	4
Total operating revenues	$ 1,517	$ 1,474	$ 43	2.9%	$ 1,444	$ 1,490	$ 1,472	$ 18	1.2%	$ 1,397
Operating expenses:										
Salaries	$ 831	$ 855	$ 24	2.8%	$ 852	$ 801	$ 846	$ 45	5.3%	$ 840
Registry	68	34	(34)	-100.0%	35	59	34	(25)	-73.5%	42
Benefits	236	258	22	8.5%	189	247	252	5	2.0%	185
Professional Fees	83	83	-	0.0%	101	89	80	(9)	-11.3%	101
Supplies	227	214	(13)	-6.1%	231	222	216	(6)	-2.8%	229
Purchase Services	107	106	(1)	-0.9%	101	101	103	2	1.9%	95
Rents and Leases	18	15	(3)	-20.0%	15	17	14	(3)	-21.4%	15
Utilities and Telephone	20	22	2	9.1%	19	21	22	1	4.5%	20
Insurance	14	17	3	17.6%	20	14	18	4	22.2%	19
Interest Expense	4	4	-	0.0%	3	4	4	-	0.0%	3
Depreciation and amortization	38	35	(3)	-8.6%	55	36	34	(2)	-5.9%	52
Other Operating Expenses	24	20	(4)	-20.0%	15	19	20	1	5.0%	12
Total operating expenses	$ 1,670	$ 1,663	$ (7)	-0.4%	$ 1,636	$ 1,630	$ 1,643	$ 13	0.8%	$ 1,613
Operating gain (loss)	$ (153)	$ (189)	$ 36	19.0%	$ (192)	$ (140)	$ (171)	$ 31	18.1%	$ (216)
Non-operating revenues (expenses):	$ 153	$ 157	$ (4)	-2.5%	$ 170	$ 147	$ 152	$ (5)	-3.3%	$ 163
Excess of revenues over expenses	-	(32)	32	100.0%	(22)	7	(19)	26	136.8%	(53)

ALAMEDA HOSPITAL - SOUTH SHORE ONLY
Summary Statement of Revenues, Expenses
For the Three Months Ended September 30, 2008

	Current Month - Per Adjusted Patient Day					Year to Date - Per Adjusted Patient Day				
	Actual	Budget	Variance	Var %	July 07	Actual	Budget	Variance	Var %	FY07
Operating revenues:										
IP Revenue	$ 682	$ 604	$ 78	12.9%	$ -	$ 674	$ 584	$ 90	15.4%	$ -
OP Revenue	-	-	-	0.0%	-	-	10	(10)	-100.0%	-
Total revenue	$ 682	$ 604	$ 78	12.9%	$ -	$ 674	$ 594	$ 80	13.5%	$ -
Less: Deductions from Revenue	(431)	(306)	(125)	-40.8%	-	(430)	(301)	(129)	-42.9%	-
Bad Debt	-	-	-	0.0%	-	-	-	-	0.0%	-
Charity	-	-	-	0.0%	-	-	-	-	0.0%	-
Net patient service revenue	$ 251	$ 298	$ (47)	-15.8%	$ -	$ 244	$ 293	$ (49)	-16.7%	$ -
	36.80%	49.34%			0.00%	36.20%	49.33%			0.00%
Other revenue	-	-	-	0.0%	-	-	-	-	0.0%	-
Total operating revenues	$ 251	$ 298	$ (47)	-15.8%	$ -	$ 244	$ 293	$ (49)	-16.7%	$ -
Operating expenses:										
Salaries	$ 166	$ 174	$ 8	4.6%	$ -	$ 156	$ 173	$ 17	9.8%	$ -
Registry	-	-	-	0.0%	-	-	-	-	0.0%	-
Benefits	5	52	47	90.4%	-	9	52	43	82.7%	-
Professional Fees	27	21	(6)	-28.6%	-	49	41	(8)	-19.5%	-
Supplies	18	16	(2)	-12.5%	-	18	16	(2)	-12.5%	-
Purchase Services	5	2	(3)	-150.0%	-	7	2	(5)	-250.0%	-
Rents and Leases	13	12	(1)	-8.3%	-	12	12	-	0.0%	-
Utilities and Telephone	2	4	2	50.0%	-	3	4	1	25.0%	-
Insurance	2	1	(1)	-100.0%	-	2	1	(1)	-100.0%	-
Interest Expense	-	-	-	0.0%	-	-	-	-	0.0%	-
Depreciation and amortization	1	2	1	50.0%	-	1	2	1	50.0%	-
Other Operating Expenses	2	2	-	0.0%	-	3	2	(1)	-50.0%	-
Total operating expenses	$ 241	$ 286	$ 45	15.7%	$ -	$ 260	$ 305	$ 45	14.8%	$ -
Operating gain (loss)	$ 10	$ 12	$ (2)	-16.7%	$ -	$ (16)	$ (12)	$ (4)	-33.3%	$ -
Non-operating revenues (expenses):	$ -	$ -	$ -	0.0%	$ -	$ -	$ -	$ -	0.0%	$ -
Excess of revenues over expenses	10	12	(2)	-16.7%	-	(16)	(12)	(4)	-33.3%	-

ALAMEDA HOSPITAL
KEY STATISTICS
September, 2008

	ACTUAL SEPTEMBER 2008	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	SEPTEMBER 2007	YTD SEPTEMBER 2008	YTD FIXED BUDGET	VARIANCE	%	YTD SEPTEMBER 2007
Discharges:										
Total Acute	216	209	7	3.3%	221	673	687	(14)	-2.0%	684
Total Sub-Acute	5	2	3	150.0%	3	11	6	5	83.3%	5
Total Skilled Nursing	10	8	2	25.0%	5	14	12	2	16.7%	24
	231	211	12	5.7%	229	684	693	(7)	-1.0%	713
Patient Days:										
Total Acute	864	837	27	3.2%	840	2,794	2,748	46	1.7%	2,652
Total Sub-Acute	985	995	(10)	-1.0%	856	2,992	3,039	(47)	-1.5%	2,542
Total Skilled Nursing	620	630	(10)	-1.6%	52	935	930	5	0.5%	270
	2,469	2,462	7	0.3%	1,748	6,721	6,717	4	0.1%	5,464
Average Length of Stay										
Total Acute	4.00	4.00	(0.00)	-0.1%	3.80	4.15	4.00	0.15	3.8%	3.88
Average Daily Census										
Total Acute	28.80	27.90	0.87	3.1%	28.00	30.37	29.87	0.50	1.7%	28.83
Total Sub-Acute	32.83	33.17	(0.32)	-1.0%	28.53	32.52	33.03	(0.51)	-1.5%	27.63
Total Skilled Nursing	20.67	21.00	(0.32)	-1.5%	1.73	20.78	20.67	0.11	0.5%	2.93
	82.30	82.07	0.23	0.3%	56.39	83.67	83.57	(0.01)	0.0%	88.13
Emergency Room Visits	1,360	1,456	(96)	-6.6%	1,430	4,074	4,416	(342)	-7.7%	4,315
Outpatient Registrations	2,528	2,562	(34)	-1.3%	2,437	7,523	7,556	(33)	-0.4%	7,428
Surgery Cases:										
Inpatient	43	49	(6)	-12.2%	50	170	159	11	6.9%	170
Outpatient	410	341	69	20.2%	357	1,279	1,050	229	21.8%	1,145
	453	390	63	16.2%	407	1,449	1,209	240	19.9%	1,315
Kaiser Inpatient Cases	9	-	9	-	2	28	-	28	-	17
Kaiser Eye Cases	157	118	39	33.1%	143	481	342	139	40.6%	402
Kaiser Outpatient Cases	158	129	29	22.5%	118	471	384	87	22.7%	386
Total Kaiser Cases	324	247	77	31.2%	263	980	726	254	35.0%	805
% Kaiser Cases	71.5%	63.3%			64.6%	67.6%	60.0%			61.2%
Adjusted Occupied Bed	143.53	143.65	0.12	0.1%	100.97	128.78	125.97	2.81	2.2%	102.09
Productive FTE	368.73	359.19	(9.54)	-2.7%	349.53	357.06	351.31	(5.75)	-1.6%	351.49
Total FTE	422.40	422.19	(0.21)	0.0%	399.68	409.13	409.10	(0.03)	0.0%	409.82
Productive FTE/Adj. Occ. Bed	2.57	2.50	(0.07)	-2.7%	3.46	2.77	2.79	0.02	0.6%	3.44
Total FTE/ Adj. Occ. Bed	2.94	2.94	(0.00)	-0.1%	3.96	3.18	3.25	0.07	2.2%	4.01

ALAMEDA HOSPITAL
12 MONTH CASH PROJECTION
PERIOD COVERED:10/1/08 THRU 9/30/09

MONTH	COLLECTIONS NON-KAISER	COLLECTIONS KAISER -USE	PROPERTY TAX[1]	W/C REFUND NET	OTHER	FY 2008 AB 915	TRANSFERS	EST. DISBURSEMENTS	BALANCE[2]
SEP 08									(359,121)
OCT 08	4,377,544	760,000	300,000		75,000		1,550,000	6,676,605	26,819
NOV 08	3,705,000	760,000	300,000		50,000		200,000	5,021,638	20,182
DEC 08	4,400,000	760,000	477,000		50,000		(650,000)	5,021,638	35,544
JAN 09	4,200,000	760,000	477,000		50,000		(200,000)	5,255,338	67,206
FEB 09	3,800,000	760,000	477,000	200,000	50,000			5,260,314	93,892
MAR 09	4,400,000	760,000	477,000		50,000		(500,000)	5,260,362	20,530
APR 09	4,410,000	790,000	477,000		50,000		(475,000)	5,226,095	46,434
MAY 09	4,620,000	790,000	477,000		50,000		800,000	6,726,950	56,484
JUNE 09	4,620,000	790,000	477,000		50,000	180,000	(850,000)	5,258,053	65,431
JULY 09	4,620,000	790,000	477,000		50,000			5,905,219	97,212
AUG 09	4,620,000	790,000	477,000		50,000		(175,000)	5,811,595	47,618
SEP 09	4,620,000	790,000	477,000		50,000		(125,000)	5,811,595	48,023
TOTALS	52,392,544	9,300,000	5,370,000	200,000	625,000	180,000	(425,000)	67,235,401	

Notes:

1. Property tax receipts will be held in an interest bearing investment account and transferred to the operating account as needed each month.
2. Reflects only cash held in concentration and disbursement accounts at month-end. An additional $1,907K and $1,081K is held on deposit in money market accounts at the Bank of Alameda and Merrill Lynch, respectively.

ALAMEDA HOSPITAL

12 Month Cash Projection - Disbursement Detail

PERIOD COVERED:10/1/08 THRU 9/30/09

	DISBURSEMENTS		13%						TOTAL CASH
MONTH	PAYROLL	PENSION	PAYROLL RELATED	Total Payroll	Health expense	Refund	A/P	Debt Service	OUTLAYS
OCT 08	3,904,296 a	157,094	386,123	4,447,513	278,000	20,000	1,829,435	101,657	6,676,605
NOV 08	2,663,138	60,500	250,000	2,973,638	278,000	20,000	1,701,716	48,284	5,021,638
DEC 08	2,663,138	60,500	250,000	2,973,638	278,000	20,000	1,701,654	48,346	5,021,638
JAN 09	2,866,589	90,750	250,000	3,207,339	278,000	20,000	1,701,583	48,417	5,255,338
FEB 09	2,901,720	60,500	250,000	3,212,220	278,000	20,000	1,701,583	48,511	5,260,314
MAR 09	2,901,720	60,500	250,000	3,212,220	278,000	20,000	1,701,583	48,559	5,260,362
APR 09	2,901,720	60,500	250,000	3,212,220	278,000	20,000	1,701,583	14,293	5,226,095
MAY 09	4,406,855 a	60,500	250,000	4,717,355	278,000	20,000	1,701,583	10,013	6,726,950
JUNE 09	2,937,903	60,500	250,000	3,248,403	278,000	20,000	1,701,583	10,067	5,258,053
JULY 09	3,491,354	60,500	343,673	3,895,527	278,000	20,000	1,701,583	10,109	5,905,219
AUG 09	3,491,354	60,500	250,000	3,801,854	278,000	20,000	1,701,583	10,158	5,811,595
SEP 09	3,491,354	60,500	250,000	3,801,854	278,000	20,000	1,701,583	10,158	5,811,595
TOTALS	38,621,138	852,844	3,229,796	42,703,778	3,336,000	240,000	20,547,052	408,571	67,235,401

a) 3 pay periods in the month

Date: November 6, 2008

To: City of Alameda Health Care District Board of Directors

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Pension Committee Report

The first meeting of the Pension Committee, an administrative committee reporting to the Board of Directors and chaired by Steve Wasson, was held on October 29, 2008. Minutes for the meeting are enclosed.

At the meeting, management reviewed all of the pension plans in effect for Alameda Hospital employees, including plans that are active, terminated or frozen. Following the meeting, management prepared a summary matrix of all of the plans, including Employer Contribution Plans, Employee Contribution Plans and Union Plans. This attached summary includes information, some of which is still being completed, about the number of participants, status, size of plan and contribution guidelines for all plans.

Of the pension plans summarized, the Board of Directors has fiduciary responsibility for only two plans. The first is the **Alameda Hospital Pension Plan ("Echo" Plan)**, which was formed in 2002 as a replacement for the Pension Plan of the non-profit, pre-district Alameda Hospital. The second plan for which the Board has fiduciary responsibility is the City of Alameda Health Care District 401(a) plan, which replaced the Echo Plan when it was frozen in 2004.

The Pension Committee discussed the status of the frozen Echo fund, which has been invested historically in a fixed income (Stable Value) fund with Union Bank of California. Our actuarial consultant, Gene Gibbs, presented his analysis of the Echo fund. The conclusion of the analysis is that the Echo plan, while funded at levels applicable to public entities such as the district, is under-funded based on actuarial projections of benefit pay-outs, given the fact that the majority of the participants in the this frozen plan are expected to access their benefits over the next 15 years.

Management recommended and the Committee approved a shift of the principal of the Echo fund from a fixed income fund to a "balanced" fund managed by High Mark, the subsidiary money manager of Union Bank of California. The balanced fund will be invested in 40-60% equity : 60-40% fixed fund portfolio, with a targeted average return of 6.5% annually instead of the 3% annual return generated by the Stable Value fund.

The transition to the new portfolio would be implemented over a two to three month period.

The Pension Committee recommends that the Board of Directors adopt of the revised investment strategy as outlined in the Attached Investment Guidelines document for the Echo plan shifting from the stable value fund to a balanced fund.

In addition, management will be recommending a schedule of additional contributions to the Echo fund over the next few years to the Pension Committee and Finance & Management Committee in order to increase the plan balance.

The Pension Committee is expected to meet on a quarterly basis. At the next meeting of the Pension Committee, the Committee will review a draft of the Committee purpose and responsibilities and forward this document to the Board of Directors for approval.

Alameda Hospital Pension Plan Matrix

Plan Name	Employee Classification	Total # employees enrolled in plan	Status	Total Plan $	Fund Manager/ Administrator	Fiduciary Responsibility	Contribution Rate Employee/Employer	Hospital contrib. FY 2008	Administrative Requirements: ERISA Y/N	5500 Y/N	IRS Det. Letter on file?
Employer Contribution Plans											
Alameda Retirement Plan **1/1/59 to 7/31/02**	Non-represented Lab (L.29) Xray (L.6) RNs until July 2001	See comment (1) below	Terminated and annuity contracts purchased with Principal Financial Group	See comment (1) below	Principal Financial Group	Principal Financial Group	Employer contributions	N/A (terminated)	Yes	N/A	Letter on file
Alameda Hospital Pension Plan ("Echo" Plan) **8/2/02 - 12/31/04**	Non-represented Lab (L.29) Xray (L.6)	155	Frozen	$1.383m. as of 9/30/08	Manager = HighMark Funds held by UBOC Admin.= Alameda Hospital Actuarial reports and benefit calculations= Altman & Cronin	Alameda Hospital	Employer contributions	2008 $45K 2009 $110K estimate	Yes only for the period from 8/1/02 - 10/31/02 See comment (2)	2002 only. N/A after 2002	Altman & Cronin has recommended plan amendments to reflect non-Erisa status. IRS TBD.
City of Alameda Healthcare District 401(a) Retirement Plan **1/1/05 to present**	Non-represented Lab (L.29) Xray (L.6)	174 as of 11/5/08	Active	$1.751m as of 11/5/08	Manager = Diversified Admin. = Alameda Hospital	Alameda Hospital	Employer contributions - 6% of all earnings	$617,671.52	No	No	Yes - in process
Employee Contribution Plans											
Tax Deferred Annuity Retirement Plan 403(b) **3/1/67 to 11/1/02**	ALL employees	101 as of 11/5/08	Frozen	$3.697m as of 11/5/08	Manager = Diversified Admin. = Alameda Hospital	Alameda Hospital	Employee contributions (Note: also employer contributions for RNs (CNA) only from 1967 until 7/01 when they adopted Steelworkers Pension Trust)	N/A	Yes	Yes	N/A
City of Alameda Healthcare District 457(b) Deferred Compensation Plan for Governmental Entities **11/1/02 to present**	ALL employees	366 as of 11/5/08	Active	$23.345m as of 11/5/08	Manager = Diversified Admin. = Alameda Hospital	Alameda Hospital	Employee contribution up to annual max. 2008 annual max.= $15,500+ addt'l. $5K if age 50+	N/A	No	No	N/A
Union Plans											
Steelworkers Pension Trust **July 2001 - current**	RNs (C.N.A.)	101	Active	N/A	Union	Union	Employer Eff. 7/08 = 7.5%	$742,308.66	N/A	N/A	N/A
SEIU - UHW Local 250	Service workers, L.V.N.s and C.N.A.s	103	Active	N/A	Union	Union	Employer Eff. 5/07 = $1.10 per hour	$241,524.66	N/A	N/A	N/A
United -Here Local 2850	Cooks	4	Active	N/A	Union	Union	Employer Eff. 7/06 $120 per month	$33,685.44	N/A	N/A	N/A
Stationary Engineers Local 39	Stationary Engineers	5	Active	N/A	Union	Union	Employer Eff. 10/08 $6.21 per hour	$63,917.16	N/A	N/A	N/A
Comments											
(1) Data collection in progress											
(2) Hospital became a District November 2002											

INVESTMENT GUIDELINES DOCUMENT

Alameda Hospital Pension Plan

Draft

Investment Guidelines Document

Overview

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

Executive Summary

Client Name: Alameda Hospital

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

Investment Authority: Full Investment Authority

Account Number: To be determined

Risk Tolerance: Moderate to high

Time Horizon: Long-Term

Investment Objective: The primary objective is to maximize total Plan return, subject to the risk and quality constraints set forth below. The Plan's targeted rate of return is 6.5%. The Investment objective selected is the Balanced Income Objective. The asset allocation ranges for this objective are listed below:

Strategic Ranges:
0 - 20% Cash
40 - 60% Fixed Income
40 - 60% Equity

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

HCM Portfolio Manager: Andrew Brown. 415-705-7605
Andrew.Brown@Uboc.com

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

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

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

Portfolio Constraints

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

Document/Legal Restrictions: None.

Unique Needs and Circumstances: None

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

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

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

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

Detailed Information for Investment Guidelines Document

Overview

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

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

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

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

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

Diversification

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

Fixed Income

- The intermediate and long-term fixed income investments (greater than one-year in maturity) shall constitute no more than 60%, nor less than 25% of the total Plan assets.
- The high-yield portion of the Plan shall constitute no more than 8%, and as little as 0% of the total Plan assets.
- The convertible bond exposure shall constitute no more than 5%, and as little as 0% of the total Plan assets.
- The short-term fixed income investments shall constitute no more than 30%, and as little as 0% of the total Plan assets.
- The target fixed income exposure should average 45% over a market cycle (three to five years.

Equity

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

- The domestic small capitalization equity investments of the Plan shall constitute no more than 15% nor less than 0% of the total Plan assets.
- The international equity investments of the Plan shall constitute no more than 15% and as little as 0% of the total Plan assets.
- The real estate investments of the Plan shall constitute no more than 10% and as little as 0% of the total Plan assets.
- The target equity exposure should average 50% over a market cycle (three to five years.

Permitted Asset Classes and Security Types

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

Asset Classes

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

Security Types

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

Prohibited assets

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

Rebalancing Procedures

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

Performance objectives

- Total Plan. To exceed over a market cycle (three to five years) a policy index composed of 5% 3-Month Treasury bills, 45% Lehman Brothers Aggregate Bond Index, 35% S&P500 Stock Index, 7.5% Russell 2000 Stock Index, and 7.5% the Morgan Stanley Capital Index EAFE Index.

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

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

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

Duties of Responsibilities of Portfolio Manager

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

Your portfolio manager shall be responsible for:

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

You shall be responsible for:

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

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

Communication

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

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

Reporting

TO BE DETERMINED

Disclosures

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

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: November 4, 2008

To: City of Alameda Health Care District Board of Directors

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Statutory Restrictions on Contracts for Health Care Districts

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At a recent Board meeting, there was discussion of what contracts, acquisitions, or services must be taken to the Board of Directors for approval. Attached is a summary prepared by Tom Driscoll outlining the statutory restrictions on contracts for Health Care Districts plus the section of the California Health and Safety that is the foundation for the restrictions.

Also attached are copies of the City of Alameda Health Care District Contract Review Policy and Scope of Purchasing Authority for Capital Equipment. Both these policies were adopted shortly after the Hospital became a District.

Note that the statutory restrictions do allow delegation of higher spending authority and more latitude on contract approval to the CEO than exists in our current policy.

At the November 10, 2008 Board meeting we will be reviewing this material for information and discussion only. Based on that discussion, Management will bring revised policies to the December Board meeting for review and approval.

THOMAS L. DRISCOLL
ATTORNEY AT LAW

MEMORANDUM

TO: Debi Stebbins

FROM: Tom Driscoll

DATE: November 3, 2008

RE: Statutory Restrictions on Contracts for Health Care Districts

Various statutes limit both the maximum terms and the manner in which contracts are entered into by a healthcare district. This memorandum summarizes those laws; however the relevant Health and Safety Code provisions are attached as Exhibit A.

1. Employment contracts. Although the healthcare district law provides for a 4 year contract for hospital administrators (Health & Safety Code section 32121.5), the Legislature has set a maximum severance period of 18 months for any public employee—including hospital administrators. Gov. Code sections 53260-53264.

By resolution, the Board may delegate to the hospital administrator the right to hire and terminate district employees. Health & Safety Code section 32121.1.

2. Physician contracts. Guarantees to physicians or surgeons of minimum income to bring them to the community cannot exceed 3 years. Health & Safety Code section 32121.3. Such physician-retention agreements must be approved by the Board, since a finding must be made that the incentives granted are necessary. Health & Safety Code section 32121.3.

However, other contracts with physicians and surgeons do not require Board approval if this authority is delegated to the hospital administrator. Health & Safety Code section 32129. Delegation can be shown by inclusion of authority in the administrator's job description or contract.

3. Leases of portion of hospital. Operating leases of a portion of a hospital cannot run longer than 10 years. Health & Safety Code section 32126.

Because this requires various determinations by the Board, board approval is required.

4. Purchase of real property. Board approval is required since the grant deed cannot be recorded without a Certificate of Acceptance which indicates the date on which the acquisition was approved by the Board. Gov. Code section 27281.

5. Sale of surplus property. A resolution of the Board is required to declare and authorize the sale of surplus property. Health & Safety Code section 32121.2. A policy declaring when property is considered to be surplus can be adopted to effectively delegate this to staff, except in the case of surplus real property, which is subject to additional rules.

6. Purchase of equipment, materials, supplies, services. The Board must approve purchases which require competitive bidding (e.g. construction contracts) because the value of the purchase or the work to be done exceeds $25,000. Health & Safety Code section 32132.

Purchases of electronic data processing and telecommunications services exceeding $25,000 also require board approval, since a competitive process must be approved and followed. Health & Safety Code section 32138.

However, include purchases of medical and surgical equipment or supplies, and most professional services—even those exceeding $25,000-- can be delegated to the hospital administrator. Health & Safety Code sections 32122, 32132(b).

7. Auditor. Hiring of the independent auditor to perform the required annual audit should be approved by the Board. Health & Safety Code section 32133.

Most hospital districts and other public agencies adopt a general resolution granting authority to their administrators to carry out routine contracting to the extent permitted by law. Often, this resolution specifies that spending is authorized in accordance with an approved budget. It may also contain a maximum dollar limit on expenditure authority which the Board feels comfortable granting the administrator, with additional authority in case of emergencies (such as natural disasters or other calamities).

Exhibit A

CALIFORNIA HEALTH AND SAFETY CODE
(Selected powers of the District relating to contracting)

32121. Each local district shall have and may exercise the following powers:

…

(c) To purchase, receive, have, take, hold, lease, use, and enjoy property of every kind and description within and without the limits of the district, and to control, dispose of, convey, and encumber the same and create a leasehold interest in the same for the benefit of the district.

32121.1. By resolution, the board of directors of a local hospital district may delegate to its administrator the power to employ (subject to the pleasure of the board of directors), and discharge, such subordinate officers and employees as are necessary for the purpose of carrying on the normal functions of any hospital operated by the district.

32121.2. Except as provided in this section, by resolution, the board of directors of a local hospital district may authorize the disposition of any surplus property of the district at fair market value by any method determined appropriate by the board.

The board of directors of a local hospital district may donate or sell, at less than fair market value, any surplus property to another local hospital district in California.

32121.3. (a) Notwithstanding any other provision of law, a hospital district, or any affiliated nonprofit corporation upon a finding by the board of directors of the district that it will be in the best interests of the public health of the communities served by the district and in order to obtain a licensed physician and surgeon to practice in the communities served by the district, may do any of the following:

(1) Guarantee to a physician and surgeon a minimum income for a period of no more than three years from the opening of the physician and surgeon's practice.

(2) Guarantee purchases of necessary equipment by the physician and surgeon.

(3) Provide reduced rental rates of office space in any building owned or leased by the district or any of its affiliated entities, or subsidize rental payments for office space in any other buildings, for a term of no more than three years.

(4) Provide other incentives to a physician and surgeon in exchange for consideration and upon terms and conditions the hospital district's board of directors deems reasonable and appropriate.

(b) Any provision in a contract between a physician and surgeon and a hospital district or affiliated nonprofit corporation is void which does any of the following:

(1) Imposes as a condition any requirement that the patients of the physician and surgeon, or a quota of the patients of the physician and surgeon, only be admitted to a specified hospital.

(2) Restricts the physician and surgeon from establishing staff privileges at, referring patients to, or generating business for

another entity.
(3) Provides payment or other consideration to the physician and surgeon for the physician and surgeon's referral of patients to the district hospital or an affiliated nonprofit corporation.

(c) Contracts between a physician and surgeon and a hospital district or affiliated nonprofit corporation that provide an inducement for the physician and surgeon to practice in the community served by the district hospital shall contain both of the following:

(1) A provision which requires the inducement to be repaid with interest if the inducement is repayable.
(2) A provision which states that no payment or other consideration shall be made for the referral of patients to the district hospital or an affiliated nonprofit corporation.

(d) To the extent that this section conflicts with Section 650 of the Business and Professions Code, Section 650 of the Business and Professions Code shall supersede this section.

(e) The Legislature finds that this section is necessary to assist district hospitals to attract qualified physicians and surgeons to practice in the communities served by these hospitals, and that the health and welfare of the residents in these communities require these provisions.

32121.5. Notwithstanding any other provision of this division, a local hospital district may enter into a contract of employment with a hospital administrator, the duration of which shall not exceed four years, but which may periodically be renewed upon expiration for not more than four years.

32122. The board of directors may purchase all necessary surgical instruments and hospital equipment and equipment for nurses' homes and all other property necessary for equipping a hospital and nurses' home.

32123. The board of directors may purchase such real property, and erect or rent and equip such buildings or building, room or rooms as may be necessary for the hospital.

32126.5. (a) The board of directors of a hospital district or any affiliated nonprofit corporation may do any of the following when it determines that the action is necessary for the provision of adequate health services to communities served by the district:
(1) Enter into contracts with health provider groups, community service groups, independent physicians and surgeons, and independent podiatrists, for the provision of health services.
(2) Provide assistance or make grants to nonprofit provider groups and clinics already functioning in the community.
(3) Finance experiments with new methods of providing adequate health care.

(b) Nothing in this section shall authorize activities which corporations and other artificial legal entities are prohibited from conducting by Section 2400 of the Business and Professions Code [referring to MD agreements that violate corporate practice].

32129. Notwithstanding the provisions of the Medical Practice Act, the board of directors of a hospital district or any affiliated nonprofit corporation may contract with physicians and surgeons, podiatrists, health care provider groups, and nonprofit corporations for the rendering of professional health services on a basis as does not result in any profit or gain to the district from the services so rendered and as allows the board to ensure that fees and charges, if any, are reasonable, fair, and consistent with the basic commitment of the district to provide adequate health care to all residents within its boundaries.

32129.5. Notwithstanding any other provision of law, the board of directors of a hospital district or any affiliated nonprofit corporation may contract with a physician and surgeon or podiatrist for the rendering of professional services in the hospital, for the purpose of assuring that a physician and surgeon or podiatrist will be on duty in an outpatient emergency department maintained by the hospital, on a basis as does not result in any profit or gain to the district from the professional services of the physician and surgeon.

For purposes of this section, the contract with the podiatrist shall be for those services which the podiatrist is licensed to practice pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

32130.6. Notwithstanding any other provision of law, a district may do any of the following by resolution adopted by a majority of the district board:

(a) Enter into a line of credit with a commercial lender that is secured, in whole or in part, by the accounts receivable or other intangible assets of the district, including anticipated tax revenues, and thereafter borrow funds against the line of credit to be used for any district purpose.

(1) Any money borrowed under this line of credit shall be repaid within five years from each separate borrowing or draw upon the line of credit.

(2) The district may enter into a new and separate line of credit to repay a previous line of credit, provided that the district complies with this section in entering into a new line of credit.

(b) Enter into capital leases for the purchase by the district of equipment to be used for any district purpose.

(1) The term of any capital lease shall not be longer than 10 years.

(2) The district may secure the purchase of equipment by a capital lease by giving the lender a security interest in the equipment leased under the capital lease.

(c) Enter into lease-purchase agreements for the purchase by the district of real property, buildings, and facilities to be used for any district purpose. The term of any lease-purchase agreement shall not exceed 10 years.

(d) Nothing in this section shall provide the district with the authority to increase taxes in order to repay a line of credit established pursuant to subdivision (a) unless the tax is passed

pursuant to Article 4.6 (commencing with Section 53750) of Chapter 4 of Part 1 of Division 2 of Title 5 of the Government Code.

32132. (a) Except as otherwise provided in this section, or in Chapter 3.2 (commencing with Section 4217.10) of Division 5 of Title 1 of the Government Code, the board of directors shall let any contract involving an expenditure of more than twenty-five thousand dollars ($25,000) for materials and supplies to be furnished, sold, or leased to the district, or any contract involving an expenditure of more than twenty-five thousand dollars ($25,000) for work to be done, to the lowest responsible bidder who shall give the security the board requires, or else reject all bids.

…

(b) Subdivision (a) shall not apply to medical or surgical equipment or supplies, **to professional services**, or to electronic data processing and telecommunications goods and services.

(c) Bids need not be secured for change orders that do not materially change the scope of the work as set forth in a contract previously made if the contract was made after compliance with bidding requirements, and if each individual change order does not total more than 5 percent of the contract.

(d) As used in this section, "medical or surgical equipment or supplies" includes only equipment or supplies commonly, necessarily, and directly used by, or under the direction of, a physician and surgeon in caring for or treating a patient in a hospital.

(e) Nothing in this section shall prevent any district health care facility from participating as a member of any organization described in Section 23704 of the Revenue and Taxation Code, nor shall this section apply to any purchase made, or services rendered, by the organization on behalf of a district health care facility that is a member of the organization.

32133. At least once each year the board shall engage the services of a qualified accountant of accepted reputation to conduct an audit of the books of the hospital and prepare a report. The financial statement of the district with the auditor's certification, including any exceptions or qualifications as part of such certification, shall be published in the district by the board pursuant to Section 6061 of the Government Code.

32136. The board of directors may, without following the bidding provisions in Section 32132 hereof, let contracts for work to be done or for materials and supplies to be furnished, sold or leased to the district, if it first determines that an emergency exists warranting such expenditure due to fire, flood, storm, epidemic, or other disaster and is necessary to protect the public health, safety, welfare, or property.

32138. (a) The board of directors shall acquire electronic data processing and telecommunications goods and services with a cost to the district of more than twenty-five thousand dollars ($25,000) through competitive means, except when the board determines either that (1) the goods and services proposed for acquisition are the only goods and services which can meet the district's need, or (2) the

goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety.

(b) As used in this section, "competitive means" includes any appropriate means specified by the board, including, but not limited to, the preparation and circulation of a request for a proposal to an adequate number of qualified sources, as determined by the board in its discretion, to permit reasonable competition consistent with the nature and requirements of the proposed acquisition.

(c) When the board awards a contract through competitive means pursuant to this section, the contract award shall be based on the proposal which provides the most cost-effective solution to the district's requirements, as determined by the evaluation criteria specified by the board. The evaluation criteria may provide for the selection of a vendor on an objective basis other than cost alone.

CITY OF ALAMEDA HEALTH CARE DISTRICT
2004-0a
CONTRACT REVIEW POLICY

I. PURPOSE

The District has more than two hundred contracts and leases (as lessor and lessee, and with respect to both real and personal property) with various suppliers of goods and services, and space and equipment. This policy is based upon existing practice and establishes the formal process for board review and approval of contracts and leases (collectively "contracts") including guidelines for delegation of review and approval authority to the Chief Executive Officer.

II. POLICY

This policy applies to contracts already in place (existing contracts) and to new contracts.

A. **Existing Contracts**: To the extent permitted by applicable law, the board delegates to the Chief Executive Officer the authority to continue or renew existing contracts as set forth hereinbelow. However, the board will review the renewal of any existing contract that exceeds budgeted amounts by $25,000 or if it has a dollar value of $25,000 or more and it has been previously renewed 3 times.

B. **New Contracts:** The board delegates to the Chief Executive Officer the authority to review and approve new contracts with suppliers of goods and services, and lessors and lessees of space and equipment, with the following exceptions:

1. New contracts that exceed budgeted amounts by $ or unbudgeted contracts with a dollar value greater than $25,000 except routine contracts for registry or traveling personnel which authority the board delegates to the CEO on an ongoing basis.

2. New contracts of high strategic importance even if the value is less than $25,000. Strategic importance means or includes, but is not limited to, contracts for other than routine patient services with (a) competing health care organizations, (b) public agencies, or (c) City of Alameda based community not-for-profit agencies.

3. New related party contracts including contracts with physicians (unless entered into pursuant to Board-adopted-physician

Comment: This proviso makes sure that the law is ultimately is the controlling factor

Deleted: including (1) contracts approved by the board as a part of the due diligence process at asset transfer or (2) contracts approved by the board subsequent to the asset transfer.

Comment: These limits can be increased

Comment: These limits can be increased

Comment: These limits can be increased

contracting guidelines).

4. New contracts with general or group purchasing organizations if the anticipated annual expenditure exceeds budgeted amounts by $ or unbudgeted annual expenditure is greater than $25,000.

Comment: These limits can be increased

5. New capitated agreements or contracts that place the District at risk for the cost of caring for a group of patients.

The delegation authority to the Chief Executive Officer to "review" and "approve" includes, but is not limited to the authority to negotiate and enter into a contract within previously approved parameters.

C. **Record Maintenance**: The Chief Executive Officer will maintain a current listing of all District contracts for review by the board or any individual board member upon request.

City of Alameda Health Care District
Policy 2002-5y
SCOPE OF PURCHASING AUTHORITY FOR CAPITAL EXPENDITURES

POLICY

Basic Legal requirements governing purchasing for Hospital Districts are to be found in Government Code Section 54201, et, seq., and the He alth and Safety Code (Div. 23, Sec. 32131) of the State of California and the appendices thereto. The Board of Directors hereby delegates certain signature authority to the Chief Executive Officer of the Hospital, and said Chief Executive Officer is able to delegate certain signature authorities to appropriate persons within the Hospital.

The following delineates the scope and limit of purchasing authority allowed the Hospital CEO for the acquisition of equipment (medical and non-medical) at Alameda Hospital.

I. DEFINITION OF CAPITAL EQUIPMENT

Capital equipment is defined as any item of equipment or construction program that has, at the time of its acquisition, an estimated useful life of at least two years, and a cost of at least $3,000, or if the asset is acquired in quantity, and the aggregate cost of the quantity is at least $3,000, it's cost must be capitalized, and written off over the estimate useful life of the asset. If depreciable assets fall below the above guidelines, its cost will be treated as an operational expense and expensed to the appropriate supply category.

II. FISCAL YEAR BUDGET

1. Each year the Chief Executive Officer shall prepare a budget and present it to the Board of Directors for their review, modification and approval for the succeeding fiscal year. The approved budget represents the formal delegation of authority to the Chief Executive Officer to meet the Hospital District's operational and financial obligations including capital expenditures during the fiscal year, and within the constraints of available funds and the established policies, practices and procedures of the District.

2. Capital expenditures in excess of $25,000, which were not authorized by the Board of Directors in the Capital Expenditures Budget during the Fiscal Year in which acquisition is desired, and budgeted items that exceed budgeted amounts by $_____ or more, shall require prior Board approval as well as all non-budgeted items allocated for other capital expenditure projects, thereby preserving the aggregate amount of funds authorized for capital expenditures by the Board during the given fiscal year.

Comment: This amount can be increased

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3. Anything in excess of $50,000 will be brought back to the Board for approval prior to purchase, even though the item had previously been approved in the capital budget.

Comment: This amount can be increased

III. NON-MEDICAL CAPITAL EQUIPMENT DELEGATION OF AUTHORITY (BUDGETED AND NON-BUDGETED)

1. Formal (sealed-written) bid (health and Safety Code, Div. 23, Sec. 32132): A formal bid is required for all expenditures over $25,000 (materials and supplies) or $25,000 (work to be done) for non-medical capital equipment. A bid will contain the specifications, both legal and descriptive, of the item or items considered for acquisition by the Hospital District.

Exceptions to competitive bid ding are granted when the board determines that the materials and supplies proposed for acquisition is necessary for the protection of the public health, welfare or safety.

The Board of Directors shall let any such contract to the lowest responsible bidder who shall give such security, as the Board requires, or else reject all bids. Thereafter, the Board shall authorize the Chief Executive Officer to enter into an agreement for the acquisition of said items.

The above bidding requirements shall not apply to energy equipment as defined in Government Code section 4217.10 et seq., or to medical or surgical equipment or supplies or to professional services, including information technology equipment (both hardware and software) or telecommunication equipment.

The Board of Directors shall acquire electronic data processing and telecommunications goods and services with a cost to the district of more than twenty-five thousand dollars ($25,000) through competitive means, except when the board determines either that (1) the goods and services proposed for acquisition are the only goods and services which can meet the district's need, or (2) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety. "Competitive means" includes any appropriate means specified by the board, including, but not limited to, the preparation and circulation of a request for a proposal to an adequate number of qualified sources, as determined by the board in its discretion, to permit reasonable competition consistent with the nature and requirements of the proposed acquisition. When the board awards a contract through competitive means pursuant to this section, the contract award shall be based on the proposal which provides the most cost-effective solution to the district's requirements, as determined by the evaluation criteria specified by the board. The evaluation criteria may provide for the selection of a vendor on an objective basis other than cost alone.

2. Informal written quotation: For expenditures under $25,000 (including materials, supplies or work to be done) the Chief Executive Officer or his delegated representative may request formal written quotations from various vendors on particularly specified and described items. Such quotations shall be carefully reviewed to determine compliance with District policy, instructions and specifications before

award is made.

3. Informal oral quotation: For expenditures under $25,000 (materials and supplies) or $25,000 (work to be done) the Chief Executive Officer may secure, when appropriate, oral or telephone quotations. When possible, this will contain at least three (3) quotations from qualified vendors in order to insure lowest prices commensurate with quality.

IV. MEDICAL/SURGICAL CAPITAL EQUIPMENT DELEGATION OF AUTHORITY (BUDGETED AND NON BUDGETED)

1. The Board of Directors delegates to the Chief Executive Officer the emergency acquisition of non budgeted medical or surgical equipment exceeding $25,000 (Div. 23, Sec. 32136) as fire, flood, storm, epidemic, or other disaster and is necessary to protect the public health, safety, welfare, or property. The Board shall meet to ratify the existence of an emergency as soon as possible, and in no event later than 7 days after the acquisition.

Comment: This amount can be increased

2. The Chief Executive Officer may purchase (through substitution for another budgeted item) non-budgeted medical/surgical capital equipment up to ~~$10,000~~ $25,000 in accordance with Sec. 32132 of the California Health and Safety Code. The Chief Executive Officer may obtain informal written quotations for this purpose.

Comment: This amount can be increased

3. All capital expenditures will be preceded by a duly completed "Capital Expenditure Request" (CER) forms and Purchase Order. In case of emergency, the Purchase Order will be filed within 72 hours of any verbal order.

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