*Posted December 2, 2011*

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

# PUBLIC NOTICE

## CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD OF DIRECTORS

## REGULAR MEETING AGENDA

**Monday, December 5, 2011**

**6:00 p.m. (Closed) | 7:00 p.m. (Open)**

**Location:** Alameda Hospital (Dal Cielo Conference Room)
2070 Clinton Avenue, Alameda, CA 94501
**Office of the Clerk: (510) 814-4001**

***PLEASE NOTE CHANGE IN START TIME FOR OPEN SESSION to 7:00 P.M.**

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

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

**II. Roll Call** — Kristen Thorson

**III. Adjourn into Executive Closed Session**

**IV. Closed Session Agenda**

A. Call to Order

B. Approval of Closed Session Minutes
   1. November 7, 2011 (Regular)
   2. November 30, 2011 (Special)

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

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

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

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

G. Adjourn into Open Session

**V. Reconvene to Public Session** **(Expected to start at 7:00 p.m. – Dal Cielo Conference Room)**

A. Announcements from Closed Session — Jordan Battani

**VI. Public Comment**

**VII. Regular Agenda**

A. Consent Agenda — **ACTION ITEMS**

✔ 1) Approval of November 7, 2011 Regular Meeting Minutes [enclosure] **(PAGES 3-11)**

✔ 2) Approval of November 30, 2011 Special Meeting Minutes [enclosure] **(PAGE 12)**

B. Action Items

| | | |
|---|---|---|
| ✔ 1) | Acceptance of October 2011 Unaudited Financial Statements and November 30, 2011 Finance and Management Committee Report [enclosure] **(PAGES 13-35)** | Michael McCormick<br>Diana Surber |
| ✔ 2) | Acceptance of FY 2011 Executive Performance Metrics Summary [enclosure] **(PAGES 36-44)** | Deborah E. Stebbins |
| ✔ 3) | District Board Referral – Assessment of Cost and Operational Impact of Implementing Changes to Public Notice and Disclosure Standards and Improvement of the Alameda Hospital Website Functionality [enclosure] **(PAGES 45)** | Jordan Battani |

C. Presidents Report — Jordan Battani

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

✔ 1) FY 2012 Goals and Objectives 1st Quarter Update [enclosure] **(PAGES 46-53)**

✔ 2) Revenue Cycle Update and Organizational Changes in Finance [enclosure] **(PAGE 54)**

3) Legislative Update

✔ 4) Governance Institute 2011 Biennial Survey of Hospital and Health Care Systems [enclosure] **(PAGES 55-68)**

5) Monthly Volume Statistics

6) Monthly Quality Metrics

a) Falls (Irene Pakel, RN)

7) Hospital Updates / Events

E. Operations and Facilities Report **INFORMATIONAL** — Kerry J. Easthope

1) Waters Edge Transition Planning Update

2) Wound Care Center Update

G. Community Relations and Outreach Committee Report **INFORMATIONAL** — Stewart Chen, DC

1) November 15, 2011 Committee Meeting

F. Medical Staff President Report **INFORMATIONAL** — James Yeh, DO

## VIII. General Public Comments

## IX. Board Comments

## X. Adjournment

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

# Minutes of the City of Alameda Health Care District Board of Directors
## Open Session
## Monday, November 7, 2011 Regular Meeting

| Board Members Present | Management Present | Legal Counsel Present | Guests |
|---|---|---|---|
| Jordan Battani<br>Stewart Chen, DC<br>Robert Deutsch, MD*<br>Elliott Gorelick<br>J. Michael McCormick | Deborah E. Stebbins<br>Kerry J. Easthope<br>Diana Surber | Thomas Driscoll, Esq. | N/A |
| | | Medical Staff Present | Excused |
| | | Jim Yeh, DO* | N/A |
| Submitted by: Kristen Thorson, District Clerk | | | |

| Topic | | Discussion | Action / Follow-Up |
|---|---|---|---|
| I. | Call to Order | The meeting was called to order at 6:08 p.m. | |
| II. | Roll Call | Ms. Thorson called roll noting a quorum of Directors was present. | |
| Director Gorelick made an objection to the Closed Session Agenda, Discussion Involving Trade Secrets, indicating that the language on the agenda was inadequate. Objection was noted. | | | |
| III. | Adjourn into Executive Closed Session | The meeting was adjourned into Executive Closed Session at 6:09 p.m. | |
| IV. | Closed Session Agenda | | |
| V. | Reconvene to Public Session | The meeting was reconvened into public session at 7:10 p.m. | |
| A. Announcements From Closed Session<br>Director Battani stated that the Minutes were approved from October 10, 2011. The Board Quality Committee Report for August was accepted as presented. The Board approved the Credentialing Recommendations of the Medical Staff as outlined below. No other action was taken. Director Battani noted that there were no discussions in closed session regarding Item G, Discussion Involving Trade Secrets. | | | |

| Topic | Discussion | Action / Follow-Up | |
|---|---|---|---|
| **Initial Appointments – Medical Staff** | | | |
| Name | Specialty | Affiliation | |
| • Ernest Bloom, MD | Dermatology | Solo Practice | |
| • Jennifer Taylor, MD | Ophthalmology | Alameda Ophthalmology Group | |
| **Reappointments – Medical Staff** | | | |
| Name | Specialty | Staff Status | Appointment Period |
| • Eric Bain, MD | Radiology | Courtesy | 12/01/11 – 11/30/13 |
| • Robert Brooks, MD | Anesthesiology | Courtesy | 12/01/11 – 11/30/13 |
| • David Bui. MD | Ophthalmology | Active | 12/01/11 – 11/30/13 |
| • Ronald Chan, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • Royce Chrys, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • Angelo Crudale, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • Rakesh Donthinini, MD | Orthopedics | Courtesy | 12/01/11 – 11/30/13 |
| • Kent Farney, MD | OB/Gyn | Active | 12/01/11 – 11/30/13 |
| • Erik Gaensler, MD | Radiology | Courtesy | 12/01/11 – 11/30/13 |
| • Stephen Hesseltine, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • William Hoddick, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • David Howard, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • James Karol, MD | Urology | Courtesy | 12/01/11 – 11/30/13 |
| • Ronisha Knight, MD | Emergency Medicine | Courtesy | 12/01/11 – 11/30/13 |
| • Bailey Lee, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • Saurabh Patel, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • Wendy Patton, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • Jonathan Posin, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| • Stephen Post, MD | Ophthalmology | Active | 12/01/11 – 11/30/13 |

| Topic | Discussion | | Action / Follow-Up | |
|---|---|---|---|---|
| | • Aseem Rawal, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| | • Joan Reynolds, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| | • Eric Saldinger, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| | • Robert Schick, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| | • Eric Tao, MD | Teleradiology | Courtesy | 12/01/11 – 11/30/13 |
| | • Daniel Ting, MD | Ophthalmology | Courtesy | 12/01/11 – 11/30/13 |
| | • Martha Tracy, MD | Hematology/Oncology | Courtesy | 12/01/11 – 11/30/13 |
| | • Elizabeth Treynor, MD | Pathology | Courtesy | 12/01/11 – 11/30/13 |
| | • Quingwei Tan, MD | Urology | Courtesy | 12/01/11 – 11/30/13 |
| **Reappointment - Allied Health Professional** | | | | |
| | Name | Specialty | Appointment Period | |
| | • Emily Wong, PA-C | Physician Assistant | 12/01/11-11/30/13 | |
| **Resignations** – No resignations submitted. | | | | |
| Director Battani adjusted the agenda as noted below to allow for public comment and the Medical Staff President's Report to occur earlier in the meeting as well as and to allow Director Deutsch and Dr. Yeh to participate in discussions on key items before they recused themselves from the meeting and the Waters Edge discussion. Public Comment will also occur at the end of the meeting. | | | | |
| General Public Comments | Irene Dieter provided input to the Board regarding the placement of public comment on the agenda, the posting of the meeting agendas and the minutes on the website. She also commented on the proposed Waters Edge transaction. | | | |
| I. Regular Agenda | | | | |
| A. Consent Agenda | | | | |
| 1) Acceptance of October 10, 2011 Regular Meeting Minutes<br>2) Approval of District Board Calendar<br>3) Approval of New Surgical Procedures for Ophthalmology | | | Director Deutsch made a motion to approve the Consent Agenda as presented. Director McCormick seconded the motion. The motion carried unanimously. | |

| Topic | Discussion | Action / Follow-Up |
|---|---|---|
| F. | Medical Staff President Report<br><br>Dr. Yeh reported that Ralph Bernstein, M.D. will be speaking on Functional Bowel Diseases for the CME program for the month on Tuesday, November 8, 2011. He also reported that Phillip Gardner, M. retired in October after 41 years on the Medical Staff. Jennifer Taylor, M.D. a ophthalmologist specializing in corneal surgery will be replacing him in his practice. | |
| B. | Action Items | |
| | 1) Acceptance of September 2011 Unaudited Financial Statements and October 26, 2011 Committee Report.<br><br>Director McCormick reviewed the notes from the October 26th committee meeting noting the following.<br><br>Average daily Census (ADC) of 79.8 versus 83.2 budgeted; variance was mainly in the acute census. ECC outpatient registrations were at budget and total outpatient registrations was 12% below budget. Overall gross revenue was Unfavorable to budget by $1.1 M. Case Mix Index was low due to low acute days. Operating expenses were $53,000 over budget due to unfavorable variances in professional fees partially offset by favorable variances in supplies. Operating loss was $349,000 versus budgeted loss of $98,000 for the month. This will change due to AB97, which would be discussed later in the meeting.<br><br>Director McCormick noted that Management presented an analysis of performance issues and corrective actions being taken to mitigate the 1st quarter financial performance noting that the overall net revenue percent was below budget and was tied to lower CMI, shift in payer mix and other revenue cycle issues with an YTD impact of approximately $425,000. Outpatient Registrations were below budget which was tied to areas in Imaging being off line due to equipment upgrades and remodeling (specifically mammography). Overall, expenses on a flex budget basis were $262,000 over budget.<br><br>Director McCormick stated that there was discussion at the meeting regarding the Revenue Cycle Review conducted by HFS Consultants that began in July 2011. Due to the complexity of the issues, there was a suggestion to form a sub-committee of that included Jordan Battani, Jim Oddie and Ann Evans to look more closely at this important area of Revenue Cycle. | Director Chen made a motion to accept the September 2011 Unaudited Financial Statements as presented. Director McCormick seconded the motion. The motion carried with one abstention (Gorelick). |

| Topic | Discussion | Action / Follow-Up |
|---|---|---|
| | Director McCormick requested from Ms. Surber data from the State OSHPD reports to compare with the information submitted by Waters Edge to validate the information. Director McCormick stated that the information that he reviewed was in line with what had been submitted and reviewed by the Board of Directors.<br><br>Director Gorelick inquired about the material changes that would be discussed later in the meeting relating to AB97 and the IGT funding, and if the financials should be modified and approved at the next meeting. Management stated that the changes would be discussed and would be reflected in the October Unaudited Financial Statements. | |
| | a) Memorandum Regarding Impact of AB97 and IGT on September 2011 Financial Statements<br><br>Ms. Stebbins reported that AB113 (IGT) was approved and the matching funds available to the hospital would only be applied for a half year, reducing the amount accrued to approximately $350,000 for FY 10-11. AB 113 will continue in perpetuity for District Hospitals. For FY12, it appears that the funds will remain at the $700,000 levels as budgeted.<br><br>Ms. Stebbins stated that CMS approved AB97 and the reduction in distinct part skilled nursing rates however CMS did not approve rate reductions for subacute rates. This resulted in a positive adjustment of $1.8 M for FY 2011 and 2012. Ms. Surber reviewed in detail the adjustments (page 38-39 of the board packet) noting that the net impact of the changes is a positive $312,631 which will be reflected in the October Financial Statements. | |
| 2) | Approval of Change of Terms to Bank of Alameda Loan Agreements<br><br>Kerry Easthope reviewed the proposed changes to the terms of the Bank of Alameda Loan Agreements and recommended that the Board approve the changes and authorize the CEO and Associate Administrator to execute the required documents as outlined in the memorandum. Director McCormick inquired about the Current Ratio falling below the 1.0. Mr. Easthope stated that there would be discussions with the Bank of Alameda if that happened. | Director Deutsch made a motion to approve the changes of terms to the Bank of Alameda Loan agreements as presented. Director McCormick seconded the motion. The motion carried unanimously with one abstention (Gorelick). |
| Director Deutsch and Dr. Yeh left the meeting at 8:05 p.m. | | |
| General Public Comments | Irene Dieter asked questions about the proposed Waters Edge sublease. | |

| Topic | Discussion | Action / Follow-Up |
|---|---|---|
| | 3) Approval of Resolution 2011-8I - Approving the Sublease Agreement and Transition Agreement to Operate Waters Edge Skilled Nursing Facility and Authorize the Chief Executive Officer to Submit Licensure and Certification Applications | Director Chen made a motion to approve Resolution 2011 Approving the Sublease Agreement and Transition Agreement to Operate Waters Edge Skilled Nursing Facility and Authorize the Chief Executive Officer to Submit Licensure and Certification Application. Director McCormick seconded the motion. The motion carried 3 to 1 (Gorelick). |
| | a) Supplemental Documentation | |
| | i. Summary of Due Diligence | |
| | ii. Capital Budget | |
| | iii. Financial Pro Formas | |
| | iv. Minutes of Public Workshop | |
| | Ms. Stebbins stated that management would provide an overview of the recommendation and the supporting supplemental documentation related to Waters Edge. Mr. Easthope reviewed the Transition Agreement and Sublease agreement as presented. He reviewed in detail the summary of due diligence related to the physical plant findings noting that overall the facility is in good condition. He stated that as with any building that is 40 years old, there will be anticipated repairs over the course of the lease which have been addressed in the capital budget presented. Mr. Easthope reviewed in detail the due diligence related to other areas not related to the physical plant (personnel, workers compensation experience, litigation, State annual surveys, facility walkthrough by consultants, operating contracts) as outlined in the memorandum. In addition, Mr. Easthope provided the Board with follow-up information regarding other California D/P skilled nursing facilities with greater than 110 beds as outline in the memorandum (page 89).<br>There was discussion regarding the early termination clause in the sublease agreement. Director Gorelick inquired about whether bankruptcy or of the hospital ceased operation of acute services, would be reason to exercise the early termination clause. Director Chen inquired about rent –lease comparisons for other skilled nursing facilities. Ms. Stebbins handed out a rent-lease comparison for Alameda County Nursing Facilities for the Board's reference. There was discussion regarding personnel and the existing union at Waters Edge. Management clarified that Waters Edge internal union is a recognized bargaining unit and there would be a process that would be initiated if they wanted to join another union. Director McCormick asked about the possibility of moving subacute beds to Waters Edge. Ms. Stebbins replied that she did not recommend doing so this time.<br>Ms. Surber presented the revised financial pro formas as presented. She also distributed a memo on the financial contributions of South Shore Skilled Nursing | |

| Topic | Discussion | Action / Follow-Up |
|---|---|---|
| | Facility as follow-up at the Board's request. The base scenario was updated to reflect an increase in other operating expenses related to additional hospital support services, the changes in Medi-Cal reimbursement rates and additional start-up costs. The adjusted contribution margin in year 1 changed to $1,520,000 and in Year 2 to $2,377,000.<br>Director Chen expressed that he was convinced that the sublease was in the best interest of the Hospital. Director Gorelick expressed his concern about the financial pro formas and the early termination clause in the sublease agreement and stated that he could not support the proposed transaction. | |
| | 4) Approval of Resolution 2011-7I – Delegation of Authority to On-Site SNF Manager | Director McCormick made a motion to approve the resolution as presented. Director Chen seconded the motion, the motion carried with one abstention |
| C. | President's Report<br>Director Battani reported that the annual CEO evaluation is still in progress and will be completed in November. She also reported that she spoke on behalf of the Board at a League of Women Voters Forum in October. | No action taken. |
| D. | Chief Executive Officer's Report | |
| | 1) FY Ending June 30, 2011 Goals and Objectives Update (Year End) | Agenda item was deferred to the next Board Meeting in the interest of time. |
| | 2) Organizational Structure<br>Ms. Stebbins distributed an updated organizational chart and reviewed the changes. | No action taken. |
| | 3) Legislative Update<br>Ms. Stebbins reported that she continues to meet with Alameda County officials and leaders to keep them informed about the District and Hospital. | No action taken. |
| | 3) Monthly Volume Statistics<br>Ms. Stebbins reviewed the monthly statistics | Agenda item was deferred in the interest of time. |

| | October | October | % Δ compared | % Δ | September |
|---|---|---|---|---|---|

| Topic | Discussion | Action / Follow-Up |
|---|---|---|

| | Preliminary | Budget | to Budget | compared to September | Actual |
|---|---|---|---|---|---|
| Average Daily Census | 83.55 | 83.84 | -0.3% | 4.7% | 79.83 |
| Acute | 30.03 | 29.61 | 1.4% | 10.1% | 27.27 |
| Subacute | 32.97 | 33.00 | -0.1% | 2.6% | 32.13 |
| South Shore | 20.55 | 21.23 | -3.2% | 0.6% | 20.43 |
| Patient Days | 2,590 | 2,599 | -0.3% | 8.1% | 2,395 |
| ER Visits | 1,407 | 1,426 | -1.3% | 1.9% | 1,381 |
| OP Registrations | 1,800 | 2,051 | -12.2% | 3.0% | 1,748 |
| Total Surgeries | 166 | 221 | -24.9% | -21.3% | 211 |
| Inpatient Surgeries | 33 | 44 | -25.0% | -10.8% | 37 |
| Outpatient Surgeries | 133 | 177 | -24.9% | -23.6% | 174 |
| Case Mix Index | 1.1633 | | | | 1.2265 |

4) Monthly Quality Metrics — No action taken.

a) HCAHPS (Hospital Consumer Assessment of Healthcare Provider and Systems)

Louise Nakada, Director of Community Relations presented the monthly quality metric of the hospital's HCAHPS scores as presented in the packet.

5) Hospital Updates / Events — No action taken.

No additional updates were given.

G. Community Relations and Outreach Report — No action taken.

Director Chen provided an update on the last committee meeting that occurred on October 25, 2011 noting that the Ms.Stebbins provided an update on the 2011 Fiancial results, the hospital's investment in the future with the radiology upgrades, the Joint Commission stroke certification, wound care center, and the Waters Edge partnership. He reported that the next committee meeting would be held on November 15, 2011. He also reported on the following community outreach activities: \

- A Stroke Risk Assessment was held on September 29, the day before the Joint Commission Stroke Survey. Approximately 45 people attended the assessment.
- The Alameda Hospital Foundation's Annual Fall Gala: "Ocean's 11" was held at the Claremont Country Club on October 1st. Approximately 150 people attend
- Community Health Fair was held on Saturday, October 22 from 9 a.m. - 12:30 p.m. and was very well attended. Over 350 flu shots were given.
- A direct mail postcard highlighting the advances in diagnostic imaging hit

| Topic | | Discussion | Action / Follow-Up |
|---|---|---|---|
| | | mailboxes the week of October 10th | |
| VII. | General Public Comments | | |
| VIII. | Board Comments | | |
| IX. | Adjournment | Being no further business, the meeting was adjourned at 10:47 p.m. | |

Attest:

Jordan Battani
President

Elliott Gorelick
Secretary

Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

# Minutes of the Board of Directors

November 11, 2011
SPECIAL MEETING
2 East Board Room – Alameda Hospital

| **Directors Present:** | | | **Legal Counsel Present:** | **Medical Staff:** | **Excused:** |
|---|---|---|---|---|---|
| Jordan Battani | Robert Deutsch, MD | J. Michael McCormick | Thomas Driscoll, Esq. | James Yeh, DO | N/A |
| Stewart Chen, DC | Elliott Gorelick | | | **Submitted by:** | **Management:** |
| | | | | Kristen Thorson | N/A |

| Topic | Discussion | Action / Follow-Up |
|---|---|---|
| I. Call to Order | Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 7:05 p.m. | |
| II. Roll Call | Kristen Thorson called roll, noting that a quorum of Directors were present. | |
| III. Closed Session Agenda | The meeting was adjourned into Executive Closed Session at 7:06 p.m. | |
| IV. Reconvene to Public Session | The meeting was reconvened into public session at 8:28 p.m.<br>A. Announcements from Closed Session | Director Battani reported that there was no action taken in closed session. |
| X. Board Comments | None | |
| VI. General Public Comments | None | |
| XII. Adjournment | A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 8:29 p.m. | |

Attest:

Jordan Battani
President

Elliott Gorelick
Secretary

# THE CITY OF ALAMEDA HEALTH CARE DISTRICT

# ALAMEDA HOSPITAL

## UNAUDITED FINANCIAL STATEMENTS

**FOR THE PERIOD ENDING OCTOBER 31, 2011**

# CITY OF ALAMEDA HEALTH CARE DISTRICT
# ALAMEDA HOSPITAL
# OCTOBER 31, 2011

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# ALAMEDA HOSPITAL
# MANAGEMENT DISCUSSION AND ANALYSIS
### OCTOBER, 2011

The management of 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 October 31, 2011 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 October, 2011*

- For the month of October 2011, combined revenue over expense is $271,000 versus a budgeted excess of revenue over expense of $122,000. This gain was the result of a positive adjustment of $815,000 related to AB 97 long term care rate reduction reserves, partially offset by a negative adjustment of $502,000 to update Inter-Governmental Transfer (IGT) revenue accruals. Year-to-date (YTD), the hospital had a combined loss of ($314,000) compared to a budget of excess revenues over expenses of $316,000. See schedule on Page 18 for detail of the impact of the adjustments and a roll forward from the October actual to adjusted results.

- Gross patient revenue for October was less than budget by $1.3 million or 5.9%. Inpatient revenue was unfavorable to budget by $477,000 (3.2%), and the outpatient programs were also unfavorable by another $864,000 (11.4%). On a year-to-date basis, gross revenue is below budget by $3.7 million (4.2%), $2.1 million (3.5%) related to inpatient and $1.6 million (5.5%) related to outpatient. The gross patient revenue Per Adjusted Patient Day (PAPD) of $5,645 was 2.8% below the budget of $5,809 and 3% below September results of $5,821.

- Patient days, while below budget, are ahead of last year's volumes. Total patient days for the month were 2,590, only .3% below the budget of 2,599, and YTD days of 10,231 are 115 days (1.1%) under budget. However, these figures represent an increase from the prior month of 2,395 and prior year's October of 2,465 total patient days as well as up from October 2010 YTD of 10,016.

- The average daily acute care census was 30.03, favorable to a budget of 29.61 by .43 ADC, and a significant increase over the 27.27 in the prior month; the average daily Sub-Acute census was 32.97 almost at budget of 33.0, and the Skilled Nursing program had an average daily census of 20.55 versus a budget of 21. Year-to-date ADC is 1.7% below the budget of 84.11 at 83.18, but still 1.75 ADC (2.2%) above the 2010 YTD ADC of 81.43.

- Emergency Care Center (ECC) visits were 1,407, 19 visits (1.3%) under the budget of 1,426 visits. YTD, the ECC visits are 25 below the budget.

- Total surgery cases were less than budgeted expectations by 24.9% for the month at 166 cases versus the budgeted 221 cases, inpatient cases were 11 (25%) under budget while outpatient cases were 44 (24.9%) under budget. Year-to-date surgery cases were 807 or 4.1% above the budget of 775, and above prior YTD of 793.

- Outpatient registrations were 1,800, or 12.2% below budget but 52 or 3% above prior month. However, the average of 58.1 visits per day was even with the prior month's 58.3 visits per day. YTD outpatient registrations are below budget by 10.1% at 7,239 versus the budget of 8,049. The outpatient visits were below budget in Radiology (71 visits), IVT Therapy (18 visits) and Occupational Therapy (26 visits), yet over budget in Ultrasound (28 visits).

## *Balance Sheet*

Total assets decreased by $388,000 from the prior month, nearly all of which was in current assets. The following items make up the increase in current assets:

- Total unrestricted cash and cash equivalents for October decreased by $68,000 and days cash on hand

including restricted use funds decreased to 9.5 days on hand in October from 9.7 days on hand in September. The decrease in cash was the result of below budget cash collections, increased accounts receivable and decreased payroll liabilities partially offset by an increase in accounts payable.

- Net patient accounts receivable increased in October by $288,000 compared to an increase of $203,000 in September. Days in outstanding receivables were 57.9 at October month end, an increase from 56.5 days in September. Collections in October were $4.4 million compared to $4.6 million in September.

- Other Receivables decreased by $806,000 from September to October due to the impact of the IGT adjustment ($502,000 decrease) and the posting of a $300,000 audit adjustment to reduce the balance carried forward from the prior fiscal year.

Total liabilities decreased by $512,000 compared to a decrease of $330,000 in the prior month. This decrease in the current month was the result of the following:

- Third party settlement accounts decreased by $830,000, due primarily to the reversal of $815,000 of reserves related to the AB 97 rate reduction for Sub-Acute days. This rate reduction had been reserved for all Sub-Acute days between June 2011 and September 2011 and was therefore over reserved by 24% as the Sub-Acute unit was budgeted at 76% Medi-Cal utilization.

- Payroll related accruals decreased by $142,000 as a result of the timing of unpaid payroll taxes at the end of the prior month.

- Deferred revenues decreased again by $477,000 due to the recognition of one-twelfth of the 2011/2012 parcel tax revenues of $5.7 million.

- The current portion of the long term debt increased $231,000 due to $250,000 in draws on the line of credit. At month end $750,000 of the board approved $750,000 had been drawn down.

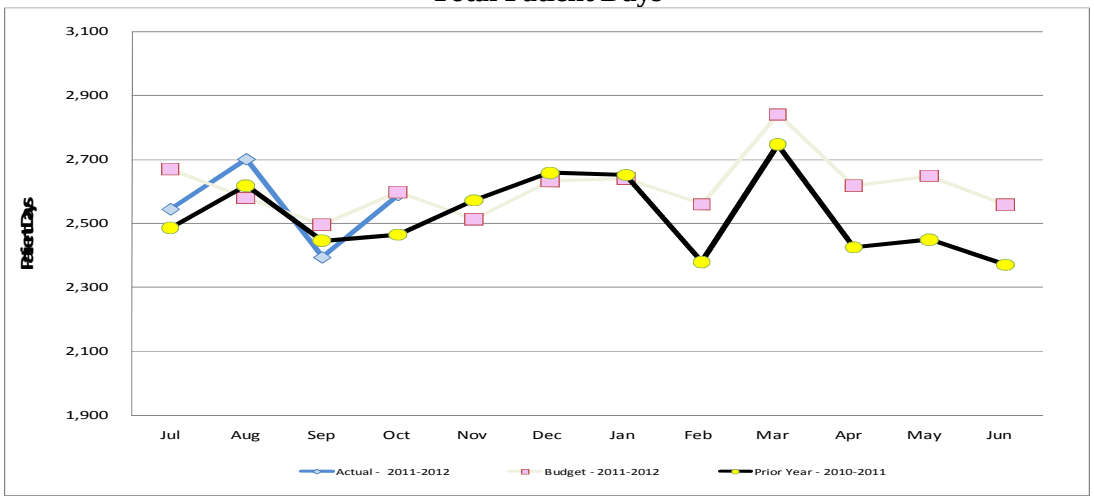
- Accounts payable and other accrued expenses increased $643,000 as vendor payments were delayed due to low cash collections.

### *Volumes*

The combined actual average daily census was 83.55 versus a budget of 83.84 or an unfavorable variance of only .4%. The current month's overall unfavorable variance was the result of average daily census that was favorable to budget in the acute care areas by .43 patients per day or 1.5%. The Sub-Acute program average daily census was also even with budget, while the Skilled Nursing program had a negative variance to budget of .7 patients per day or 3.3%. October's total census represents a 4.7% increase from the September's average census levels.

The graph on the next page shows the total patient days by month for fiscal year 2012 compared to the operating budget and fiscal year 2011 actual.

**Total Patient Days**

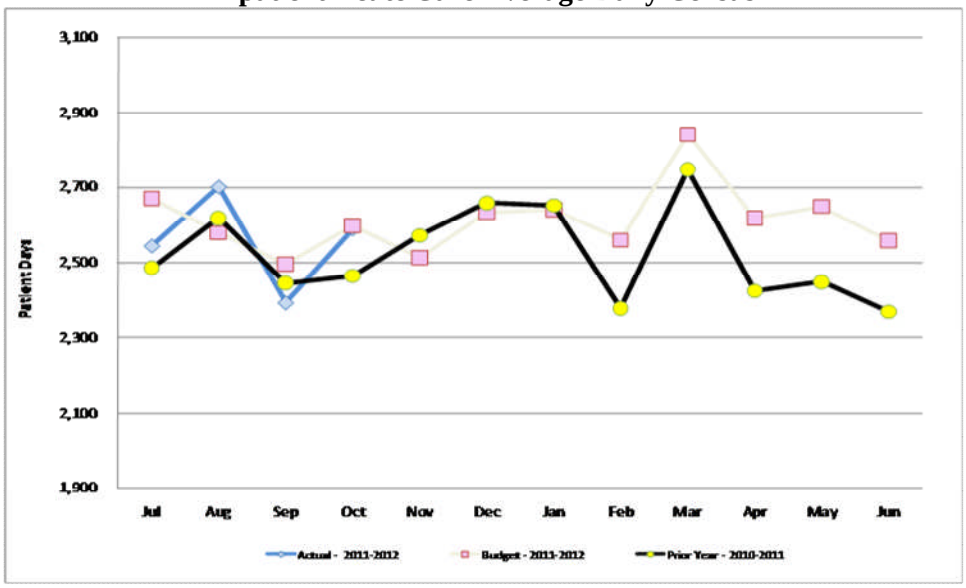



The various components of our inpatient volumes for the month of October are discussed in the following sections.

## Acute Care

The acute care patient days were 1.4% (13 days) more than budgeted and 22% above the prior year's average daily census of 24.55 for October. The acute care program is comprised of the Critical Care Unit (3.2 ADC, 25.6% unfavorable to budget), Definitive Observation Unit (12 ADC, 5.7% above budget) and Med/Surg Units (14.8 ADC, 6.2% favorable to budget). The graph below shows the inpatient acute care census by month for the current fiscal year, the operating budget and prior fiscal year actual.

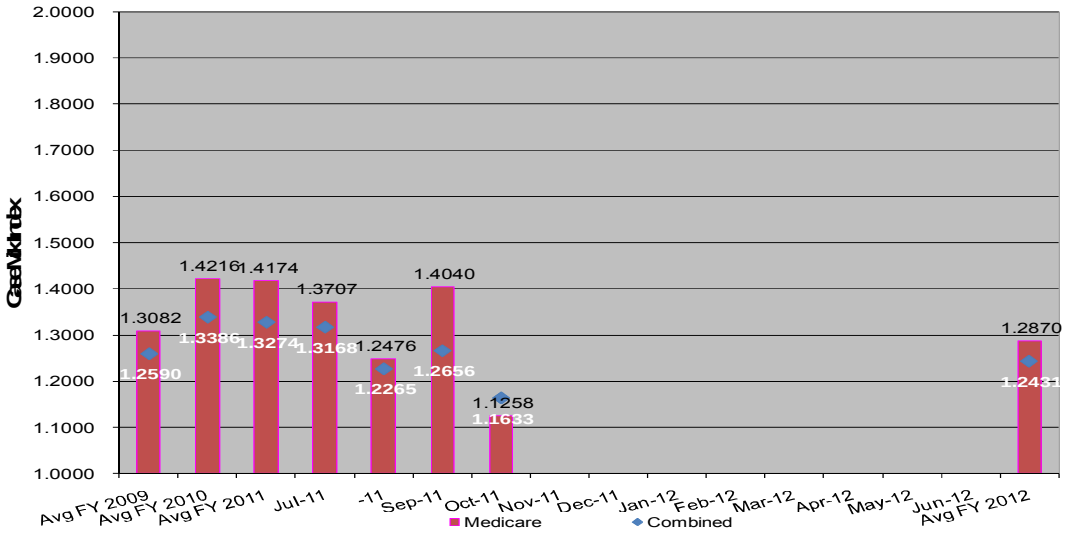
**Inpatient Acute Care Average Daily Census**




### *Case Mix Index*

The hospital's overall Case Mix Index (CMI) decreased to 1.1633, down from the prior month of 1.2655, and below the prior fiscal year average of 1.3274. The Medicare CMI decreased from 1.4040 in September to 1.1258 in October. The graph below shows the CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

**Case Mix Index Trend**



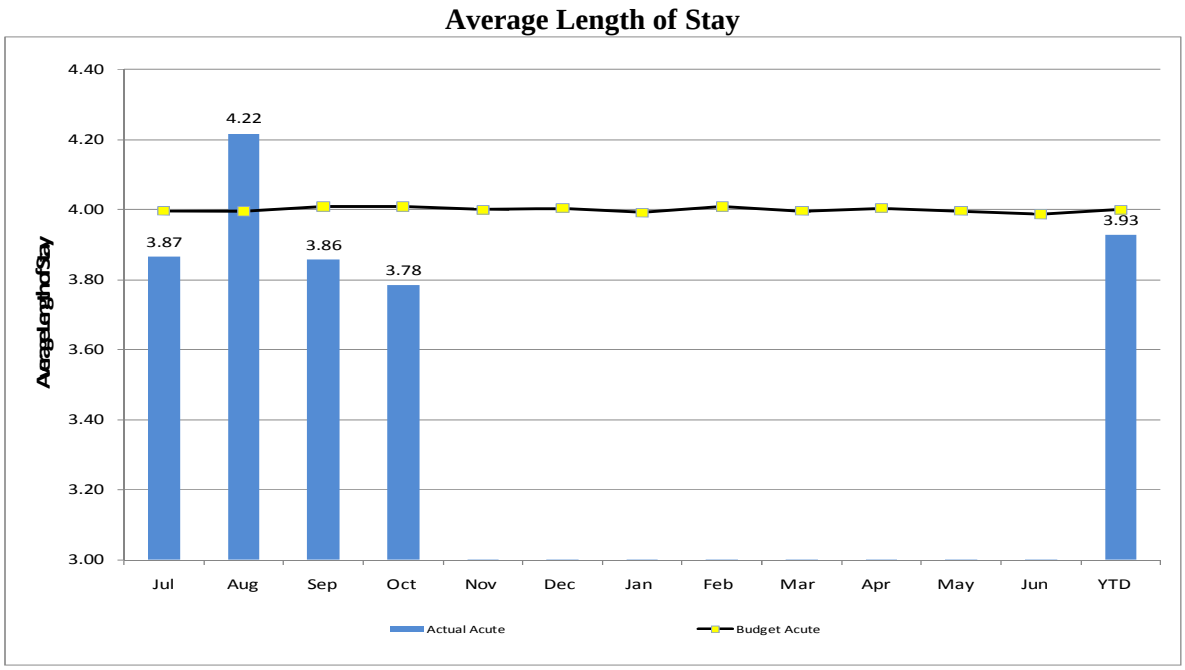

The CMI at the time of forecasting this year's budget, June 2010 through March 2011, the combined CMI was 1.3758. Comparing the first quarter of last year versus the first four months of this year, the average CMI has dropped from 1.3793 in July - October 2010 to 1.2456 in July – October 2011, or a 9.7% decline. Note that payers with lower volume can have substantial swings in CMI from one period to another. See the table below that compares the CMI by payer for the three periods.

**Case Mix Index Comparison**

| Financial Class | Jun 10 - Mar 11 | Oct 10 YTD | Oct 11 YTD | Oct 11 YTD Volume |
|---|---|---|---|---|
| Commercial - Non-Contracted | 1.9649 | 2.4050 | 0.6522 | 1 |
| HMO | 1.2522 | 1.1370 | 1.4596 | 47 |
| Industrial | 1.8373 | 0.8857 | 1.8162 | 4 |
| Kaiser | 1.8412 | 2.3422 | 1.2440 | 4 |
| Medi-Cal HMO | 1.0008 | 1.0060 | 1.0081 | 47 |
| Medi-Cal | 1.2724 | 1.1704 | 1.1098 | 68 |
| Medicare | 1.4724 | 1.4808 | 1.2869 | 476 |
| Medicare HMO | 1.3568 | 1.3456 | 1.3689 | 88 |
| Personal Pay | 1.0105 | 1.1010 | 1.0215 | 56 |
| Medi-Cal Pending | 1.8334 | 3.1061 | 2.0751 | 4 |
| PPO | 1.2613 | 1.3628 | 1.0922 | 92 |
| VA | 1.4051 | 1.3381 | 1.3454 | 15 |
| | | | | |
| **Combined** | **1.3758** | **1.3793** | **1.2456** | 902 |

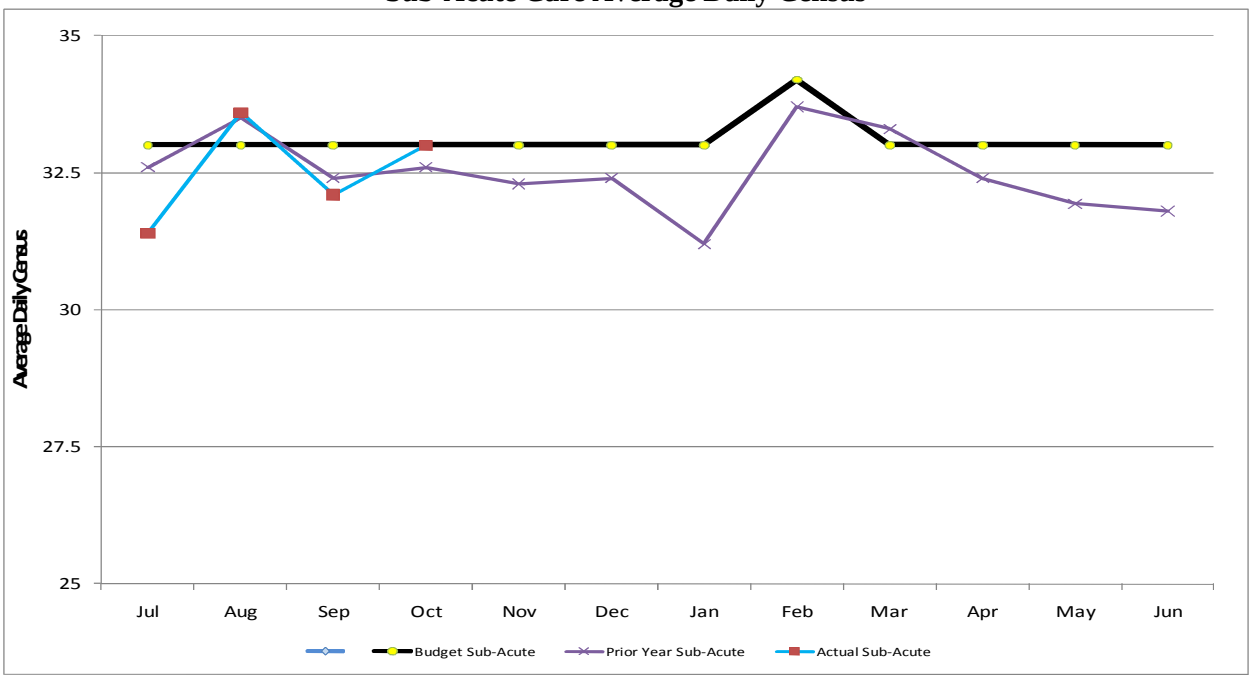
### *Average Length of Stay - Acute*

The acute average length of stay (ALOS) decreased from the September low of 3.86 to 3.78 in October, which is also below October in the prior year of 3.98. Budgeted acute ALOS is 4.0. The overall acute ALOS for FY 2011 was 4.13. The graph below shows the ALOS by month and the budgeted ALOS for fiscal year 2012.




## Sub-Acute Care

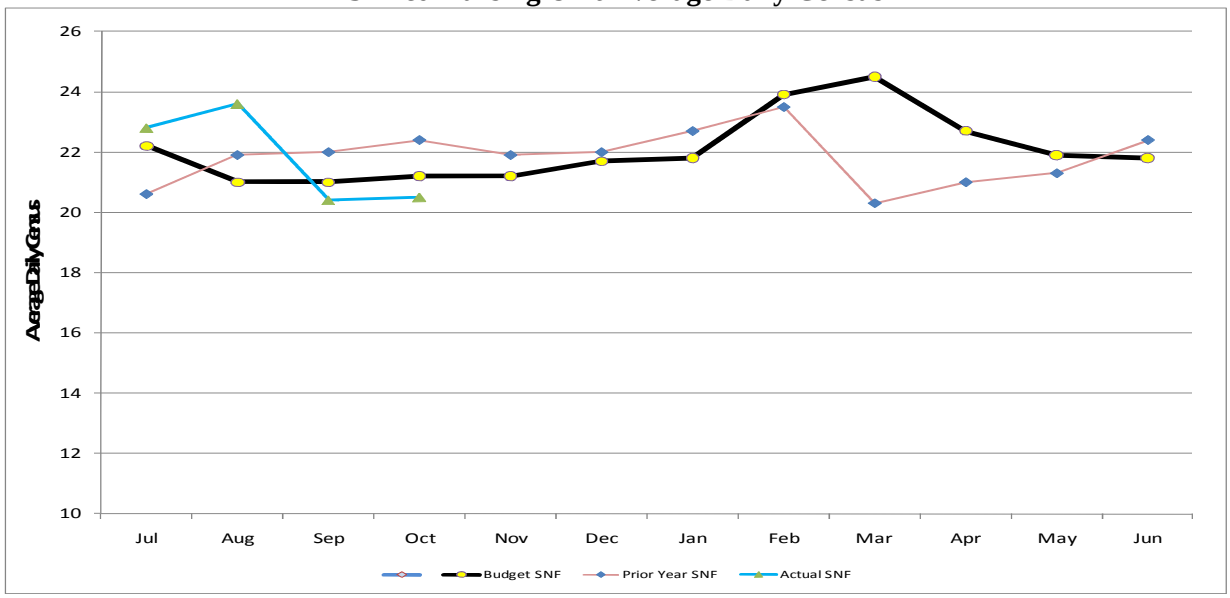
The Sub-Acute program average daily census of 33.0 in October was at budgeted projections of 33.0. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.



## Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were 3.2% or 21 patient days lower than budgeted for the month of October, but up 24 days or 3.9% from September. This program's volume remains greater than the prior year-to date, with October 2011 year-to-date patient days higher than October 2010 year-to-date by 15 days or .56% and a year-to-date average daily census of 21.72 versus 21.85 in fiscal year 2011. The following graph shows the Skilled Nursing Unit monthly average daily census as compared to budget and the prior year.

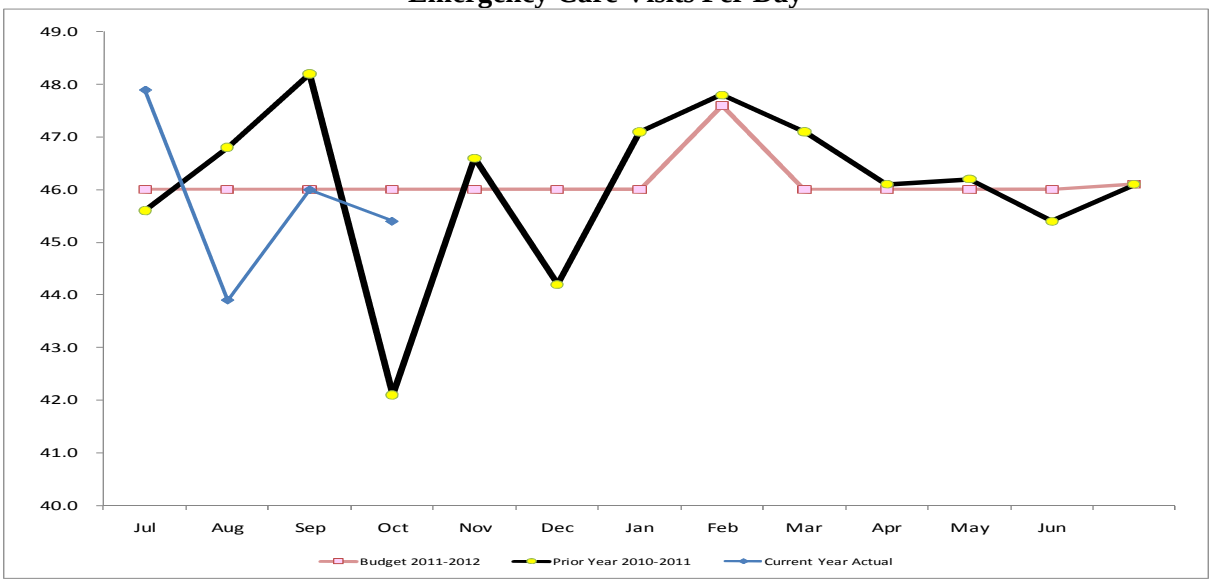
**Skilled Nursing Unit Average Daily Census**




## Emergency Care Center (ECC)

Emergency Care Center visits in October totaled 1,407, 19 visits (1.3%) under the budget of 1,426. 17.5% of these visits resulted in inpatient admissions versus 16.3% in September. On a per day basis, the total visits represent a decrease of 1.3% from the prior month daily average. In October, there were 332 ambulance arrivals versus 308 in the prior month. Of the 332 ambulance arrivals in the current month, 209 or 62.95% were from Alameda Fire Department (AFD) ambulances.

**Emergency Care Visits Per Day**

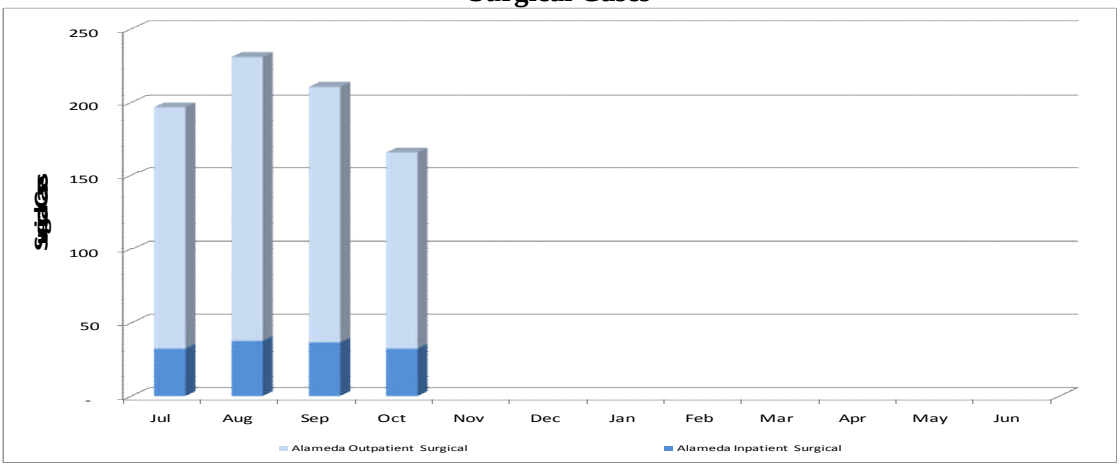


## Surgery

In October, surgery cases were 166 versus 221 budgeted cases and 215 cases in the prior October. Surgery volume was considerably lower than September. Inpatient and outpatient cases totaled 33 and 133 versus 39 and 174 in October and September, respectively. Surgeries were down in October due to the Operating Room being closed for two Mondays, in addition to doctor illness and conflicts making it necessary for surgeons to cancel surgery block time.

The graph below shows the number of inpatient and outpatient surgical cases by month for fiscal year 2012.

**Surgical Cases**

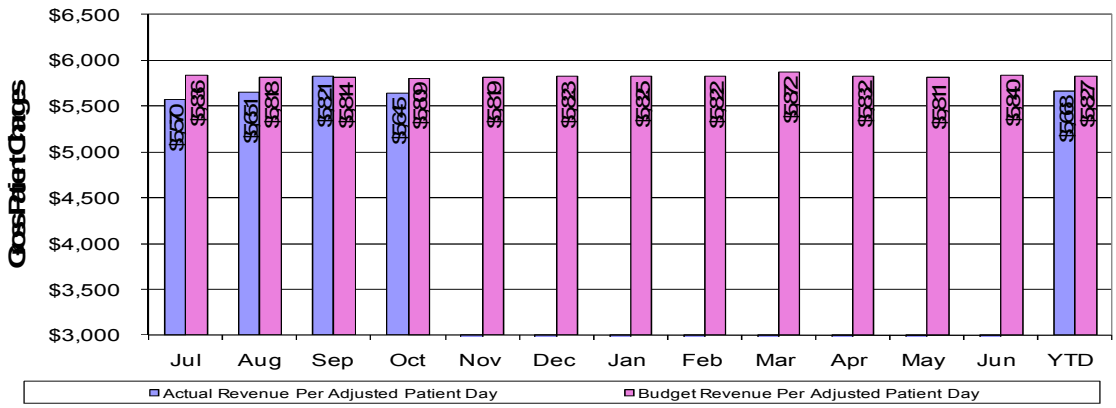



# *Income Statement*

### *Gross Patient Charges*

Gross patient charges in October were less than budget by $1.3 million, or 5.9%, mostly driven by lower outpatient surgeries and other outpatient volumes. This unfavorable variance was comprised of an unfavorable variance to inpatient of $477,000 and unfavorable variance to outpatient of $864,000. The decrease in inpatient gross revenues was driven by lower volume in Acute Care, primarily CCU which was closed for part of the month, as well as inpatient surgery. Outpatient revenues were lower than budgeted as a result of lower than expected outpatient registrations (12.2%) as well as lower outpatient surgeries. On an adjusted patient day basis, total patient revenue was $5,645 below the budget of $5,809 for the month of October and below the September gross revenue per APD of $5,821. In addition, clinical laboratory, emergency care and some of the imaging services were below budget for the month, while the acute 3 West and Telemetry units were above budget. The following table shows the hospital's monthly gross revenue per adjusted patient day by month and year-to-date for fiscal year 2012 compared to budget.

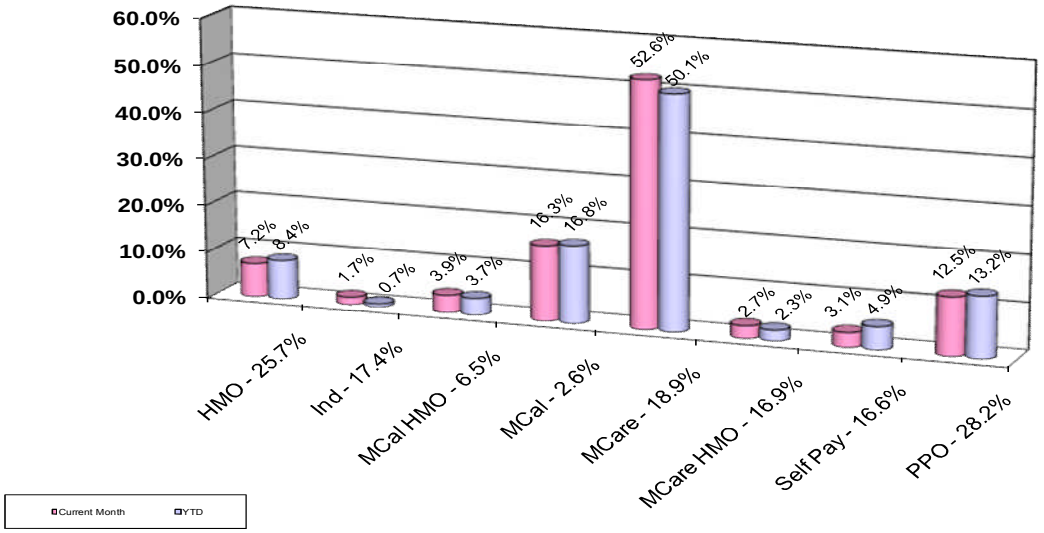
**Gross Charges per Adjusted Patient Day**



## *Payer Mix*

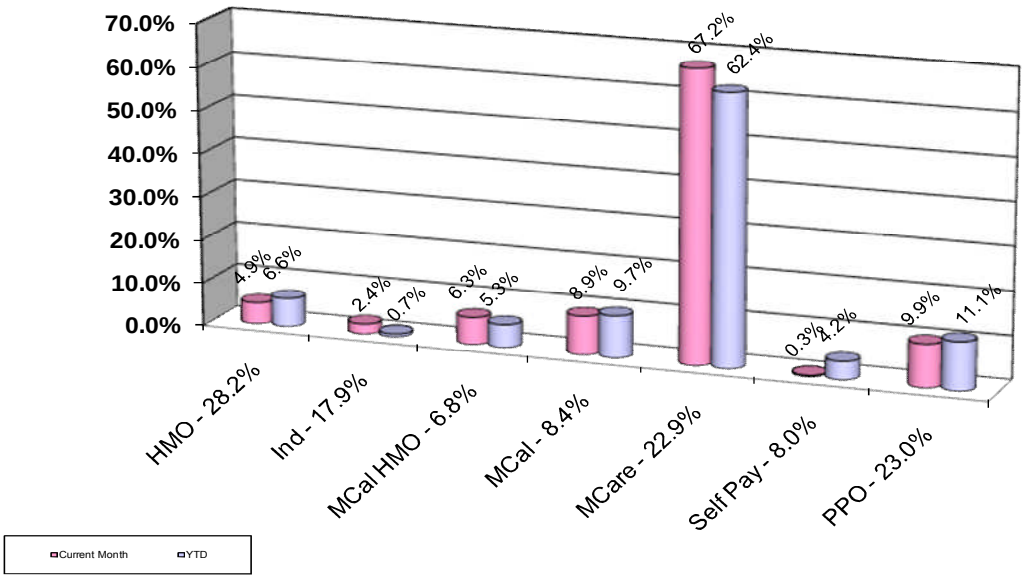
*Combined acute care services, inpatient and outpatient,* Medicare and Medicare Advantage total gross revenue in September made up 55.3% of the month's total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 19.7%, Medi-Cal Traditional and Medi-Cal HMO utilization at 20.2% and self pay at 3.1%. The graph on the following page shows the percentage of gross revenues generated by each of the major payers for the current month and fiscal year to date as well as the current month's estimated reimbursement for each payer for the combined inpatient and outpatient acute care services.

**Combined Acute Care Services Payer Mix**



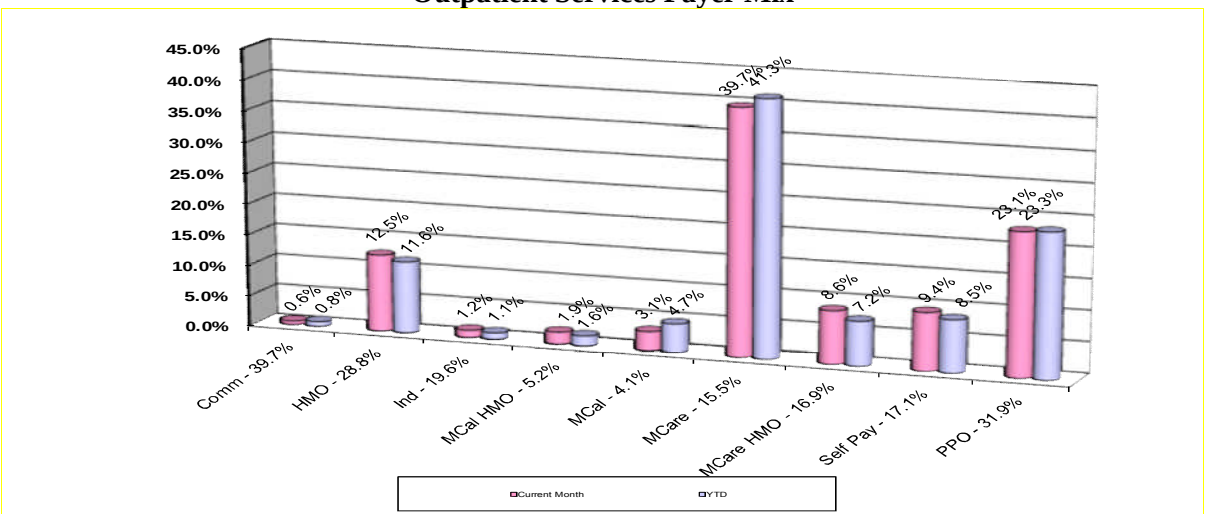

The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 67.2% of our total inpatient acute care gross revenues followed by HMO/PPO at 14.8%, Medi-Cal and Medi-Cal HMO at 15.2% and Self Pay at .3% of the inpatient acute care revenue. The graph below shows inpatient acute care current month and year to date payer mix and current month estimated net revenue percentages for fiscal year 2012.

**Inpatient Acute Care Payer**



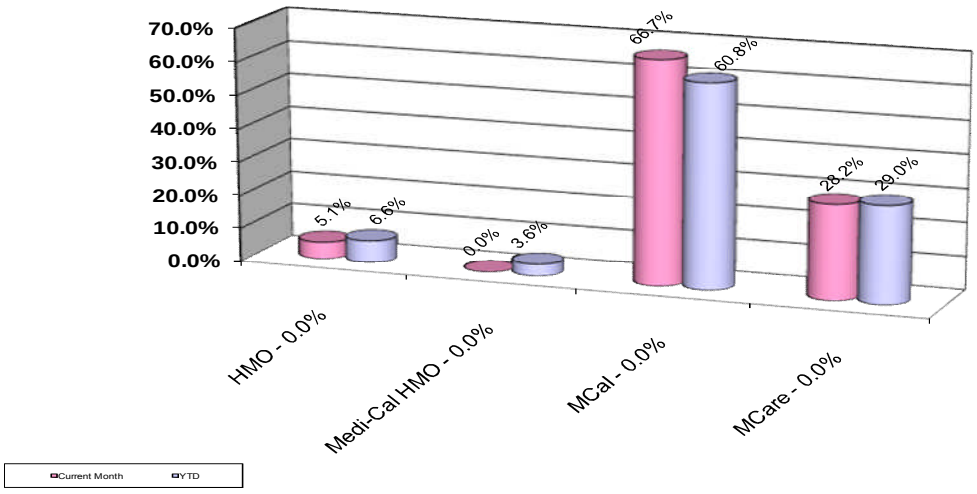
The outpatient gross revenue payer mix for October was comprised of 48.3% Medicare and Medicare Advantage, 36.2% HMO/PPO, 5.0% Medi-Cal and Medi-Cal HMO, and 9.4% self pay. The graph below shows the current month and fiscal year to date outpatient payer mix and the current months estimated level of reimbursement for each payer.

**Outpatient Services Payer Mix**



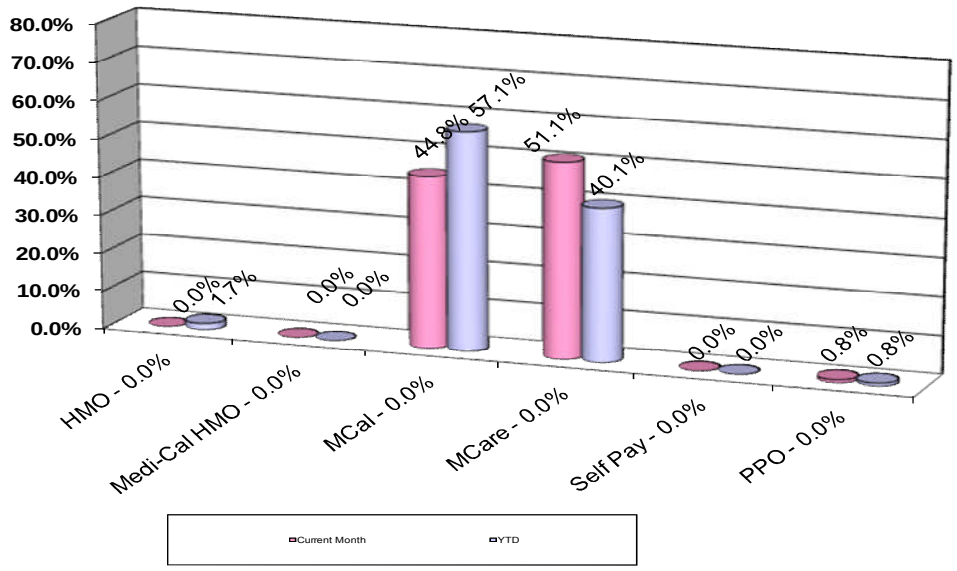

In October, the Sub-Acute care program again was dominated by Medi-Cal utilization of 66.7%, up from 62.8% in September. One anomaly in long term care patients is they are registered as Medicare, usually exhaust their benefits and transition to Medi-Cal. However, the financial class is not changed on the patient causing a mis-match when charges are billed and payments are received. Medicare was 28.2% and HMO/PPO rounds out the unit at 5.1%. The graph below shows the payer mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payer.

**Inpatient Sub-Acute Care Payer Mix**



In October, the Skilled Nursing program gross revenues were comprised primarily of Medicare at 51.1% and Medi-Cal at 44.8%. The graph below shows the current month and fiscal year to date skilled nursing payer mix and the current month's estimated level of reimbursement for each payer. It should be noted that even though the payor mix reflects 51.1% Medicare, most of these patients have exhausted their long-term care Medicare benefits and are Part B only, converting to Med-Cal benefits for skilled nursing days. These days will, therefore, be paid by Medi-Cal. We are reviewing the registration and billing procedures to better align revenues with payments by payor.

**Inpatient Skilled Nursing Payer 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 October contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 75.2% versus the budgeted 77.6%. The positive contractual percent to budget is the major contributor in this month's positive bottom line and is due primarily to the favorable adjustment to reverse the AB 97 Medi-Cal rate reduction reserve for Sub-Acute days. The AB 97 reserve is now calculated for SNF days only and $201,000 is reserved for June through October. There will be an ongoing favorable variance of roughly $150,000 per month for the Sub-Acute reserve that is included in the budget deductions from revenue but not in actual results.

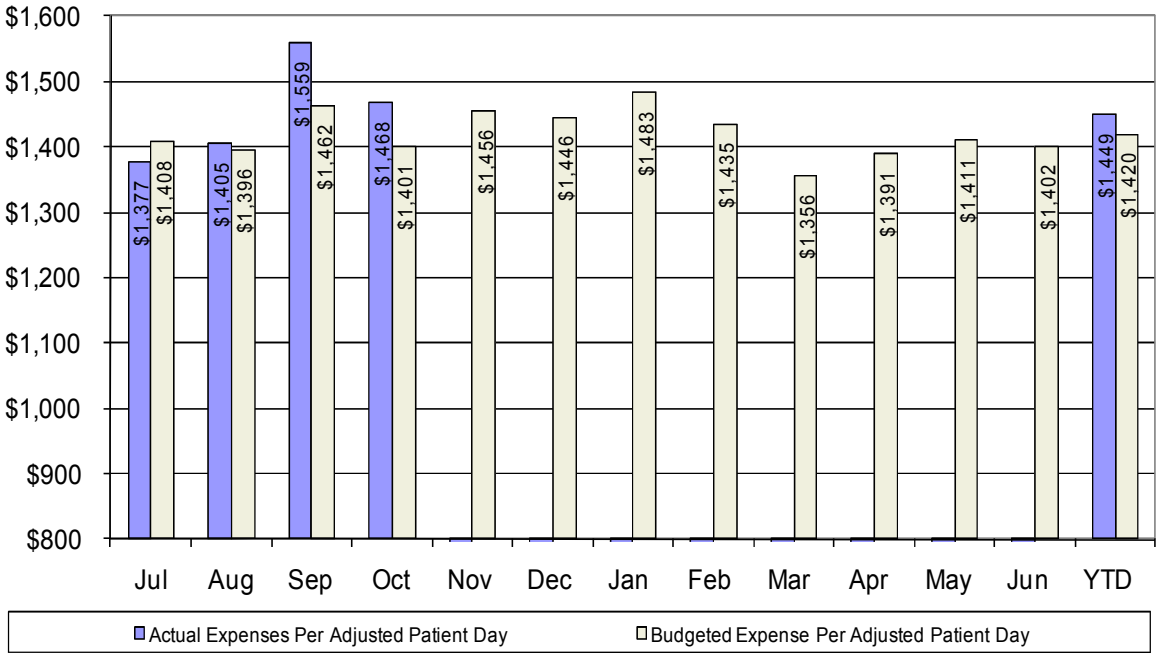
### *Net Patient Service Revenue*

Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. In addition, current month and year to date net patient service revenues include estimates for payments from the State of California's FY 2011 Intergovernmental Transfer (IGT) Program. The IGT revenue is estimated at $53,000 per month and is $212,000 year to date. This revenue had been accrued at the rate of $93,000 per month through September; however, the accrual calculation was updated in October based on information recently regarding the payment methodology. This resulted in an unfavorable adjustment of $502,000 to net revenue in October.

### *Total Operating Expenses*

Total operating expenses were higher than the fixed budget by $78,000 or 1.4%. On an adjusted patient day basis, our cost per adjusted patient day was $1,468 which was $67 per adjusted patient day unfavorable to budget but $91 lower than the prior month. This variance in expenses per adjusted patient day was primarily the result of unfavorable variances in salaries, benefits as well as non-medical professional fees due to consulting fee accruals. The graph on the following page shows the actual hospital operating expenses on an adjusted patient day basis for the 2012 fiscal year by month as compared to budget and is followed by explanations of the significant areas of variance that were experienced in the current month.

**Expenses per Adjusted Patient Day**

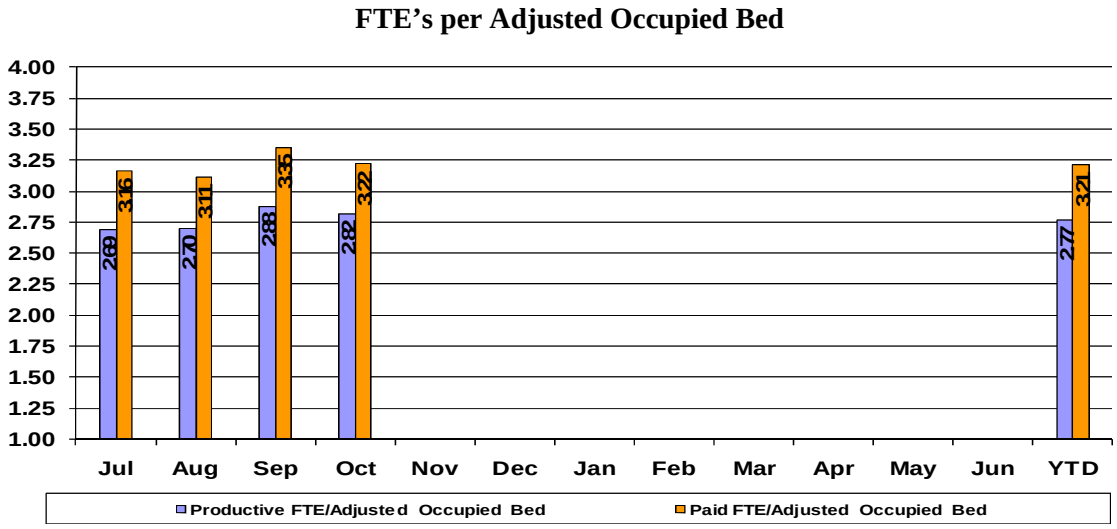



### *Salary and Temporary Agency Expenses*

Salary and temporary agency costs combined were unfavorable to the fixed budget by $49,000 and were unfavorable to budgeted levels on a per adjusted patient day (PAPD) basis by $39 or 4.9%. On an adjusted occupied bed basis, productive FTE's were 2.82, above the budget of 2.73 FTE's and paid FTE's were 3.22 or 3.0% above budget.

Productive salaries per patient day in the CCU were 5% above budget, productive salaries per patient day in the DOU were 23.8% above budget, and productive salaries in Sub-Acute were 3.1% above budget on a per patient day basis. Salaries per visit in the Emergency Care Center were again above budget 17.8% while the volume in the ECC was slightly below budget.

The graph on the next page shows the productive and paid FTE's per adjusted occupied bed for FY 2012 by month.




### *Benefits*

Benefits were unfavorable to the fixed budget by $57,000 or 7.2%, due to final Worker's Comp audit payment of $40,708 for FY 2011, plus final payments for vacation benefit to terminated employees of $49,000.

### *Professional Fees*

Professional fees were unfavorable to budget by $135,000 in October due to Revenue Cycle assessment from June – September $54,000, PHM fees for Water's Edge project $10,000, Joint Commission fee for primary stroke center $8,000. HFS fees for Accounting, Business Office and Pharmacy were $15,000.

### *Supplies*

Supplies were favorable to budget by $198,000 (25.2%) or $46 per adjusted patient day in October. As in prior months, this favorable variance was the result of lower than budgeted patient related supplies such as medical supplies expense, pharmacy supplies, and prosthetics due to lower patient volume, acuity and below budget surgeries.

### *Purchased Services*

Purchased services were below budget by $32,000 compared to fixed budget and $6 favorable PAPD.

### *Rents and Leases*

Rents and leases were below the fixed budget by $5,000, and $21 PAPD in October, versus budget of $22.

### *Other Operating Expense*

Other operating expenses were $58,000 over budget due primarily to $37,000 in license fees issued to California Department of Public Health in preparation for the Water's Edge change of ownership application.

The following pages include the detailed financial statements for the four (4) months ended October 31, 2011, of fiscal year 2012.

# ALAMEDA HOSPITAL
## KEY STATISTICS
## OCTOBER 2011

| | ACTUAL OCTOBER 2011 | CURRENT FIXED BUDGET | VARIANCE (UNDER) OVER | % | OCTOBER 2010 | YTD OCTOBER 2011 | YTD FIXED BUDGET | VARIANCE | % | YTD OCTOBER 2010 |
|---|---|---|---|---|---|---|---|---|---|---|
| ***Discharges:*** | | | | | | | | | | |
| Total Acute | 246 | 229 | 17 | 7.4% | 191 | 902 | 915 | (13) | -1.4% | 800 |
| Total Sub-Acute | 2 | 2 | - | 0.0% | 1 | 9 | 6 | 3 | 50.0% | 6 |
| Total Skilled Nursing | 8 | 9 | (1) | -11.1% | 7 | 26 | 35 | (9) | -25.7% | 35 |
| | 256 | 240 | 16 | 6.7% | 199 | 937 | 956 | (19) | -2.0% | 841 |
| ***Patient Days:*** | | | | | | | | | | |
| Total Acute | 931 | 918 | 13 | 1.4% | 761 | 3,543 | 3,662 | (119) | -3.2% | 3,313 |
| Total Sub-Acute | 1,022 | 1,023 | (1) | -0.1% | 1,010 | 4,001 | 4,059 | (58) | -1.4% | 4,031 |
| Total Skilled Nursing | 637 | 658 | (21) | -3.2% | 694 | 2,687 | 2,625 | 62 | 2.4% | 2,672 |
| | 2,590 | 2,599 | (9) | -0.3% | 2,465 | 10,231 | 10,346 | (115) | -1.1% | 10,016 |
| ***Average Length of Stay*** | | | | | | | | | | |
| Total Acute | 3.78 | 4.01 | (0.22) | -5.6% | 3.98 | 3.93 | 4.00 | (0.07) | -1.9% | 4.14 |
| ***Average Daily Census*** | | | | | | | | | | |
| Total Acute | 30.03 | 29.61 | 0.43 | 1.5% | 24.55 | 28.80 | 29.77 | (0.97) | -3.2% | 26.93 |
| Total Sub-Acute | 32.97 | 33.00 | (0.03) | -0.1% | 32.58 | 32.53 | 33.00 | (0.47) | -1.4% | 32.77 |
| Total Skilled Nursing | 20.55 | 21.23 | (0.70) | -3.3% | 22.39 | 21.85 | 21.34 | 0.50 | 2.4% | 21.72 |
| | 83.55 | 83.84 | (0.30) | -0.4% | 79.52 | 83.18 | 84.11 | (1.44) | -1.7% | 81.43 |
| ***Emergency Room Visits*** | 1,407 | 1,426 | (19) | -1.3% | 1,306 | 5,633 | 5,658 | (25) | -0.4% | 5,616 |
| ***Outpatient Registrations*** | 1,800 | 2,051 | (251) | -12.2% | 2,032 | 7,239 | 8,049 | (810) | -10.1% | 7,970 |
| ***Surgery Cases:*** | | | | | | | | | | |
| Inpatient | 33 | 44 | (11) | -25.0% | 38 | 143 | 173 | (30) | -17.3% | 191 |
| Outpatient | 133 | 177 | (44) | -24.9% | 177 | 664 | 602 | 62 | 10.3% | 602 |
| | 166 | 221 | (55) | -24.9% | 215 | 807 | 775 | 32 | 4.1% | 793 |
| ***Adjusted Occupied Bed (AOB)*** | 121.83 | 126.16 | (4.33) | -3.4% | 125.46 | 122.45 | 125.53 | (3.08) | -2.5% | 123.72 |
| ***Productive FTE*** | 343.30 | 344.35 | (1.05) | -0.3% | 355.04 | 342.84 | 341.78 | 1.06 | 0.3% | 359.02 |
| ***Total FTE*** | 392.18 | 394.26 | (2.08) | -0.5% | 407.15 | 397.19 | 401.73 | (4.54) | -1.1% | 414.94 |
| ***Productive FTE/Adj. Occ. Bed*** | 2.82 | 2.73 | 0.09 | 3.2% | 2.83 | 2.80 | 2.72 | 0.08 | 2.8% | 2.90 |
| ***Total FTE/ Adj. Occ. Bed*** | 3.22 | 3.13 | 0.09 | 3.0% | 3.25 | 3.24 | 3.20 | 0.04 | 1.4% | 3.35 |

**City of Alameda Health Care District**
**Statements of Financial Position**
October 31, 2011

| | Current Month | Prior Month | Prior Year End |
|---|---|---|---|
| **Assets** | | | |
| Current Assets: | | | |
| Cash and Cash Equivalents | $ 874,083 | $ 941,631 | $ 1,802,225 |
| Patient Accounts Receivable, net | 8,943,459 | 8,655,232 | 7,249,185 |
| Other Receivables | 6,704,953 | 7,509,956 | 8,216,998 |
| Third-Party Payer Settlement Receivables | 481,578 | 360,158 | 278,580 |
| Inventories | 1,188,641 | 1,179,225 | 1,238,762 |
| Prepaids and Other | 336,680 | 319,472 | 262,359 |
| Total Current Assets | 18,529,394 | 18,965,674 | 19,048,109 |
| Assets Limited as to Use, net | 525,869 | 518,081 | 483,716 |
| **Fixed Assets** | | | |
| Land | 877,945 | 877,945 | 877,945 |
| Depreciable capital assets | 43,427,774 | 43,429,274 | 43,385,071 |
| Construction in progress | 3,265,416 | 3,163,020 | 2,921,048 |
| Depreciation | (39,149,362) | (39,088,895) | (38,862,494) |
| Property, Plant and Equipment, net | 8,421,773 | 8,381,344 | 8,321,570 |
| **Total Assets** | **$ 27,477,036** | **$ 27,865,099** | **$ 27,853,395** |
| **Liabilities and Net Assets** | | | |
| Current Liabilities: | | | |
| Current Portion of Long Term Debt | $ 1,389,472 | $ 1,158,483 | $ 711,784 |
| Accounts Payable and Accrued Expenses | 8,438,441 | 7,795,234 | 7,025,089 |
| Payroll Related Accruals | 3,568,689 | 3,710,336 | 4,003,695 |
| Deferred Revenue | 3,817,825 | 4,294,838 | 5,725,900 |
| Employee Health Related Accruals | 642,835 | 568,693 | 343,382 |
| Third-Party Payer Settlement Payable | 236,318 | 1,066,399 | 267,474 |
| Total Current Liabilities | 18,093,580 | 18,593,983 | 18,077,324 |
| Long Term Debt, net | 991,805 | 1,002,937 | 1,142,109 |
| Total Liabilities | 19,085,385 | 19,596,920 | 19,219,433 |
| Net Assets: | | | |
| Unrestricted | 7,695,783 | 7,522,521 | 8,022,670 |
| Temporarily Restricted | 695,869 | 745,657 | 611,292 |
| Total Net Assets | 8,391,652 | 8,268,178 | 8,633,962 |
| **Total Liabilities and Net Assets** | **$ 27,477,036** | **$ 27,865,099** | **$ 27,853,395** |

# City of Alameda Health Care District

**Statements of Operations**

October 31, 2011

$'s in thousands

| | Current Month | | | | | Year-to-Date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | $ Variance | % Variance | Prior Year | Actual | Budget | $ Variance | % Variance | Prior Year |
| Patient Days | 2,590 | 2,599 | (9) | -0.3% | 2,465 | 10,231 | 10,346 | (115) | -1.1% | 10,016 |
| Discharges | 256 | 240 | 16 | 6.7% | 199 | 937 | 956 | (19) | -2.0% | 841 |
| ALOS (Average Length of Stay) | 10.12 | 10.83 | (0.71) | -6.6% | 12.39 | 10.92 | 10.82 | 0.10 | 0.9% | 11.91 |
| ADC (Average Daily Census) | 83.5 | 83.8 | (0.29) | -0.3% | 79.5 | 83 | 84.1 | (0.93) | -1.1% | 81.4 |
| CMI (Case Mix Index) | 1.1633 | | | | 1.2866 | 1.3168 | | | | 1.3763 |
| Revenues | | | | | | | | | | |
| Gross Inpatient Revenues | $ 14,620 | $ 15,097 | $ (477) | -3.2% | $ 12,014 | $ 57,999 | $ 60,132 | $ (2,132) | -3.5% | $ 53,629 |
| Gross Outpatient Revenues | 6,699 | 7,563 | (864) | -11.4% | 7,000 | 27,889 | 29,500 | (1,611) | -5.5% | 27,958 |
| Total Gross Revenues | 21,319 | 22,660 | (1,341) | -5.9% | 19,014 | 85,888 | 89,632 | (3,744) | -4.2% | 81,587 |
| Contractual Deductions | 15,297 | 16,704 | 1,406 | 8.4% | 13,266 | 63,443 | 65,985 | 2,541 | 3.9% | 58,411 |
| Bad Debts | 740 | 709 | (32) | -4.5% | 649 | 2,317 | 2,837 | 520 | 18.3% | 2,523 |
| Charity and Other Adjustments | - | 170 | 170 | 100.0% | 113 | 760 | 682 | (78) | -11.4% | 609 |
| Net Patient Revenues | 5,281 | 5,077 | 204 | 4.0% | 4,986 | 19,367 | 20,128 | (760) | -3.8% | 20,044 |
| Net Patient Revenue % | 24.8% | 22.4% | | | 26.2% | 22.5% | 22.5% | | | 24.6% |
| Net Clinic Revenue | 32 | 23 | 9 | 40.2% | 9 | 130 | 44 | 86 | 195.4% | 120 |
| Other Operating Revenue | 10 | 10 | (0) | -0.4% | 10 | 192 | 40 | 152 | 376.4% | 37 |
| **Total Revenues** | **5,323** | **5,110** | **213** | 4.2% | **5,005** | **19,690** | **20,212** | **(522)** | -2.6% | **20,202** |
| Expenses | | | | | | | | | | |
| Salaries | 2,869 | 2,782 | (88) | -3.2% | 2,867 | 11,425 | 11,177 | (248) | -2.2% | 11,810 |
| Temporary Agency | 112 | 151 | 39 | 25.7% | 143 | 439 | 597 | 159 | 26.6% | 628 |
| Benefits | 846 | 789 | (57) | -7.2% | 850 | 3,472 | 3,173 | (298) | -9.4% | 2,985 |
| Professional Fees | 422 | 286 | (135) | -47.2% | 306 | 1,419 | 1,149 | (270) | -23.5% | 1,232 |
| Supplies | 590 | 789 | 198 | 25.2% | 692 | 2,490 | 3,046 | 556 | 18.3% | 3,113 |
| Purchased Services | 332 | 364 | 32 | 8.9% | 366 | 1,354 | 1,480 | 126 | 8.5% | 1,455 |
| Rents and Leases | 80 | 84 | 5 | 5.4% | 65 | 326 | 321 | (6) | -1.8% | 258 |
| Utilities and Telephone | 67 | 65 | (2) | -3.5% | 63 | 263 | 259 | (4) | -1.7% | 231 |
| Insurance | 25 | 17 | (8) | -47.6% | 33 | 112 | 67 | (45) | -66.5% | 128 |
| Depreciation and amortization | 73 | 68 | (4) | -6.1% | 81 | 299 | 273 | (26) | -9.7% | 328 |
| Other Opertaing Expenses | 130 | 72 | (58) | -80.1% | 75 | 362 | 289 | (73) | -25.3% | 321 |
| **Total Expenses** | **5,545** | **5,467** | **(78)** | -1.4% | **5,540** | **21,960** | **21,831** | **(129)** | -0.6% | **22,489** |
| **Operating gain (loss)** | **(222)** | **(357)** | **135** | 37.9% | **(535)** | **(2,270)** | **(1,619)** | **(652)** | 40.3% | **(2,287)** |
| **Non-Operating Income / (Expense)** | | | | | | | | | | |
| Parcel Taxes | 488 | 478 | 10 | 2.2% | 478 | 1,924 | 1,912 | 12 | 0.6% | 1,912 |
| Investment Income | 1 | 0 | 0 | 169.3% | 1 | 2 | (50) | 52 | -104.6% | 6 |
| Interest Expense | (20) | (12) | (8) | -62.8% | (10) | (65) | (13) | (52) | 407.1% | (32) |
| Other Income / (Expense) | 23 | 12 | 11 | 86.5% | 12 | 95 | 85 | 9 | 11.1% | 84 |
| **Net Non-Operating Income / (Expense)** | **492** | **478** | **14** | **2.9%** | **481** | **1,956** | **1,935** | **21** | **1.1%** | **1,970** |
| **Excess of Revenues Over Expenses** | **$ 271** | **$ 122** | **$ 149** | **122.8%** | **$ (54)** | **$ (314)** | **$ 316** | **$ (631)** | **-199.4%** | **$ (317)** |

## City of Alameda Health Care District

**Statements of Operations - Per Adjusted Patient Day**

October 31, 2011

| | Current Month | | | | | Year-to-Date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | $ Variance | % Variance | Prior Year | Actual | Budget | $ Variance | % Variance | Prior Year |
| Revenues | | | | | | | | | | |
| Gross Inpatient Revenues | $ 3,871 | $ 3,870 | $ 1 | 0.0% | $ 3,079 | $ 3,828 | $ 3,899 | $ (71) | -1.8% | $ 3,519 |
| Gross Outpatient Revenues | 1,774 | 1,939 | (165) | -8.5% | 1,794 | 1,841 | 1,913 | (72) | -3.8% | 1,835 |
| Total Gross Revenues | 5,645 | 5,809 | (164) | -2.8% | 4,874 | 5,669 | 5,812 | (143) | -2.5% | 5,354 |
| Contractual Deductions | 4,050 | 4,282 | 231 | 5.4% | 3,400 | 4,188 | 4,279 | 91 | 2.1% | 3,833 |
| Bad Debts | 196 | 182 | (14) | -7.9% | 166 | 153 | 184 | 31 | 16.9% | 166 |
| Charity and Other Adjustments | - | 44 | 44 | 100.0% | 29 | 50 | 44 | (6) | -13.4% | 40 |
| Net Patient Revenues | 1,398 | 1,301 | 97 | 7.4% | 1,278 | 1,278 | 1,305 | (27) | -2.1% | 1,315 |
| Net Patient Revenue % | 24.8% | 22.4% | | | 26.2% | 22.5% | 22.5% | | | 24.6% |
| Net Clinic Revenue | 9 | 6 | 3 | 44.8% | 2 | 9 | 3 | 6 | 200.7% | 8 |
| Other Operating Revenue | 3 | 3 | 0 | 2.9% | 2 | 13 | 3 | 10 | 384.9% | 2 |
| **Total Revenues** | **1,409** | **1,310** | **99** | 7.6% | **1,283** | **1,300** | **1,311** | **(11)** | -0.8% | **1,326** |
| Expenses | | | | | | | | | | |
| Salaries | 760 | 713 | (47) | -6.5% | 735 | 754 | 725 | (29) | -4.0% | 775 |
| Temporary Agency | 30 | 39 | 9 | 23.2% | 37 | 29 | 39 | 10 | 25.2% | 41 |
| Benefits | 224 | 202 | (22) | -10.7% | 18 | 229 | 206 | (23) | -11.4% | 196 |
| Professional Fees | 112 | 73 | (38) | -52.1% | 78 | 94 | 75 | (19) | -25.7% | 81 |
| Supplies | 156 | 202 | 46 | 22.7% | 177 | 164 | 197 | 33 | 16.8% | 204 |
| Purchased Services | 88 | 93 | 6 | 5.9% | 94 | 89 | 96 | 7 | 6.9% | 96 |
| Rents and Leases | 21 | 22 | 0 | 2.3% | 17 | 22 | 21 | (1) | -3.6% | 17 |
| Utilities and Telephone | 18 | 17 | (1) | -6.9% | 16 | 17 | 17 | (1) | -3.5% | 15 |
| Insurance | 7 | 4 | (2) | -52.5% | 8 | 7 | 4 | (3) | -69.5% | 8 |
| Depreciation and Amortization | 19 | 18 | (2) | -9.6% | 21 | 20 | 18 | (2) | -11.6% | 22 |
| Other Operating Expenses | 34 | 19 | (16) | -86.0% | 19 | 24 | 19 | (5) | -27.5% | 21 |
| **Total Expenses** | **1,468** | **1,401** | **(67)** | -4.8% | **1,220** | **1,449** | **1,416** | **(34)** | -2.4% | **1,476** |
| **Operating Gain / (Loss)** | **(59)** | **(91)** | **33** | 35.9% | **63** | **(150)** | **(105)** | **(45)** | 42.9% | **(150)** |
| **Non-Operating Income / (Expense)** | | | | | | | | | | |
| Parcel Taxes | 129 | 123 | 7 | 5.6% | 123 | 127 | 124 | 3 | 2.4% | 125 |
| Investment Income | 0 | 0 | 0 | 178.1% | 0 | 0 | 0 | 0 | 178.4% | 0 |
| Interest Expense | (5) | (3) | (2) | -68.1% | (3) | (4) | (3) | (1) | 32.5% | (2) |
| Other Income / (Expense) | 6 | 3 | 3 | 92.7% | 3 | 6 | 6 | 1 | 13.1% | 5 |
| **Net Non-Operating Income / (Expense)** | **130** | **123** | **8** | **6.3%** | **123** | **129** | **126** | **3** | **2.2%** | **129** |
| **Excess of Revenues Over Expenses** | **$ 72** | **$ 31** | **$ 41** | 130.1% | **$ 186** | **$ (21)** | **$ 22** | **$ (42)** | -194.9% | **$ (21)** |

**City of Alameda Health Care District**
**Statement of Cash Flows**
**For the Four Months Ended October 31, 2011**

| | Current Month | Year-to-Date |
|---|---|---|
| **Cash flows from operating activities** | | |
| Net Income / (Loss) | $ 270,724 | $ (314,331) |
| Items not requiring the use of cash: | | |
| Depreciation and amortization | 72,537 | $ 298,938 |
| Write-off of Kaiser liability | - | $ - |
| Changes in certain assets and liabilities: | | |
| Patient accounts receivable, net | (288,227) | (1,694,274) |
| Other Receivables | 805,003 | 1,512,045 |
| Third-Party Payer Settlements Receivable | (951,501) | (234,154) |
| Inventories | (9,416) | 50,121 |
| Prepaids and Other | (17,208) | (74,321) |
| Accounts payable and accrued liabilities | 643,207 | 1,413,352 |
| Payroll Related Accruals | (141,647) | (435,006) |
| Employee Health Plan Accruals | 74,142 | 299,453 |
| Deferred Revenues | (477,013) | (1,908,075) |
| Cash provided by (used in) operating activities | (19,399) | (1,086,252) |
| **Cash flows from investing activities** | | |
| (Increase) Decrease in Assets Limited As to Use | (7,788) | (42,153) |
| Additions to Property, Plant and Equipment | (112,966) | (399,141) |
| Other | (97,462) | (12,556) |
| Cash provided by (used in) investing activities | (218,216) | (453,850) |
| **Cash flows from financing activities** | | |
| Net Change in Long-Term Debt | 219,857 | 527,384 |
| Net Change in Restricted Funds | (49,788) | 84,577 |
| Cash provided by (used in) financing and fundraising activities | 170,069 | 611,961 |
| Net increase (decrease) in cash and cash equivalents | (67,546) | (928,141) |
| **Cash and cash equivalents at beginning of period** | 941,631 | 1,802,225 |
| **Cash and cash equivalents at end of period** | $ 874,085 | $ 874,084 |

# City of Alameda Health Care District

**Statements of Operations**

October 31, 2011

$'s in thousands

| | Current Month | | | | Year-to-Date | | | |
|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | $ Variance | % Variance | Actual | Budget | $ Variance | % Variance |
| Net Patient Revenues | 4,938 | 5,077 | (139) | -2.7% | 19,025 | 20,128 | (1,103) | -5.5% |
| Net Patient Revenue % | 23.2% | 22.4% | | | 22.2% | 22.5% | | |
| Net Clinic Revenue | 32 | 23 | 9 | 40.2% | 130 | 44 | 86 | 195.4% |
| Other Operating Revenue | 10 | 10 | (0) | -0.4% | 192 | 40 | 152 | 376.4% |
| **Total Revenues** | **4,980** | **5,110** | **(130)** | -2.5% | **19,347** | **20,212** | **(865)** | -4.3% |
| **Total Expenses** | **5,545** | **5,467** | **(78)** | -1.4% | **21,960** | **21,831** | **(129)** | -0.6% |
| **Operating gain (loss)** | **(564)** | **(357)** | **(207)** | -58.1% | **(2,613)** | **(1,619)** | **(994)** | 61.4% |
| **Net Non-Operating Income / (Expense)** | **492** | **478** | **14** | **2.9%** | **1,956** | **1,935** | **21** | **1.1%** |
| **Excess of Revenues Over Expenses** | **$ (72)** | **$ 122** | **$ (193)** | **-159.2%** | **$ (657)** | **$ 316** | **$ (973)** | **-307.6%** |
| **IGT True Up FY 2011** | **(381)** | | **(381)** | | **(381)** | | **(381)** | |
| **IGT True Up FY 2012** | **(121)** | | **(121)** | | **(121)** | | **(121)** | |
| **AB 97 - Reverse Sub-Acute FY 201** | **198** | | **198** | | **198** | | **198** | |
| **AB 97 - Reverse Sub-Acute FY 201** | **617** | | **617** | | **617** | | **617** | |
| **SNF True Up FY 11** | **18** | | **18** | | **18** | | **18** | |
| **SNF True Up FY 12** | **12** | | **12** | | **12** | | **12** | |
| **Adjusted October Revenue Over E** | **$ 271** | **$ 122** | **$ 149** | **122.7%** | **$ (314)** | **$ 316** | **$ (631)** | **-199.4%** |
| **Less: Budgeted AB 97 Reserve** | | **159** | **(159)** | | | **630** | **(630)** | |
| **Total with Adjusted Budget** | **$ 271** | **$ 281** | **$ (10)** | **-3.5%** | **$ (314)** | **$ 946** | **$ (1,261)** | **-133.2%** |
| **Annual Budgeted AB 97 Reserve** | | | | | | **1,875** | | |

# City of Alameda Health Care District
## Ratio's Comparison

| Financial Ratios | Audited Results FY 2008 | FY 2009 | FY 2010 | Unaudited Results FY 2011 | YTD 10/31/2011 |
|---|---|---|---|---|---|
| **Profitability Ratios** | | | | | |
| Net Patient Revenue (%) | 22.48% | 22.69% | 24.16% | 23.58% | 22.15% |
| Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA) | -0.72% | 3.62% | 4.82% | -1.01% | -1.77% |
| EBIDAP[Note 5] | -10.91% | -5.49% | -3.66% | -13.41% | -11.74% |
| Operating Margin | -3.75% | 1.03% | 2.74% | -2.61% | -3.31% |
| **Liquidity Ratios** | | | | | |
| Current Ratio | 0.98 | 1.15 | 1.23 | 1.05 | 1.02 |
| Days in accounts receivable ,net | 51.70 | 57.26 | 51.83 | 46.03 | 57.87 |
| Days cash on hand ( with restricted) | 30.61 | 13.56 | 21.60 | 14.14 | 9.51 |
| **Debt Ratios** | | | | | |
| Cash to Debt | 187.3% | 115.3% | 249.0% | 123.3% | 58.79% |
| Average pay period | 58.93 | 58.03 | 57.11 | 62.68 | 71.62 |
| Debt service coverage | (0.14) | 3.87 | 5.98 | (0.70) | (0.24) |
| Long-term debt to fund balance | 0.26 | 0.20 | 0.14 | 0.18 | 0.22 |
| Return on fund balance | -29.59% | 8.42% | 18.87% | -19.21% | -8.41% |
| Debt to number of beds | 20,932 | 13,481 | 10,482 | 11,515 | 14,791 |

# City of Alameda Health Care District
## Ratio's Comparison

| Financial Ratios | Audited Results FY 2008 | FY 2009 | FY 2010 | Unaudited Results FY 2011 | YTD 10/31/2011 |
|---|---|---|---|---|---|
| **Patient Care Information** | | | | | |
| Bed Capacity | 135 | 161 | 161 | 161 | 161 |
| Patient days( all services) | 22,687 | 30,463 | 30,607 | 30,270 | 10,231 |
| Patient days (acute only) | 11,276 | 11,787 | 10,579 | 10,443 | 3,543 |
| Discharges( acute only) | 2,885 | 2,812 | 2,802 | 2,527 | 902 |
| Average length of stay ( acute only) | 3.91 | 4.19 | 3.78 | 4.13 | 3.93 |
| Average daily patients (all sources) | 61.99 | 83.46 | 83.85 | 82.93 | 83.18 |
| Occupancy rate (all sources) | 45.92% | 52.94% | 52.08% | 51.51% | 51.66% |
| Average length of stay | 3.91 | 4.19 | 3.78 | 4.13 | 3.93 |
| Emergency Visits | 17,922 | 17,337 | 17,624 | 16,816 | 5,633 |
| Emergency visits per day | 48.97 | 47.50 | 48.28 | 46.07 | 45.80 |
| Outpatient registrations per day[Note 1] | 84.54 | 82.05 | 79.67 | 65.19 | 58.85 |
| Surgeries per day[Note 1] | 14.78 | 16.12 | 13.46 | 6.12 | 6.56 |

Notes:

1. Includes Kaiser Outpatient Sugercial volume in Fiscal Years 2008, 2009 and through March 31, 2010.
2. In addition to these general requirements a feasibility report will be required.
3. Based upon Moody's FY 2008 preliminary single-state provider medians.
4. EBIDA - Earnings before Interest, Depreciation and Amoritzation
5. EBIDAP - Earnings before Interest, Depreciation and Amortization and Parcel Tax Proceeds

# Glossary of Financial Ratios

| Term | What is it? Why is it Important? | How is it calculated? |
|---|---|---|
| EBIDA | A measure of the organization's cash flow | Earnings before interest, depreciation, and amortization (EBIDA) |
| Operating Margin | Income derived from patient care operations | Total operating revenue less total operating expense divided by total operating revenue |
| Current Ratio | The number of dollars held in current assets per dollar of liabilities. A widely used measure of liquidity. An increase in this ratio is a positive trend. | Current assets divided by current liabilities |
| Days cash on hand | Measures the number of days of average cash expenses that the hospital maintains in cash or marketable securities. It is a measure of total liquidity, both short-term and long-term. An increasing trend is positive. | Cash plus short-term investments plus unrestricted long-term investments over total expenses less depreciation divided by 365. |
| Cash to debt | Measures the amount of cash available to service debt. | Cash plus investments plus limited use investments divided by the current portion and long-term portion of the organization's debt insruments. |
| Debt service coverage | Measures total debt service coverage (interest plus principal) against annual funds available to pay debt service. Does not take into account positive or negative cash flow associated with balance sheet changes (e.g. work down of accounts receivable). Higher values indicate better debt repayment ability. | Excess of revenues over expenses plus depreciation plus interest expense over principal payments plus interest expense. |
| Long-term debt to fund balance | Higher values for this ratio imply a greater reliance on debt financing and may imply a reduced ability to carry additional debt. A declining trend is positive. | Long-term debt divided by long-term debt plus unrestricted net assets. |

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: December 2, 2011

For: December 5, 2011 District Board Meeting

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

From: Deborah E. Stebbins

Subject: Acceptance of FY 2011 Executive Performance Metrics Summary

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Recommendation:

This outlines the management year end self-assessment of our performance against the Executive Performance Metrics for FY 2011 (see attached). Management recommends that the Board accept this as the final report for Performance Metrics for the year.

Background and Discussion:

The weightings for the four goal categories for FY 2011 were: Financial Success (40%), Growth (25%), Quality/Satisfaction (5&), Physicians (10%), Operational Success (15%), and Workforce Success (5%).

**Financial:**

1. The threshold metric for entire Performance Metric plan was the achievement of the budgeted excess revenue over expense of $490,853. The actual excess revenue over expense for the hospital for FY 2011 was a negative $1,644,000. For this reason, regardless of achievements in the other goal categories, the threshold for incentive compensation was not achieved. Nevertheless management is providing a report and self assessment in the other categories.

2. Blue and Gold Plan preferred provider.

**Growth:**

1. A new plastic surgeon and orthopedist were recruited to the staff (Drs. Daane, Dothinini and J. Chang), but their activity was not enough to achieve the targets outlined: Inpatient major cases actually dropped by 15% instead of the target 10% increase. The block scheduling was successfully implemented, but some blocks are still not fully utilized. Non-Kaiser outpatient surgery did significantly, with an increase of 28% rather than the target 20%

2. There was a delayed start to the Wound Care program due to protracted lease negotiations. The Accelecare relationship was fully implemented the plans for the tenants improvements finalized and 19 physicians have applied to work in the clinic and begin orientation.

3. The inpatient census remained virtually flat between FY 2010 and FY 2011. There was not a significant increase in Medi-Cal volume.

4. Inpatient ancillary volume did not increase significantly, including the targeted imaging goal of 12%. The PACS system was fully implemented but due largely due to downtime during construction, there were months where volume dropped significantly.

5. There was major progress toward the partnership with Waters Edge, including discussions with 4 other facilities in Alameda, which finally culminated in the sublease approved in November, 2011. Staff also completed all the preparation for the Primary Stroke Program with a certification from the Joint Commission and filed an application (still under appeal with the State) for the expansion of our Subacute program by 12 beds.

6. We met with Sutter facilities in the West and East Bay (subacute contracts), with UCSF on medical group and referral collaboration, and El Camino regarding programmatic collaboration. The discussions with Sutter and UCSF are on-going.

**Quality / Satisfaction Success:**

1. Most recent quarter available (Quarter ending 03/30/2011) three of four core measures (AMI, ASA at Discharge, Smoking Cessation, and Heart Failure - Smoking Cessation) all at 100%. Fourth measure, Heart Failure – Discharge Instructions at 53% but this was prior to implementation of improves discharge process. (Data available through March 30, 2011)

2. Falls 1.69 per 100 patient days (acute
HAPU 2.11 per 1000 patient days (acute)
(Data available through June 30, 2011)

**Physicians:**

1. Nursing, physicians and case management instituted a much more orderly discharge process to facilitate shorter lengths of stay.

   Several meetings were held between Affinity and Hospital leadership about the direction of ACO development in this area. Management evaluated the Hospital Council Master Medical Foundation model as an ACO vehicle for independent hospitals and recommended Alameda Hospital not participate. There has been no real progress on the Hospital Council project since then.

2. Complete preparation for physician order entry in FY12 is still in process.

3. Clinic visits increased from 823 (6 months of data) in FY 2010 to 2,167 in FY 2011.

a. Annualized visits for FY 2010 = 1,646 (823x2)
b. Percent Increase from FY 2010 = 31.7%

**Operational Success:**

1. Management presented an assessment and proposed schedule for Alameda Hospital to achieve compliance with the SB 90 provisions in March, 2011. In May, 2011, management presented an assessment of all work necessary to achieve compliance with the non-structural performance category (NPC). We made significant progress in discussions with the staff of Cal Mortgage regarding financing of our seismic project requirements which was also quantified for the first time. Pursuit of financing was delayed in order to achieve appropriate operating performance for a sufficient period for Cal Mortgage to capitalize the project.

2. While PCS did not achieve the original "go live", we did implement the Emergency Department components of the program and have kept all provider training on track. The required upgrade of Meditech to 5.65 was planned during FY 2011 and went live in November, 2011.

3. PACS system went live three months after schedule mainly due to the protracted OSHPD approval process

**Workforce Success:**

1. Second employee satisfaction survey completed in May, 2011 with overall improvement in scores. Specifically the score for satisfaction for training and development activities improved from 12.7 (2009) to 15.8 (2011), a 24% increase compared the 10% target and getting much closer to the NRC comparative average satisfaction of 17.2.

2. Nursing has conducted numerous programs to reinforce need to use English in patient care areas, which is believed to have resulted in more compliance by staff. Negative comments on our patient satisfaction surveys regarding the issue have declined from earlier surveys.

**City of Alameda Health Care District**

# FY2011 Executive Performance Metrics Summary

## INTRODUCTION

Payment of any incentive compensation to an executive is predicated upon a performance evaluation of "meets expectations" or above. The base percentage bonus (based on % base compensation) for the Chief Executive Officer is established by the Board. The incentive compensation levels for other participating executives are established by the CEO.

The Chief Executive Officer (CEO) is responsible for recommending additional executive participants in an incentive plan to the Board. The CEO is responsible for structuring the terms of their incentive in a manner consistent with the executive incentive compensation system. In FY 2011 the full incentive compensation target for the CEO and other participating executives was budgeted at the "target" financial level and at close to full achievement of the other three areas to ensure that the incentive payments are appropriately funded. The excess revenue over expense will include the Hospital, South Shore and any new business entity or location which the hospital may operate under its license, only and exclude CW&S and the 501(c)3 corporation. For purposes of clarifying exact time frames associated with metrics, FY 2011 is the period between July 1, 2010 and June 30, 2011.

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

| | FY 2011 Self Ranking | FY 2011 Weighting | FY 2010 Weighting* |
|---|---|---|---|
| Financial Success | 1% | 40% | 50% |
| Growth | 14% | 25% | 10% |
| Quality / Satisfaction | 4% | 5% | 10% |
| Physicians | 8% | 10% | (not separate category) |
| Operational Success | 10% | 15% | 20% |
| Workforce Success | 5% | 3% | 10% |
| Total | 42% | 100% | 100% |

*For Reference: The proportion of pay-out for FY 2010 is also listed.

| FINANCIAL SUCCESS | | | | | Weighting Points | Management Self Ranking |
|---|---|---|---|---|---|---|
| **Goals** | **Actions** | **Measures** | | | **40** | **1** |
| **1. Achieve our FY11 Financial Targets & Goals** | Tripwire: Excess Revenue over Expense. Must meet threshold or no incentive compensation paid | Threshold | Target | High | **37** | **0** |
| | | $490,853 (FY 2011 Budget) | $750,000 | $1.8 million | | |
| **2. Optimize 3rd Party Referral Relationships and Contracts** | | | | | **3** | **1** |

| GROWTH | | | Weighting Points | Management Self Ranking |
|---|---|---|---|---|
| **Goals** | **Actions** | **Measures** | **25** | **14** |
| **1. Replace portion of surgical volume loss due to expiration of Kaiser contract** | Block scheduling<br>Physician Recruitment | 10% increase in "Alameda" major surgery ( non-eye / GI) over average of July 2009-March 2010 levels (pre-Kaiser) | **3** | **2** |
| | | 20% in minor procedures | **1** | **1** |
| **2. Establish Comprehensive Wound Care Center** | Identify physician panel<br>Open program | Compliance with ramp-up pro forma volume projections. | **4** | **2** |
| **3. Increase In-patient Census** | Attract additional Medi-Cal patients through outreach to community clinics<br>Forge relationships with Alameda Alliance | 50% increase in inpatient Medi-Cal volume | **2** | **0** |
| | | Target: Increase ADC by 5 acute patients by fiscal year end. | **4** | **0** |

| | | | | |
|---|---|---|---|---|
| **4. Increase outpatient ancillary volume** | Market Diagnostic Imaging capabilities | 12% increase in Imaging volume over FY 2010 levels | **1** | **0** |
| **5. Evaluate at least 2 new programs or services for feasibility** | Formulate strategy for Long Term Care Service Line Development<br>Determine best mechanism for subacute expansion<br>Evaluate ortho service line development | Identification of source to generate at least $1 million in additional net revenue | **6** | **6** |
| **6. Seek Strategic Partner Organization** | Meetings and presentation to at least 2 target organizations as identified at July 23, 2010 Special Board Meeting | Board development of more defined strategy on development of strategic partnership | **4** | **3** |
| **Quality / Satisfaction Success** | | | **Weighting Points** | **Management Self Ranking** |
| **Goals** | **Actions** | **Measures** | **5** | **4** |
| **1. Improve Core Measure scores in all Indicators** | Continue to track core measures<br>Educate Medical Staff and Nursing Staff on compliance and importance of scores | Each indicator at 90% or greater | **3** | **2** |

| | | | | |
|---|---|---|---|---|
| **2. Reduce rate of incidence for Falls and Hospital Acquired Pressure Ulcers (HAPU)** | Continue performance improvement plans for fall reductions and skin care protocols.<br>**Score in HAPU and Falls to be better that the CalNoc "like hospital" mean** | *HAPU 2009 Mean = 2.01*<br>Alameda Hospital to be consistently below 2.0 for FY 2011 | **1** | **1** |
| | | *Falls 2009 Mean = 3.21*<br>Alameda Hospital to be consistently below 2.5 for FY 2011. Should continue PI focus on reducing rate of falls resulting in injury. | **1** | **1** |
| **Physicians** | | | **Weighting Points** | **Management Self Ranking** |
| **Goals** | **Actions** | **Measures** | **10** | **8** |
| **1. Prepare Organization to participate in an Accountable Care Organization in anticipation of Health Care Reform** | Continue to streamline processes to support efficient case and utilization management | Sustain orientation and preparation for value based payment system to be implemented under health care reform. | **2** | **1** |
| | Work with medical community to evaluate optional relationships with physician organizations | Options for preferred physician organizational structure discussed in depth | | |
| **2. Complete preparation of physician order entry in FY 2012** | Complete orientation of Medical Staff to | Orientation completed by June 2011 | **2** | **1** |

| | | | | |
|---|---|---|---|---|
| | patient care system (PCS) | | | |
| **3. Continued recruitment of new physicians in primary care and selected specialties** | Market practices established in 1206(b) community clinic<br>Primary care<br>OB-GYN<br>General Surgery | 25% increase in 1206 (b) community clinic visits during FY 2011 over FY 2010. | **6** | **6** |
| **Operational Success** | | | **Weighting Points** | **Management Self Ranking** |
| **Goals** | **Actions** | **Measures** | **15** | **10** |
| **1. Conclude seismic retrofit project through either:** | Securing financing and completing contractor selection and initiating project (pending OSHPD's review and issuance of permit)<br>or<br>Identifying that financing at this time is not feasible and seeking extension on 2013 seismic standards | Secure financing or extension for seismic retrofit | **7** | **5** |

| | | | | |
|---|---|---|---|---|
| **2. Continue to advance IT planning to prepare for "meaningful use" status by 2013** | Complete all planning, design and training for Patient Care System (PCS) phase | PCS phase 'go live' by the end of June 2011 | **6** | **4** |
| **3. Implement PACS and Imaging Upgrade** | Complete PACS and imaging upgrade installation | "Go Live" by March 2011 | **2** | **1** |
| **Workforce Success** | | | **Weighting Points** | **Management Self Ranking** |
| **Goals** | **Actions** | **Measures** | **5** | **5** |
| **1. Increase employee satisfaction levels regarding training / development opportunities** | 2nd Employee Satisfaction Survey<br>Continue increases development opportunities | Increase in training satisfaction score over last survey of 62.4% by 10% | **3** | **3** |
| **2. Enhance compliance with hospital customer service policy that directs staff to speak English in all patient care areas, room, hallways adjacent to patient rooms, and other areas where patients are present.** | Reorientation to importance of English only being spoken in patient care areas | Reduction in negative comments from patients and visitors on this problem | **2** | **2** |

Date: November 28, 2011

DISTRICT BOARD REFERRAL FORM

(To Be Submitted to the District Clerk)

Name of District Board Member Requesting Referral: Jordan Battani

Date of Submission to District Clerk (must be submitted to the District Clerk before 5:00 p.m. on the Monday of the week prior to each regular monthly Monday District Board meeting and seven (7) days prior to each other District Board meeting and/or Board designated committee meeting: December 5, 2011

Brief Description of the subject to be printed on the agenda, sufficient to inform the District Board and public of the nature of the District Board Referral:

I'd like to propose the following District Board Referral for the Board to consider on December 5th.

Ask staff to prepare an assessment of the cost and operational impact of implementing changes suggested by the Public Comment at the November Board meeting:

1. Adopting public notice and disclosure standards that have recently been adopted by the City of Alameda (as a result of the recommendations of the Sunshine Task Force)

2. Make improvements to the functionality and usability of the Alameda Hospital website, specifically with reference to the public notice of meetings and availability and usability of the documents and attachments for Board and Committee meetings.

December 5, 2011

City of Alameda Health Care District

2009-2013 Goals and Objectives

*1st Quarter - FY 2012 Update*

| Financial Strength | |
|---|---|
| Achieve long-term financial viability | |
| **Measures of success:** | |
| ■ Achievement of positive operating margin = 3% of net revenues by 2013 | |
| ■ Generate operating profitability levels necessary to support capital needs/service debt | |
| ■ Raise $500,000 per year through Foundation fundraising initiatives | |
| ■ Shift reliance on parcel tax from support of operations to support for capital investments and strategic development projects | |
| ■ Sustain Performance vis-à-vis operating benchmarks at 90th percentile levels (e.g., FTE/Adj. Occupied Bed, Length of Stay, Costs per UOS) | |
| **Initiatives** | **Status** |
| (A) STRATEGY: Seek $250,000 contribution from Alameda County to assist with capital improvements of clinic space at Marina Village designed to serve low income patients | |
| | |
| (B) STRATEGY: Seek $1 million from Alameda County to underwrite uncompensated care delivered in Alameda Hospital Emergency Department | |
| | |
| (C) STRATEGY: Improve Revenue Cycle Metrics * | |
| 1. Reduce Gross Days in Accounts Receivable, excluding unbilled by 5% to 47.1 days from the current 49.6 days (4th Qtr HARA Report indicated the National Average at 49.4 days). | Revenue Cycle Project has been underway for 3 months; revenue cycle metrics will be revised from these targets based on significant new information on problems identified thus far. |
| 2. Reduce volume of late charges as a percentage of gross charges (posted after bill drop) by 10%. (Current baseline: 0.9% for the last 4 months) | |
| 3. Increase percentage of AR less 60 days to 65% from current 60% | |
| 4. Achieve Reimbursement in compliance with contract terms to 90% | |
| 5. Reduce percentage of self pay by 10% | |
| (E) STRATEGY: Reduce readmission rates (same DRG within 30 days) by 3% by end of FY 2012. Baseline = 29% | |
| | Data being analyzed |
| (F) STRATEGY: Reduce the percentage of observation patients to inpatient from 25% (baseline) to 19% (a 25% reduction) within the first 6 months of FY 2012 with the assistance of Executive Health Resources. | |
| | Q1 FY 2012 = 19.3% readmission rate which is slightly above the goal of 19%. |
| **Growth** | |

| Pursue fiscally responsible growth in services that target the most pressing acute and non-acute healthcare needs of the community. | | | |
|---|---|---|---|
| **Measures of success:** | | | |
| ■ Market share growth.<br>■ From 31.25 percent to 35.0 percent – Alameda Island (ZIP Codes 94501 and 94502).<br>■ From 0.94 percent to 1.10 percent - Off-Island. | | | |
| ■ Service line growth: volume targets defined by service line. | | | |
| ■ Development of new access points and locations. | | | |
| ■ Increase inpatient census by 5 ADC by 2013 to offset loss of Kaiser revenue and to support basic INP/ER infrastructure. | | | |
| **Initiatives** | **Status** | | |
| (A) STRATEGY: Secure partnership with one additional long-term care facility within the District | | | |
| | Waters Edge Sublease signed November, 2011. Transition Agreement in progress. Licensure transfer application submitted to State in November, 2011 | | |
| (B) STRATEGY: Complete implementation of Wound Care Program, achieving volumes (IP and OP) services as projected in pro forma | | | |
| 1. For 6 months of FY 2012: 125 patients, 1,250 patient visits, $26,000 Net Income | Projected implementation in early Spring, 2012 | | |
| (C) STRATEGY: Implement one new surgical program reflecting an integrated continuum of services from pre-surgical to post surgical care. Programs to be considered include orthopedics and plastic surgery. This should contribute to the 5 % increase in surgeries. | | | |
| | Not complete. | | |
| (D) STRATEGY: Increase selective higher outpatient services by the following: | | | |
| 1. Diagnostic Imaging – 2% Increase | YTD Volume: 8,068 | Budget: 9,011 | % Increase: -10.5% |
| 2. Therapy: 5% Increase | YTD Volume: 4,819 | Budget: 5,704 | % Increase -15.5% |
| 3. Surgery: 5% Increase | YTD Volume: 807 | Budget: 775 | % Increase: 4.1% |
| (E) STRATEGY: Increase nursing home admissions by 2% through improved transfer systems and quarterly communication from Case Management and SNF Liaison to nursing home leadership. Baseline = 19% | | | |
| | Q1 FY 2012 (July –September)at 19.2% compared to Q1 FY2011 (July – September) at 17.8% an increase of 1.4% from prior year, but slightly below goal by 0.8%<br>December, 2011 Communication with Alameda skilled nursing facilities regarding Waters Edge Sublease<br>Outreach continues through work of SNF Liaison (meeting with Oakland Rehab Center in November, 2011) | | |

| Facilities and Technology | |
|---|---|
| Enhance our facility and technological capabilities to foster the achievement of our goals. | |
| Measures of success: | |
| ■ Percentage of physicians who sign up for electronic access. | |
| ■ Volume of hits to hospital website. | |
| ■ Fund depreciation to TBD% in order to create capital reserve fund . | |
| **Initiatives** | **Status** |
| (A) STRATEGY: Develop master facility plan for Marina Village Space | |
| | In process. |
| (B) STRATEGY: Improve HCAHPS scores for cleanliness of facility to 67.5% (quarterly average) | |
| | Cleanliness went from 54% in Q1 to 64% in Q2<br>PI Team Charter developed and will begin work in mid December\| early January to look at cleanliness of facility and ways to improve scores. |
| (C) STRATEGY: Improve signage and way-finding systems in the following areas to improve image and reduce traffic through inpatient areas. Incorporate Bilingual signage where appropriate. | |
| 1. South Shore Skilled Nursing Unit | Not complete. |
| 2. South Shore Center Medical Office Building | Not complete. |
| 3. East Building (Clinton and Doctor's parking lot entrance) | Not complete. |
| (D) STRATEGY: Implement ECHO System upgrade | |
| | |
| (E) STRATEGY: Finalize scope and budget for implementation of required NPC-2 work. Meet reporting milestones for seismic extension provided by SB90 | |
| | NPC-2: Completing testing for structural engineer to determine options for compliance for bulk oxygen anchorage and bracing.<br>SB90: Working with consultants to submit application prior to the March 31, 2012 required date. |
| (F) STRATEGY: Evaluate all Meditech modules which are currently being underutilized (ESS, PCS, EDM), making appropriate recommendations, if any, that should be activated. | |
| | |
| (G) STRATEGY: Evaluate formation of a dedicated surgical inpatient unit as mechanism to enhance quality of patient care and to increase surgical volume | |
| | **Not started** |

| | |
|---|---|
| (H) STRATEGY: | Explore use of Hospital website for improved patient accessibility and access to information, including online registration and appointment scheduling. |
| | Exploring online pre-registration forms to secure host site. |
| (I) STRATEGY: | Complete 3 year schedule, key milestones, budget and impact on cash flow of progression to full meaningful use no later than October 2011. |
| | |
| (H) STRATEGY: | Define alternative plan for reducing manual labor necessary to capture payroll information (in wake of discontinuing McKesson Project) by September 2011 |
| | Not done, pending selection of new CFO. |

| **Physicians** | |
|---|---|
| Ensure that the Hospital attracts qualified and capable physicians through collaboration and alignment. | |
| **Measures of success:** | |
| ■ Increase number and reduce average age of active physicians through targeted recruitment. | |
| ■ Achieve annual recruitment goals. | |
| ■ Increase volume of work by Alameda surgeons. | |
| **Initiatives** | **Status** |
| (A) STRATEGY: Continue to strengthen partnerships with key physician groups (Affinity, ABMG, Hill, AFP) to secure referral patterns, improve patient management, and coordinate approach to health plans. | |
| 1. Enhanced use of long term care placement to reduce acute care utilization | Meetings held between leadership at both Affinity and UCSF |
| 2. Coordinated management of patients with chronic disease (e.g. CHF, Diabetes) | |
| 3. Quarterly meetings | |
| (B) STRATEGY: Complete an inventory of physician practice based information systems and establish plan for gradual implementation of connectivity with MediTech system | |
| | |
| (C) STRATEGY: Establish data collection system for tracking admission and referral patterns by physician and/or institution (e.g. SNF's) or point of entry (e.g. Emergency Department | |
| | New Director of Decision Support and Financial Planning to set up tracking system. |
| (D) STRATEGY: Track utilization under new contracts (e.g. Alameda Alliance, Medi-Cal, Blue and Gold Plan, etc) | |

| | |
|---|---|
| | New Director of Decision Support and Financial Planning to set up tracking system. |
| (E) STRATEGY: Complete first physician satisfaction survey by 4th quarter of FY 2012 | |
| | Not started. |
| (F) STRATEGY: Maintain regular contact with East Bay physicians who are seeking practice setting alternatives other than those offered by existing large multispecialty groups. | |
| | Ophthalmologist Jennifer Taylor, MD joined Medical Staff (October 2011)<br>Recruited Pleasanton physician Bhoomika Kamath, MD to AFP (November 2011)<br>Fall physician Mixer held in November, 2011<br>Fall Physician Newsletter sent November, 2011 |
| (G) STRATEGY: Complete evaluation of outsourcing management of 1206 (B) clinic to practice management company | |
| | Solicited one request for proposal from Affinity, who chose not propose at this time. |

| **Quality/Service** | |
|---|---|
| Achieve superior clinical and service results on a consistent basis. | |
| **Measures of success:** | |
| ■ Patient satisfaction (patient experience) as measured by 95% or more willing to recommend hospital to a friend | |
| ■ Joint Commission Core Measure compliance | |
| ■ Joint Commission/CMS/CDPH Accreditation | |
| ■ QI/Risk Reports that demonstrate improvement in problem areas | |
| ■ Improve accuracy of information collection at time of registration | |
| **Initiatives** | **Status** |
| (A) STRATEGY: Improve aggregate HCAHPS scores (willingness to recommend) to 66%. Current baseline: | |
| | Q3 2011 score was 66%. |
| (B) STRATEGY: Redesign hospital website functionality as portal for patient service | |
| 1. Evaluate on-line registration and appointment scheduling | Exploring online pre-registration to secure site |
| 2. Add testimonials from patients and physicians | Reviewing web site redesign options to improve functionality. |
| 3. Report key quality data on website | Hospital Compare Quality Data Link on main webpage. Monthly Board Quality Metrics posted with Board packets. |

| | |
|---|---|
| 4. Add key educational and instructional material for patients discharged or treated as outpatients | Outpatient Imaging forms currently available on website. |
| (C) STRATEGY: Improve HCAHPS scores for cleanliness and noise and communication by 10%. | |
| | Improvements from Q2 to Q3 2011 have been noted in cleanliness and communication. Cleanliness went from 54% in Q1 to 64% in Q2 |
| (D) STRATEGY: All Core Measure scores above the 90th percentile | |
| | Q3 data currently being abstracted, preliminary results anticipated in January, 2012. |
| (E) STRATEGY: Provide additional resources to patients upon discharge to raise awareness of hospital as broad health resource (e.g. Vial of Life, battery operated or crank radio or flash light, etc.) | |
| | Not started. |
| (F) STRATEGY: Complete The Joint Commission (TJC) certification process for Primary Stroke Program | |
| | Certification awarded on September 30, 2011<br>Custom stroke signs and symptoms magnets are provided at discharge for stroke patients. |
| (G) STRATEGY: Implement childhood obesity prevention program in conjunction with schools (Let's Move Alameda) | |
| | Summer 2011 Activity Journal Implemented<br>Next initiative to focus on Healthy Eating, to begin in Spring, 2012 |

| **People** |
|---|
| Foster a culture of exemplary performance through recruitment and retention practices that are founded on adherence to core performance standards and the continual development and celebration of our employees. |
| **Measures of Success:** |
| ■ Increase number of Staff Nurse III among nursing staff by 2 in FY 2010-11 and by 1 each year thereafter (4 SN III in FY 2010). |
| ■ Maintain employee vacancy rates below regional benchmarks. |
| ■ Develop and monitor employee satisfaction surveys. |
| ■ Turnover rates of ***15%*** or less (Q42009 = 3.58%). |
| ■ Less comments about non-English in the workplace. |
| ■ Annual performance evaluations include aggregate measurement of service excellence. |

| Initiatives | Status |
|---|---|
| (A) STRATEGY: Establish annual master calendar of quarterly Town Hall Meetings with employees to communicate effectively and maintain employee confidence and inclusiveness | |
| | Master Calendar developed, meetings scheduled for January, April, July, October. |
| (B) STRATEGY: Conduct quarterly update forums for medical staff at one of medical staff educational conferences | |
| | Not started. |
| (C) STRATEGY: In addition to maintaining ongoing annual events, consider increasing key employee morale building events that may include: | |
| 1. Annual picnic for employees, medical staff, auxiliary and their families | |
| 2. Administrative Hospital Rounding for all shifts / departments | |
| 3. Weekend Pet parade | |
| 4. Fall Pumpkin Carving contest | Held October 31, 2011<br>Additional morale building events:<br>Hospital Night Oakland A's baseball Game: Held September 6, 2011.<br>Annual Holiday Cheer and Employee Appreciation: Scheduled for December 14-15, 2011 |
| (D) STRATEGY: Hold quarterly lunches with new employees (approximately 90 days after employment) and executive staff to communicate further and obtain input from new hires | |
| | First Luncheon scheduled in January 2012. |

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: November 30, 2011

For: December 5, 2011 District Board Meeting

To: City of Alameda Health Care District, Board of Directors
Alameda Hospital Medical Staff
Management Staff
Alameda Hospital Staff

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Changes in Alameda Hospital Finance Department

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This memorandum outlines recent changes in the organization of the Finance Department.

Effective December 5, 2011, **Robert "Bob" Anderson** will be joining the staff at Alameda Hospital as Interim CFO. Bob will assume the responsibilities which Diana Surber has covered for the last few months. Diana is returning to HFS Consulting to resume previous commitments she had in place with other clients. On behalf of the Hospital, I want to thank Diana for her work here and wish her continued success in her work as a financial consultant. Diana will stay on board for a few days to orient Bob Anderson.

Bob has worked as a CFO in several organizations including Mendocino Coast District Hospital, Sutter Lakeside Hospital, Verduga Hills Hospital, and UC Davis Medical Center. He holds a B.S. in Finance from University of Santa Clara.

Bob will oversee the functions of the Finance Department, including accounting, accounts payable and payroll. I will personally continue to oversee operations of the Revenue Cycle function, including registration and billing. Since the resignation of Portia Dixon, our Business Office Manager, we have contracted on a temporary basis with HFS Consulting for the day-to-day management of the Business Office, which will continue to be directed by **Diane Gramse** (x4386). She will be accountable to **Teresa Jacques**, who will work as the Project Manager for the Revenue Cycle Project and report to me. Teresa will be on-site at least two weeks out of every month.

Finally, **Anita Mayo-Green** will continue to oversee Registration and PBX and will report to Teresa Jacques while HFS continues to provide temporary management in the Business Office.

If you have any questions about this information, please contact me.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: November 29, 2011

For: December 5, 2011 District Board Meeting

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

From: Deborah E. Stebbins, Chief Executive Officer

Subject: Governance Institute 2011 Biennial Survey of Hospital and Health Care Systems

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We just received the report prepared for members of The Governance Institute, the 2011 Biennial Survey of Hospitals and Health Care Systems analyzing Board Structure and Governance Practices. I am attaching a copy of the Table of Contents, the Executive Summary, and A Guide for Readers. If you would like to review any of the topics in the report in more detail, please contact either me or Kristen Thorson, and we'll be happy to make them available to you.

# *Memorandum*

**TO:** Governance Institute Members

**FROM:** Kathryn C. Peisert, Managing Editor

**DATE:** October 28, 2011

**SUBJECT:** *Dynamic Governance: An Analysis of Board Structure and Practices in a Shifting Industry.*
2011 Biennial Survey of Hospitals and Healthcare Systems

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The Governance Institute surveys U.S. not-for-profit hospitals and health systems on governance structure and board activities every other year. As healthcare governance continues to evolve to meet the demands of individual organizations, their communities, and the legal and regulatory environment, the results from this survey present new trends and movements in the healthcare industry. Enclosed is the 2011 Biennial Survey of Hospitals and Healthcare Systems, *Dynamic Governance: An Analysis of Board Structure and Practices in a Shifting Industry.*

Since we last reported on governance structure and practices in 2009, the healthcare industry looks drastically different, due to the passage of the Patient Protection and Affordable Care Act, an increase in hospital mergers and consolidations, and the nation's continued struggle to recover from the Great Recession. This year's survey included new questions relating to both governance structure and practices, in an effort to reveal subtle shifts connected to how organizations may be beginning to respond to these unprecedented marketplace dynamics.

The report is organized into two sections. The first section of the report focuses on governance structure and offers comparisons with previous reporting years, as well as notable variations by organization type. The second section reports prevalence of adoption of recommended governance practices, and overall board performance for each area of board oversight responsibility.

This year's report also includes commentaries on the survey results from our governance advisors Don Seymour, Roger Witalis, Pam Knecht, and Ed Kazemek, as well as Jim Rice, Larry Gage, David Nash, and Ken Kaufman.

We hope you find this report helpful in learning more about the current trends and developments in healthcare governance. As always, we value your feedback.

Enclosures: *Dynamic Governance: An Analysis of Board Structure and Practices in a Shifting Industry*
Order Form

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# Table of Contents

# Executive Summary

SINCE WE LAST REPORTED ON GOVERNANCE STRUCTURE and practices in 2009, the healthcare industry looks drastically different, due to the passage of the Patient Protection and Affordable Care Act in March 2010, an increase in hospital mergers and consolidations, and the nation's continued struggle to recover from the Great Recession. The Affordable Care Act is in the earliest stages of implementation, with much of the potential benefits yet to be realized. However, the law's future may be at stake as many states are refusing to participate in certain reform programs including insurance exchanges and loss ratios, not to mention the various lawsuits challenging the constitutionality of the individual mandate (and/or the law in its entirety). Adding to this uncertainty is the federal budget crisis and the delicate position of Medicare and Medicaid in Washington budget conversations.

These factors have created a time in history like no other, both for our country as well as for the directors who oversee the nation's non-profit hospitals and health systems. Thus, our list of "recommended practices"—fundamental board activities necessary to fulfill the fiduciary responsibilities and ensure proper oversight of the charitable mission—continues to evolve in order to help boards frame their work more effectively and enhance their ability to respond to a dynamic marketplace. This year's survey included new questions relating to both governance structure and practices, in an effort to reveal subtle shifts connected to how organizations may be beginning to respond to these unprecedented marketplace dynamics.

## Governance Structure

Governance structure is an essential component of the effectiveness of a board. Without the proper structure, boards cannot easily or effectively perform the essential practices to fulfill their duties. Thus, the first portion of our survey focuses on how the board structures itself. Board size and composition, committees and committee meeting frequency, board meeting frequency, and allocation of board meeting time all are fundamentally related to overall board performance. And, significantly, the size and composition of the board overall, are important ingredients in accomplishing the board's work. This year we added governance structure questions specific to the makeup of the quality committee (which is becoming an essential arm of the board), more specific information about who sits on the board, and the use of a board portal or other online tool for communication between board meetings.

Governance structure has remained relatively consistent over the past few surveys, with boards moving towards the optimal size and structure for their needs. A few differences this year are briefly summarized below.

**Board composition:** Overall board size increased only slightly. Health system board size decreased slightly, while board size for all other organization types increased slightly. The most significant change is an increase in average physician representation on the board (employed physicians and "outside" physician representation increased across all organization types). However, most respondents indicated that there has been no change in physician representation on the board as a result of employing physicians. We asked this year about nurse representation on the board; subsidiary hospitals have the highest average number of nurses on the board (0.51).

**Committees:** The average number of committees increased significantly (7.6 vs. 5.1 in 2009); it is possible this is due to an increase in board activity in response to market changes. The percentage of organizations reporting audit and compliance committees (separate) increased by 6 percentage points compared to 2009. With the exception of health systems, there has been a significant increase in the number of organizations with a community benefit committee; there is a higher percentage of investment committees this year. And the percentage of organizations with a quality committee has increased again. The makeup for the quality committee for most respondents is primarily non-physician board members, physicians (either board members or medical staff physicians), and nurses.

The executive committee has less authority than it did in 2009. The percentage of respondents indicating that the executive committee has full authority to act on behalf of the board decreased from 51% to 45%. The percentage of respondents noting activities for which the executive committee is responsible has decreased for each activity, with the exception of board member selection. And more respondents noted that all executive committee decisions must be ratified by the full board (28% vs. 23% in 2009).

**Board meeting time:** Boards continue to devote about half of their meeting time to hearing reports from management and board committees (49%). Meeting time spent for board education increased slightly from 15% to 16%; however, time spent discussing strategy and setting policy remained the same at 32% (well below recommendations from governance experts). This year's analysis shows a positive correlation between the amount of meeting time spent on strategy and overall board performance (the more time spent on strategy, the higher the performance).

**Board member compensation:** This year marks the first significant increase in the overall percentage of organizations that compensate their board chair and other board members. Twelve percent (12%) of respondents said their board chair is compensated (up from 10% in 2009), and 15% said all or some other board members are compensated (up from 10% in 2009). For most respondents, the amount of compensation is less than $5,000.

**Use of board portal or similar online tool:** Fifty-four percent (54%) of respondents either use a board portal or are in the process of implementing a board portal or similar online tool for board members to access board materials and for board member communication. Forty-four percent (44%) said the most important benefit of using a board portal is the reduction of paper waste and duplication costs.

## Governance Practices

This year, we increased the number of recommended practices to 95. This list has slowly been growing from a list of 50 practices in 2003. Some practices have been updated; others were added—most notably practices related to compliance (duty of obedience) and new provisions within the Affordable Care Act. As the list of practices grows and becomes more complete, we are careful to maintain consistency over reporting years for the sake of comparison, while still having the ability to reflect market changes and new governance responsibilities. Thus, the list includes both fundamental governance practices that are not likely to change, as well as leading-edge practices that reflect priorities for boards given the current environment.

This year's results show that adoption of our list of recommended practices is, for the most part, widespread. However, this is the first year that we do not see a significant increase in adoption of most practices compared to our last reporting year (2009), nor have we seen an increase in boards' ratings of overall performance in most of the oversight areas covered in the survey. The leap in adoption and performance from years 2007 to 2009 was significant, and in 2011 we see a slight leveling-off, which could be related to two major factors: 1) trend lines often grow in a linear fashion for only so long before there is a natural stasis and, 2) it is possible that this year survey respondents are expressing some degree of doubt or uncertainty as to how their organizations will be able to respond to the many changes soon to come.

Health systems and subsidiary hospitals again show a stronger consistency of adoption compared to independent hospitals and government-sponsored hospitals.

Financial oversight continues to be rated first in board performance and the practices in this area are most widely adopted. The duties of care and loyalty also rated high in performance. Quality oversight performance was rated higher this year than in 2009 (the performance score itself remained the same, but its ranking compared with other oversight areas was slightly higher this year), although adoption of practices did not increase significantly. Board self-assessment/development and advocacy remain the two weakest areas in both performance and adoption of practices.

Thus, the survey data reveal opportunities for hospitals and health systems to enhance their performance in ways that support all other board responsibilities. Board self-assessment/development activities include a regular performance assessment of the board, which boards can use to develop an action plan for performance improvement, and ongoing education programs on industry trends and governance information that can be tailored to the board's areas of weakness identified in the self-assessment. There has been increased attention in the industry on the importance of conducting individual board member assessments both to improve overall board performance and also to provide data to assist in the board member reappointment process; this is not reflected in the adoption scores this year. More focus on board self-assessment and development can help boards perform better in all areas, helping them to better anticipate obstacles to achieving board goals and identifying gaps in oversight responsibilities and practices.

Advocacy has long been an area of low performance, and with the current uncertainty in the industry regarding reimbursement levels and new payment models, advocacy efforts and fundraising should be top of mind for boards in helping their organizations have the financial means to continue to provide quality healthcare for the community.

# Introduction and Reader's Guide

HEALTHCARE GOVERNANCE CONTINUES TO evolve to meet the demands of individual organizations, their communities, and the legal and regulatory environment. The Governance Institute surveys U.S. not-for-profit hospitals every other year and, although the framework of the surveys remains similar, the information sought varies slightly from year to year. Given the volatility of the healthcare industry since the passage of the Patient Protection and Affordable Care Act in March 2010, as well as recent federal and state budget deficits and related cuts or potential cuts to entitlement programs including Medicare and Medicaid, this year's survey sought information that might show some indication of how healthcare organizations are beginning to respond to these dynamics.

This year's report presents results by topic. The first section of the report focuses on governance structure and offers comparisons with previous reporting years, as well as notable variations by organization type—systems, independent hospitals, hospitals that are part of a multi-hospital system ("subsidiary" hospitals), and government-sponsored hospitals.

The second section reports prevalence of adoption of recommended governance practices, and overall board performance for each area of board oversight responsibility. Variations by organization type that are notable are included here as well. This year, we increased the number of recommended practices to 95. This list has slowly been growing from a list of 50 practices in 2003. Some practices have been updated; others were added—related to compliance (duty of obedience) and new provisions within the Affordable Care Act. As the list of practices grows and becomes more complete, we are careful to maintain consistency over reporting years for the sake of comparison, while still having the ability to reflect market changes and new governance responsibilities. Thus, the list includes both fundamental governance practices that are not likely to change, as well as leading-edge practices that reflect priorities for boards given the current environment.

When reporting on governance structures, we use frequency tables (reported as a percentage of the total responding to specific questions). For governance practices, the body of this report shows results as composite scores, both practice adoption rates and overall performance in each oversight area.

The appendices included in this report include 1) results by frequency (percentages) for governance structure, by organization type, AHA designation, and bed size; 2) results by frequency for governance practices, by organization type; and 3) a table of all governance practices, using composite scores to determine the rate of adoption of the practices; this table highlights

**Table 1. Survey Responses**

| | 2011 | | 2009 | | 2007 | |
|---|---|---|---|---|---|---|
| | Respondents | Population | Respondents | Population | Respondents | Population |
| **Organization** | N = 660 | N = 4,250 | N = 740 | N = 4,250 | N = 718 | N = 4,271 |
| Religious (73) | 11% | 13% | 12% | 13% | 11% | 14% |
| Secular: | | | | | | |
| Government (164) | 25% | 25% | 24% | 25% | 25% | 24% |
| Non-Government (423) | 64% | 62% | 64% | 62% | 64% | 62% |
| **Number of Beds** | | | | | | |
| < 100 (256) | 39% | 46% | 36% | 45% | 41% | 44% |
| 100–299 (229) | 35% | 31% | 35% | 32% | 35% | 33% |
| 300 + (174) | 26% | 23% | 29% | 23% | 24% | 23% |
| **System Affiliation** (234) | 35% | 53% | 35% | 52% | 45% | 45% |

the most and least observed practices and compares the scores to the 2009 results.

For both governance structure and practices, the results reported here do not include those responding "not applicable" nor missing responses. Therefore, the "N" (denominator) is not fixed; it varies by question. For total number of responses for each question—overall and for the various subsets on which we report—see the appendices.

## Who Responded?

All U.S. not-for-profit acute care hospitals and health systems, including government-sponsored organizations (but not federal, state, and public health hospitals), received a copy of the survey—a total of 4,250. We received 660 responses (15.5%).[1]

In general, distribution of responding organizations matched those types of organizations in the surveyed population (see Table 1).

The largest group of responding organizations (39%) is hospitals with fewer than 100 beds. Government-sponsored hospitals represent 43% of those organizations—see detail in Table 2. More than one-third of all responding organizations (35%) are a system or affiliated with a system.

We also looked at system type and size—Catholic and other church systems appear to be larger among our panel of health system respondents (see Table 3).

### Comparison of Respondents 2011 vs. 2009

Just under half (47%) of the respondents in 2011 also completed and returned the survey in 2009 (see Table 4).

**Table 2. Respondents with Fewer than 100 Beds (N = 256)**

| | |
|---|---|
| Government-Sponsored Hospitals (111) | 43% |
| Subsidiary Hospitals (47) | 18% |
| Independent Hospitals (98) | 38% |

**Table 3. Health System Respondents by System Type and Size**

| | Number of Beds | | | | |
|---|---|---|---|---|---|
| | 100–299 | 300–499 | 500–999 | 1000–1999 | 2000+ |
| Catholic Systems (14) | 7% | 0% | 14% | 7% | 71% |
| Other Church Systems (6) | 0% | 0% | 17% | 50% | 33% |
| Other Systems (64) | 8%* | 28% | 35% | 23% | 5% |

*1.6% of "other system" respondents had < 100 beds.

**Table 4. 2011 vs. 2009 Respondents**

| | Number of Respondents in 2009 | Number of Respondents in 2011 | Number of Respondents Who Completed the Survey in both 2009 and 2011 |
|---|---|---|---|
| Systems | 126 | 81 | 53 |
| Independent Hospitals | 301 | 262 | 140 |
| Subsidiary Hospitals | 133 | 153 | 44 |
| Government-Sponsored Hospitals | 180 | 164 | 71 |
| Total | 740 | 660 | 308 |

1 About 35% of the 660 respondents are members of The Governance Institute.

# Governance Structure

## Board Size and Composition

### Summary of Findings

Average board size: 13.3

Median board size: 13

Voting board members:

- Medical staff physicians: average is 2.3; median is 2
- "Outside" physicians: average is 0.5; median is 0
- Nurses: average is 0.4; median is 0
- Management: average is 0.7; median is 0
- Independent board members: average is 9.98; median is 10
- Female board members: average is 3.4; median is 3
- Ethnic minority board members: average is 1.2; median is 1

Board member age limits: average is 73.6; median is 75

The average number of board members is slightly higher than reported in 2009—13.3 vs. 13.1. The median nained 13. There has been only a slight ft in board composition from 2009 to this ar. Table 5 shows the comparison; Tables 9 show a comparison of board composin for each organization type.

Board size generally increases with organization size for independent and subsidy hospitals. For systems, average board e is similar to the overall system average gardless of size, with the exception of smallest systems (for systems with )–299 beds, the average board size is much lower than the overall average). r government-sponsored hospitals, ose in the category of 300–499 beds e second largest group) have a higher mber of board members than the overall

**Table 5. 2011 and 2009 Board Composition**

| | Total # of Voting Board Members | | Management | | Medical Staff Physicians | | Outside* | |
|---|---|---|---|---|---|---|---|---|
| | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 |
| Average # of Voting Board Members | 13.3 | 13.1 | 0.7 | 0.6 | 2.3 | 2.1 | 10.3 | 10.3 |
| Median # of Voting Board Members | 13 | 13 | 0 | 0 | 1 | 2 | 10 | 11 |

*Includes physicians who are not on the organization's medical staff/not employed by the organization; also includes nurses who are not employed by the organization and independent board members.

**Table 6. System Board Composition**

| Systems | Total # of Voting Board Members | | Management | | Medical Staff Physicians | | Outside* | |
|---|---|---|---|---|---|---|---|---|
| | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 |
| Average # of Voting Board Members | 15.7 | 16.5 | 1 | 1 | 2.6 | 2.4 | 12.1 | 13.1 |
| Median # of Voting Board Members | 15 | 15 | 1 | 1 | 2 | 2 | 12 | 12 |

*Note:* Outside representation decreased; also, there was a small increase in physician representation. Average board size decreased slightly.

**Table 7. Independent Hospital Board Composition**

| Independent Hospitals | Total # of Voting Board Members | | Management | | Medical Staff Physicians | | Outside* | |
|---|---|---|---|---|---|---|---|---|
| | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 |
| Average # of Voting Board Members | 14.9 | 14.4 | 0.6 | 0.6 | 2.6 | 2.6 | 11.7 | 11.2 |
| Median # of Voting Board Members | 14 | 14 | 1 | 1 | 2 | 2 | 11 | 11 |

*Note:* Management and physician representation remained the same. Average board size increased slightly, reflected in "outside" board members.

**Table 8. Subsidiary Hospital Board Composition**

| Subsidiary Hospitals | Total # of Voting Board Members | | Management | | Medical Staff Physicians | | Outside* | |
|---|---|---|---|---|---|---|---|---|
| | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 |
| Average # of Voting Board Members | 15.1 | 14.5 | 1.3 | 0.9 | 2.9 | 2.8 | 10.9 | 10.8 |
| Median # of Voting Board Members | 15 | 14 | 1 | 1 | 2 | 2 | 12 | 11 |

*Note:* Average and median number of board members increased; management representation on the board also increased.

average for this type of organization (11.1 board members, compared with an overall average of 8 members). However, the largest government-sponsored hospitals (500–999 beds) have an average of 7 board members.

This year we asked about the number of nurses on the board, as well as the number of independent board members (i.e., those who do not have a material financial relationship with the organization and fit the definition of "independent" according to IRS guidelines). Health systems reported the highest average number of independent board members (12.49); subsidiary hospitals have the highest average number of nurses on the board (0.51). (Note that health system and subsidiary boards are the largest boards.)

See Exhibit 1 for a breakdown of board members overall and by organization type for 2011.

**Table 9. Government-Sponsored Hospital Board Composition**

| Government-Sponsored Hospitals | Total # of Voting Board Members | | Management | | Medical Staff Physicians | | Outside* | |
|---|---|---|---|---|---|---|---|---|
| | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 |
| Average # of Voting Board Members | 8.0 | 7.4 | 0.1 | 0 | 0.9 | 0.7 | 7 | 6.7 |
| Median # of Board Members | 7 | 7 | 0 | 0 | 0 | 0 | 7 | 7 |

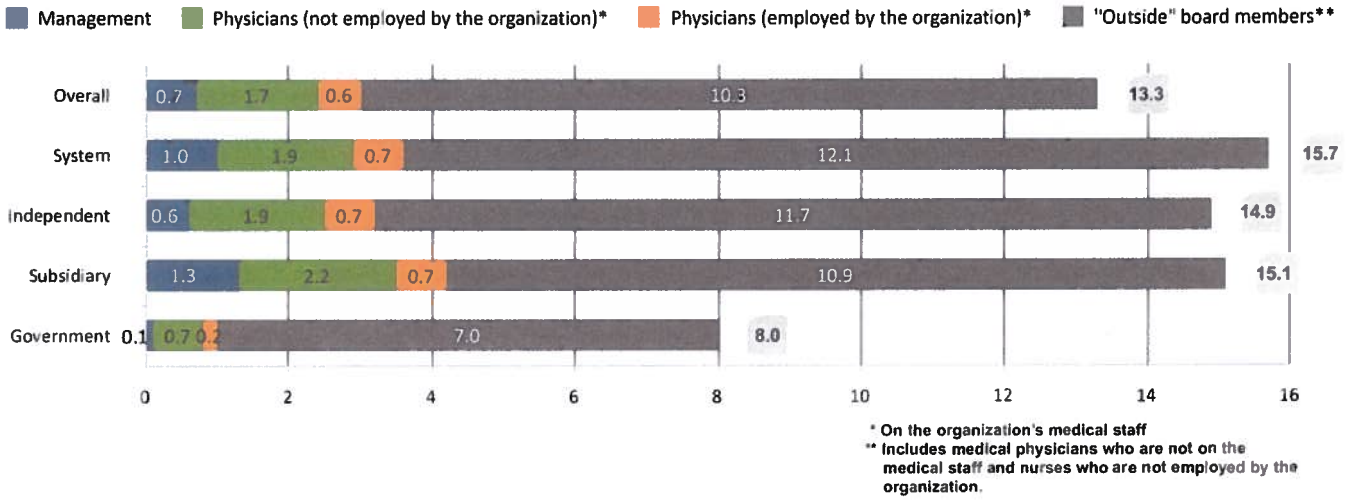
*Note:* There was a slight increase in average board size and medical staff physicians on the board.

**Table 10. Physicians on the Board 2011 vs. 2009**

| | On the medical staff but not employed by the organization | | On the medical staff and employed by the organization | | Not on the medical staff not employed by the hospital ("outside") | |
|---|---|---|---|---|---|---|
| | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 |
| Average | 1.7 | 1.7 | 0.6 | 0.4 | 0.5 | 0.3 |
| Median | 1 | 2 | 0 | 0 | 0 | 0 |

*Note:* Health systems and subsidiary hospitals tend to have more physicians on the board (average 3.31 and 3.41 physicians as voting members, respectively); government sponsored hospitals have the fewest physician board members (average 1.23). Note that health systems and subsidiary hospitals have larger boards, and government sponsored hospitals have smaller boards.

**Exhibit 1. Average Number of Board Members (Overall and by Organization Type)**




* On the organization's medical staff
** Includes medical physicians who are not on the medical staff and nurses who are not employed by the organization.

## Largest Boards

Independent hospitals with 300+ beds: 17.7

Systems with 1000–1999 beds: 17.2

Subsidiary hospitals with 500–999 beds: 17.0

### ysicians on the Board

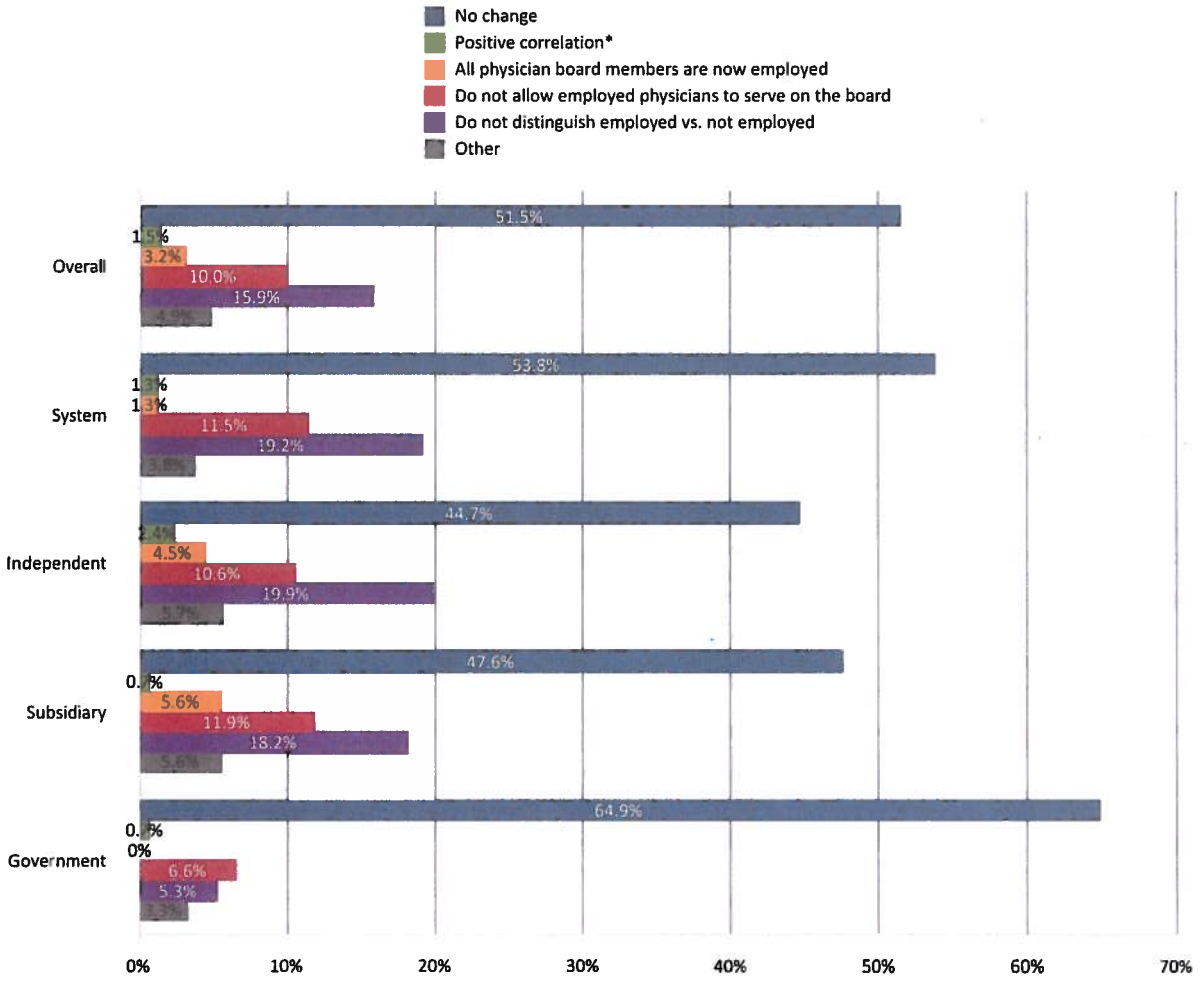
spondents noted physician board mbership in the following categories:

- hysicians who are on the medical staff nd *not* employed by the hospital
- hysicians who are on the medical staff nd employed by the hospital
- Physicians who are on the medical staff and have contracts with the hospital (there may be some overlap here with physicians who are on the medical staff and not employed by the hospital)
- Physicians who are not on the medical staff (and qualify as "outside" board members)

The total average number of physicians on the board (all types of physicians including "outside" physicians; excluding medical staff physicians with contracts) is 2.68; the median is 2. Overall, the breakdown for these categories is shown in Table 10.

The number of voting board members who are employed physicians has increased for all types of organizations (overall average is 0.58 vs. 0.39 in 2009). This year, we asked respondents to note if there have been any changes in physician representation on the board resulting from employing physicians. The vast majority of respondents indicated that there has been no change (or, any changes in physician representation on the board have not been attributed to employing physicians). A breakdown of results by organization type appears in Exhibit 2.

**Exhibit 2. Changes in Physician Representation on the Board Resulting from Employing Physicians**




* The number of employed physicians on the board corresponds with the percentage of physicians employed by the organization.

## Females and Ethnic Minorities on the Board

Most boards (97%) have at least one female board member, but just over 50% have ethnic minorities represented on the board (see Exhibits 3 and 4). Responses from systems, independent hospitals, and subsidiary hospitals suggest that in general, as these organizations get larger, female and ethnic minority representation increases (see Table 11).

**Table 11. Female and Ethnic Minority Representation on the Board—by Organization Size**

| | Females | Ethnic Minorities |
|---|---|---|
| | Average / *Median* | Average / *Median* |
| < 100 beds | 2.9 / 2 | 0.5 / 0 |
| 100–299 beds | 3.7 / 3 | 1.4 / 1 |
| 300–499 beds | 3.8 / 4 | 1.8 / 1 |
| 500–999 beds | 3.7 / 3 | 1.8 / 1 |
| 1000–1999 beds | 3.7 / 4 | 1.4 / 1 |
| 2000 + beds | 5.7 / 7 | 2.3 / 2 |

## Age Limits

The number of organizations that have specified a maximum age for board service has decreased slightly from 2009—7.6% in 2011 vs. 8.1% in 2009. The median age for the 48 respondents to this question is 75 years.

**Exhibit 3. Female Board Members (All Respondents)**

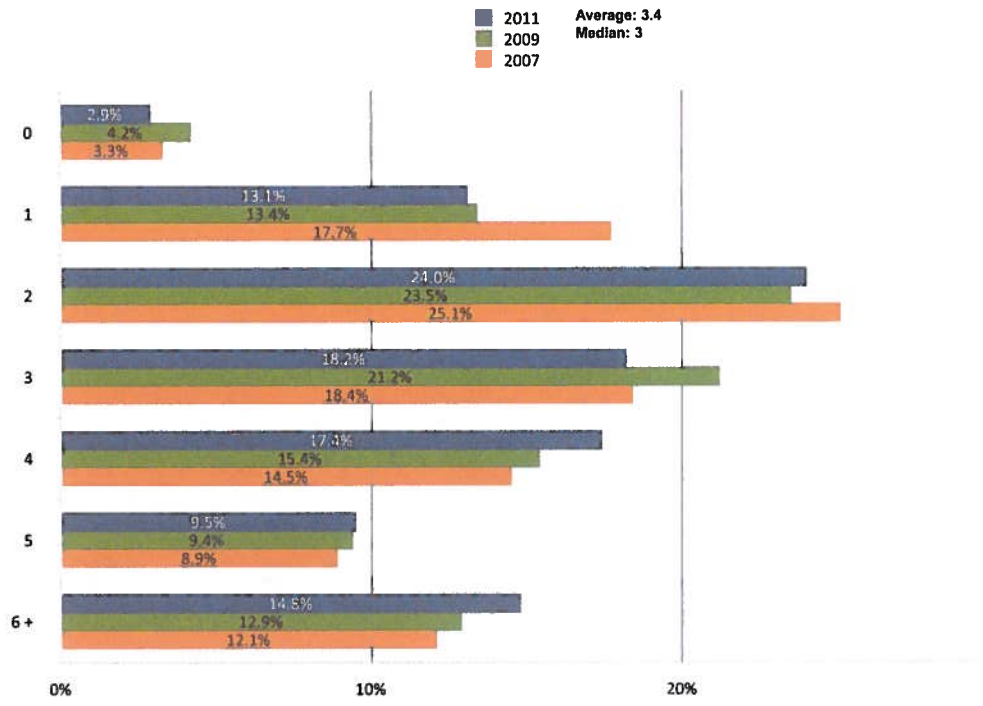
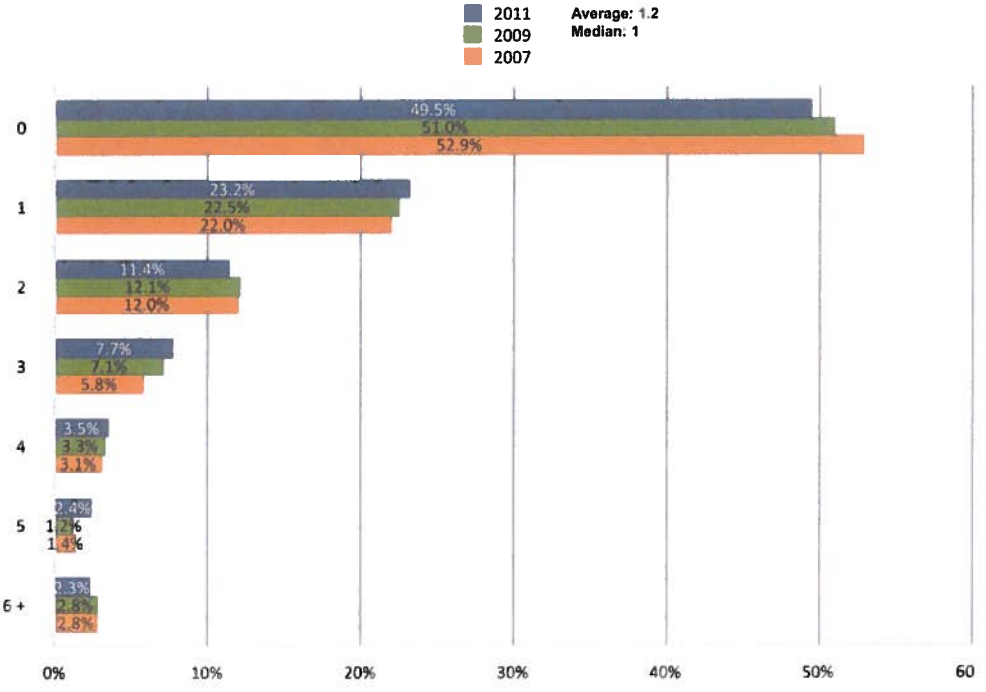



**Exhibit 4. Ethnic Board Members (All Respondents)**



## Defined Terms of Service

### Summary of Findings

of the respondents limit the number of ;ecutive terms, compared to 65% who rted term limits in 2009.

/pe of organization:

ystems—78%
ıdependent hospitals—70%
ubsidiary hospitals—77%
;overnment-sponsored hospitals—35%

Most respondents (91%) have defined terms for the length of elected service—the median term length is 3 years. A significantly lower percentage of respondents has defined limits for the maximum number of consecutive terms (the deciding factor in "term limits")—64%.

This year represents a significant increase in the number of government-sponsored hospitals respondents reporting term limits (see Exhibit 5). Thirty-five percent (35%) of the respondents from government-sponsored hospitals reported having term limits, up from 25% in 2009 and 24% in 2007. Term limits are not customary among government-sponsored hospitals, where board members usually are appointed by a government agency or elected by the general public. For district/authority hospitals, terms themselves may be determined by the public election cycle, and those elected may, in some areas, be "term limited." But this is not standard. For other hospitals and systems, more often than not, boards have chosen to adopt term limits.

For nearly all types and sizes of non-government-sponsored hospitals and systems, more than 70% report term limits. The exceptions are:

- Systems with 300–499 beds (47% have term limits)
- Independent hospitals with fewer than 100 beds (65% have term limits)

**Exhibit 5. Limits on the Maximum Number of Consecutive Terms (Overall and by Organization Type)**

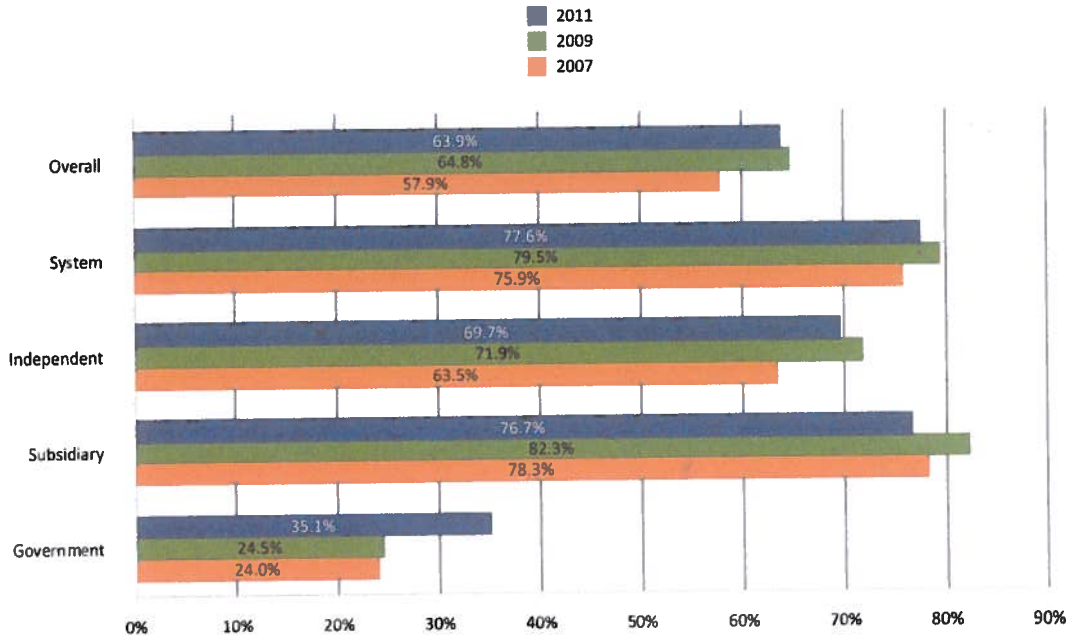


**Table 12. Frequency of Position and Board Participation 2011 vs. 2009**

| | % of respondents with this position | | % of respondents noting presence in boardroom | | % of respondents noting board member (voting and non-voting) | |
|---|---|---|---|---|---|---|
| | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 |
| CFO | 83.9% | 97.2% | 96.2% | 97.9% | 3.2% | 3.3% |
| CNO | 80.3% | 92.8% | 85.3% | 85.9% | 3.6% | 3.1% |
| Compliance Officer | 72.9% | 85.8% | 45.2% | 49.3% | 1.7% | 1.3% |
| Legal Counsel | 58.4% | 65.4% | 65.0% | 65.3% | 2.8% | 3.5% |
| CIO | 56.7% | 66.5% | 31.2% | 28.0% | 1.0% | 0.2% |
| VPMA/CMO | 50.5% | 51.2% | 93.5% | 89.7% | 8.6% | 8.7% |
| COO | 46.8% | 56.6% | 95.0% | 95.2% | 5.5% | 3.8% |

## Participation on the Board

### Summary of Findings

- President/CEO:
  - Voting board member: 47%
  - Non-voting board member: 16%
- Chief of staff:
  - Voting board member: 39%
  - Non-voting board member: 12%
- 14% (71 of 492 respondents) said the chief of staff is a voting member of the board and the CEO is either a non-voting member or not a board member.

Respondents told us about executive and medical staff participation on the board—as voting or non-voting members, and as non-board members who regularly attend board meetings.

There has been little change in CEO status as an *ex officio* voting board member. In 2009, 2007, and 2005, 48% of the responding organizations overall have the CEO as a voting member of the board. This number decreased only slightly in 2011—47%. Health systems have the highest percentage of voting CEO board members: 81% (up from 76% in 2009). In contrast, government-sponsored hospitals have the lowest percentage of voting CEO board members (7%). For a large majority of government-sponsored hospitals (84%, up from 78% in 2009), the CEO is not a board member but regularly attends meetings.

The chief of staff is a voting board member for 39% of respondents this year. In 2009, fewer respondents said the chief of staff is a voting board member—38% in 2009 vs. 43% in 2007 and 2005. For 27% of health systems, the chief of staff is not a board member and does not attend meetings.

Most respondents said their executives, other than the compliance officer and the chief information officer, regularly attend board meetings. There are interesting variances by type of organization; for example, 81% of health systems and 68% of subsidiary hospitals said the legal counsel regularly attends board meetings or is a board member, vs. only 53% for independent hospitals (for detail, see Appendix 1).

Only 45% of health systems said they ha a chief of staff position at the system lev (down from 59% in 2009). In general, the larger the system, the less likely it is to have this position.

We added a few new positions on t year's survey, based on movement in industry (see Exhibit 6 for all positions). those organizations with an owned or af ated medical group or physician enterp (26% of respondents), 22% of those hav representative from this group as a vot member of the board. For those organi tions that are sponsored by a religious en (11% of respondents), 63% have a represer tive from the religious sponsor as a vot member of the board.

Given the variation in board comp tion—specifically CEO and chief of s board membership—we looked spec cally at these two positions across type organizations (see Table 13). (Please n these results are reported in *numbers*, percentages.)

**Exhibit 6. Participation on the Board (All Respondents)**
(includes only organizations where specific job titles apply)

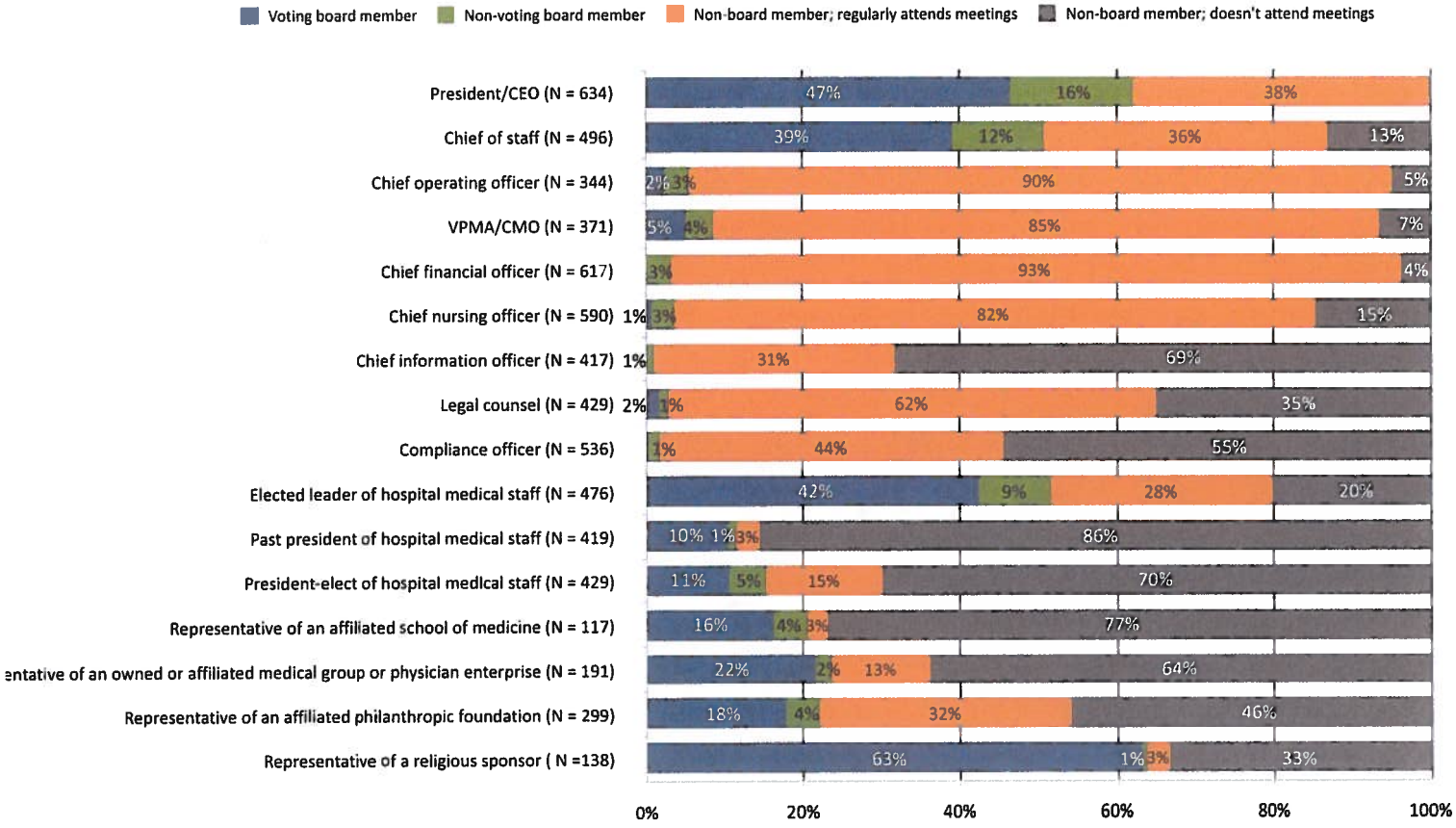



**Table 13. CEO and Chief of Staff Board Participation by Organization Type**

| Number of Respondents | Overall N = 492 | | Systems N = 40 | | Independent Hospitals N = 198 | | Subsidiary Hospitals N = 117 | | Government-Sponsored Hospitals N = 137 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 |
| EO=Voting board member AND hief of Staff=Voting member | 122 | 160 | 12 | 19 | 57 | 93 | 50 | 47 | 3 | 1 |
| EO=Non-voting board member AND hief of Staff=Voting board member | 26 | 23 | 0 | 0 | 20 | 11 | 3 | 9 | 3 | 3 |
| EO=Non-voting board member OR not a board ember AND hief of Staff=Voting board member | 71 | 79 | 0 | 2 | 47 | 46 | 11 | 16 | 13 | 14 |
| EO=Voting board member AND hief of Staff=Non-voting board member | 18 | 31 | 3 | 5 | 4 | 13 | 10 | 13 | 1 | 0 |
| EO=Voting board member AND hief of Staff=Not a board member | 66 | 93 | 16 | 28 | 27 | 33 | 19 | 25 | 4 | 7 |
| EO=Not a board member AND hief of Staff=Not a board member | 155 | 185 | 6 | 15 | 35 | 15 | 14 | 10 | 100 | 119 |