CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

Finance and Management Committee

Wednesday, April 25, 2012

7:30 a.m.

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

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.

This is being noticed as a Board Meeting as a quorum of Directors may be present. Ex-officio members and non-committee members cannot vote on any item, whether or not a quorum of the Board is present.

I. Call To Order — Michael McCormick

II. Action Items

- A. Acceptance of March 28, 2012 Minutes [enclosure] — Michael McCormick
- B. Recommendation to Accept March 2012 Unaudited Financial Statements [enclosure] — Bob Anderson
- C. Recommendation to Enter into an Agreement with Select Therapies for Long Term Care Rehabilitation Services Management and Recommendation for Reorganization of Rehabilitation Services [enclosure] — Kerry Easthope

III. Chief Executive Officer Report — Deborah E. Stebbins

- A. Organizational Management Changes
- B. Revenue Cycle Update [enclosure]
- C. Charge Master Description (CDM) Review Update
- D. RAC Review Update
- E. Comprehensive Orthopedic Program Update

IV. Chief Financial Officer Report

- A. FY 2012-2013 Budget – Volume Assumptions [enclosure] — Bob Anderson, Katy Silverman

V. Board / Committee / Staff Comments

VI. Adjournment

NEXT MEETING SCHEDULED: MAY 30, 2012

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Finance and Management Committee Minutes March 28, 2012

DRAFT

Members Present: (Voting)	Mike McCormick Elliott Gorelick (partial)	Ann Evans Ed Kofman	Jim Yeh, DO
Management Present:	Deborah E. Stebbins Kerry J. Easthope Bob Anderson	Katy Silverman Tony Corica Mary Bond, RN	Becky Pavone Teresa Jacques
Ex Officio/Guests:	Robert Deutsch, MD		
Absent:	Elliott Gorelick	James Oddie	
	William Sellman, MD	Jordan Battani	
Submitted by:	Kristen Thorson		

TOPIC		DISCUSSION	ACTION | FOLLOW-UP
I. Call to Order		Director McCormick called the meeting to order at 7:35 a.m.	
II. Action Items	A.	Acceptance of February 29, 2012 Minutes	Ms. Evans made a motion to accept the minutes as presented. Mr. Oddie seconded the motion. The motion carried.
	B.	Recommendation to Accept February 2012 Unaudited Financial Statements Bob Anderson presented the financial statements as referenced in the packet. For the month of February, there was a positive bottom line of $175,000.	Mr. Kofman made a motion to recommend approval of the February 2012 Unaudited Financial Statements as presented. Ms. Evans seconded the motion. The motion carried.
	C.	Recommendation to Approve the Establishment of a Comprehensive Orthopedic Program at Alameda Hospital and Approval to Enter into a professional Services Agreements with Two Orthopedic Surgeons Tony Corica, director of Physician Relations and Mary Bond, Executive Director of Nursing Services presented a recommendation to the committee regarding the establishment of a comprehensive orthopedic program and the recruitment of two orthopedic physicians through professional services agreements. A revised proforma was distributed to the committee which has been included in the original packet and posted on the website. Their presentation included a review of	Ms. Evans made a motion to recommend the establishment of a comprehensive orthopedic program at Alameda Hospital and to recommend approval to enter into a professional services agreements with two orthopedic surgeons Mr. Kofman seconded the motion. The motion carried.

		the current state of orthopedics in Alameda, current opportunities, what new orthopedists will bring to Alameda, the hospital orthopedic capabilities, quantitative and qualitative analysis, funding the program, benefits of the program to the strategic initiatives of the hospital / district, demographics affecting orthopedics in the future, and the financial proformas. There was discussion on the term of the professional services agreement (3yrs) office location for the orthopedists, and the structure program in general. The committee requested month by month detail on the financial proformas as well as a detailed description of a marketing strategy for the program that included key metrics to be included in the recommendation to the Board of Directors for the April 2, 2012 meeting.	
III. Chief Executive Officer Report	A.	Revenue Cycle Update Teresa Jacques from HFS and Becky Pavone, Interim Business Office Manager reviewed the updated work plan for the revenue cycle and business office that was included in the packet.	No action taken.
	B.	Charge Master Description (CDM) Review Ms. Stebbins stated that the company Panacea completed their review of the Charge Master. She noted that initial findings indicate that there would be a sizable opportunity for improvement. More information will be reviewed at the next committee meeting.	No action taken.
	Ms. Stebbinsm in the interest of time, stated that she would cover the following items in her CEO report to the Board of Directors for the April 2 Board meeting.		
	C.	RAC Review Update	No action taken.
	D.	Rebate on Workers Compensation Reserves	No action taken.
	E.	Update on Medi-Cal DP/NF Rates	No action taken.
IV. Chief Financial Officer Report	A.	FY 2012-2013 Budget – Volume Projections The Volume assumptions were briefly presented and will be discussed in more detail at the April committee meeting.	No action taken.
V. Board / Committee / Staff Comments	No board, Committee or Staff comments.		
VI. Adjournment	Being no further business, the meeting was adjourned at 9:26 a.m.		

DRAFT

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING MARCH 31, 2012

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
MARCH 31, 2012

Table of Contents **Page**

Financial Management Discussion 1 – 11

- Highlights
- Activity
  - Payer Mix
  - Case Mix Index
- Income Statement
  - Revenues
  - Expenses
- Balances Sheets
- FTE’s and Key Ratios

Statements

Key Statistics for Current Month and Year-to-Date	12
Statement of Financial Position	13
Statement of Operations	14
Statements of Operations - Per Adjusted Patient Day	15
Statement of Cash Flows	16
Ratio Comparisons	17-18
Glossary of Financial Ratios	19

ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
MARCH, 2012

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 March 31, 2012 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.

Highlights

This month the hospital experienced a negative bottom line. $295,000 was budgeted and a negative ($401,000) was realized. Year-to-date the hospital's bottom line is negative by ($1,112,000).

This month's results included two unusual adjustments to contractual allowances. $35,000 was established as a reserve for a potential pay-back associated with this year's Skilled Nursing payments. As was discussed last month, the state has the ability to recapture certain skilled nursing payments for services unpaid as of 12/31/2011. Additionally, the 2010 Medi-Cal cost report was settled with a payable of $402,000. This is $203,000 greater than anticipated. Without these two adjustments the month's bottom line would have been negative by $163,000.

In addition to the contractual adjustments, March activity was down. March is historically a very busy month. As such, March activity was budgeted very high. This year February was the busy month and March ended up being a down month. Therefore there is a large budget variance for both inpatient and outpatient services. Compared to how the hospital has been performing this year, March inpatient revenues are down about 4.6% and outpatient revenues are actually up 6.9%.

March discharges are below budget 6.1% and patient days were under budget 11.7%. The average length of stay was 7.6% below budget. Patients days in all inpatient services were down with acute patients down 14.5%, Sub-Acute down 7.0% and Skilled Nursing down 14.0%. On the other hand, inpatient surgery cases were 57 which was above the budgeted volume of 50.

Overall outpatient activity was mixed this month. This month outpatient registrations were down 16.3% yet Emergency Room visits were above budget by 5.6%. YTD outpatient volumes are about 8.5% below budget while Emergency visits equal to budget. Outpatient surgeries were below budget for the month by 4.2%, but continue above budget YTD by 5.8%.

Gross revenue in March is generally in line with activity. Overall gross revenues were 11.1% below budget, with the inpatient component down 15.2% and outpatient down 2.5%. The inpatient revenue variance is largely due to revenues being budgeted at a relatively high level in March. The outpatient budget includes $428,000 for Wound Care. Without this budget item, outpatient revenues would be slightly above budget. Net patient revenues were 22.9% of Gross revenues. This is slightly above the YTD net to gross value.

The Case Mix Index (CMI) ran above the YTD average. The overall CMI in March was 1.3071; down from last month's of 1.3572, but still above the YTD average.

There were a number of expenses categories that ran over budget this month. Employee benefit costs, purchased service and other operating costs were significantly over budget. Employee benefit costs include costs associated with employee health usage. These costs fluctuate according to their usage. March billings for these costs were unusually high. Purchased services were high because of services for outside billing, information systems and engineering. Other operating expenses include costs for employee recruitment. This month's costs include the fees associated with two recruited employees. On the other hand, Labor and supply costs continue below budget. Supply costs had been averaging about $150,000/mo. under budget. This month supply costs were $40,000 under. YTD expenses are very close to budget, just 0.3% over budget or $166,000.

Actual cash is down significantly from the prior month. It decreased from $1,825,000 to $428,000. Expressed in days-cash-on-hand, the hospital went from 12.4 days in February to 2.2 days in March. The reason for this decrease is two-fold. The timing of Payroll at month-end caused a $642,000 decrease. Also, the IGT program was funded in March which utilized $820,000 in cash.

Cash should improve significantly over the next few weeks. It is expected that the hospital will not only receive its initial IGT contribution but an additional $547,000 in early May. This month the hospital will receive approximately $2,600,000 in tax monies and then in June, the hospital should receive its AB915 monies. AB 915 is a program designed to reimburse government hospitals for underfunded Medi-Cal outpatient services. This should result in an additional $480,000 in reimbursement.

Cash collections in March were $5.5M. This is the first time this year cash collections exceeded net revenues and caused net Accounts Receivable to decrease.

Accounts payable grew slightly by $57,000 from $8,885,000 to $8,942,000. AP days were 142. This is down slightly from the previous month. The cash coming in from Tax, IGT and AB915 plus improved AR collections should allow for a significant reduction in AP and allow the hospital to set aside a reasonable cash reserve.

Lastly, the current ratio ended the month at 1.0. This is a decrease from the previous month and is right on the threshold necessary to meet Bank of Alameda's criteria for funding the Wound Care project and extending the hospitals line of credit.

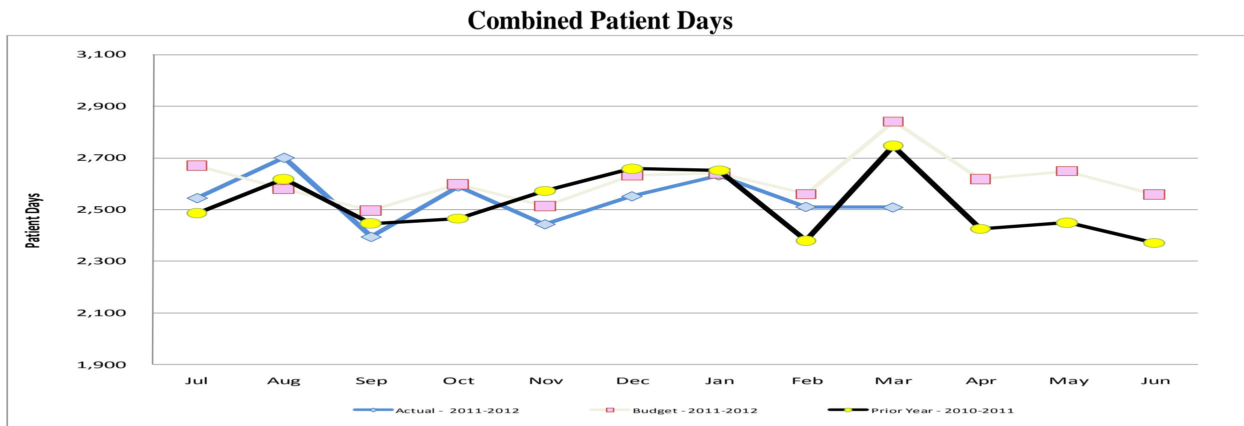
ACTIVITY

ACUTE, SUBACUTE AND SNF SERVICES

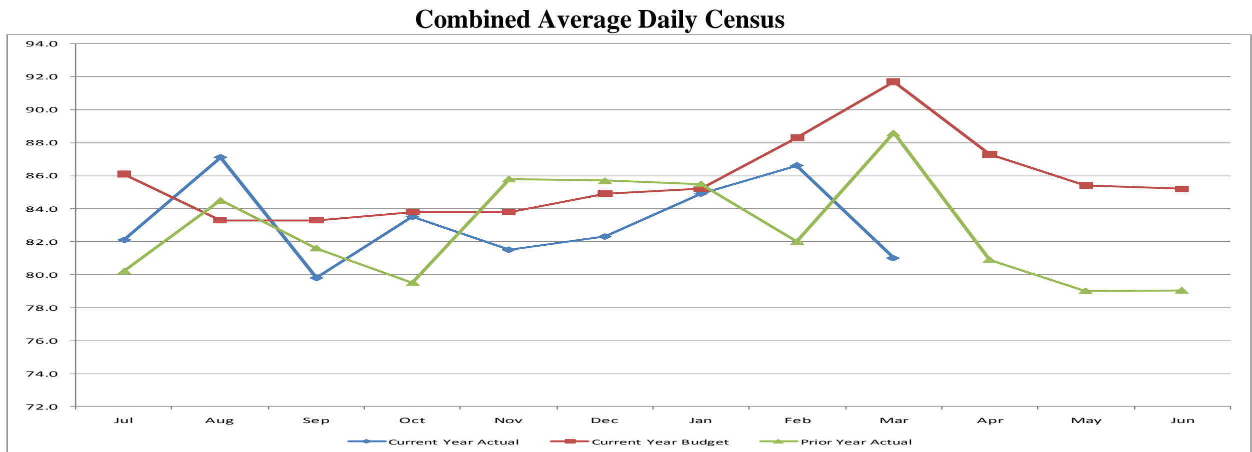
Patient days were below budget for the month and below March of last year. This month's acute days were down 14.5%, Sub-Acute was down 7.0% and Skilled Nursing was down 14.0%. YTD days are now (2.8%) under budget.

March's acute care patient days were 154 days less than budget for the month and 16.6% below the prior year's average daily census of 35.0. The acute care program is comprised of the Critical Care Unit (2.7 ADC, below budget 52.0%), Definitive Observation Unit (10.2 ADC, 13.6% below budget) and Med/Surg Units (16.3 ADC, 2.9% below budget). The CCU unit was closed a few days during the month, and the nice weather in March contributes to the lower acute census.

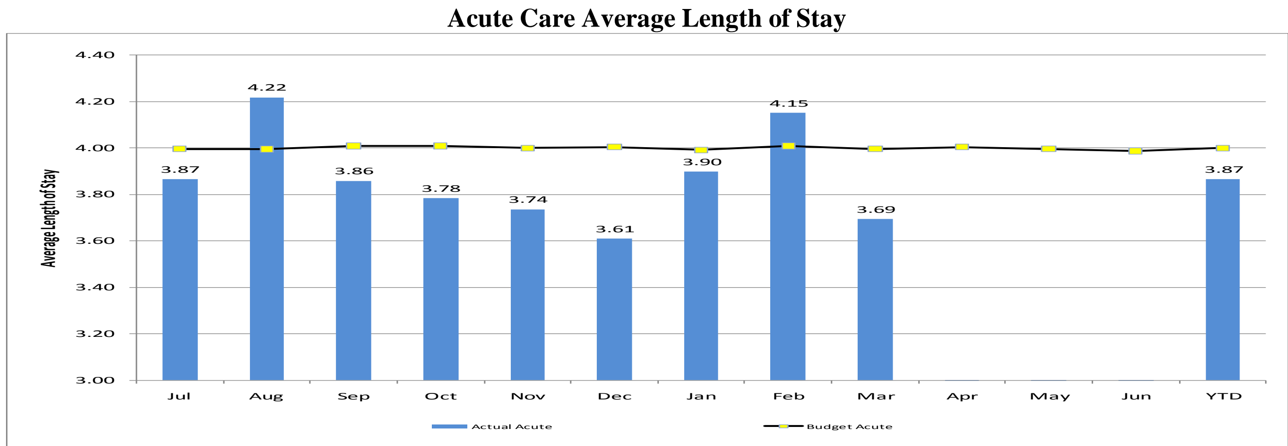
The graph, below, shows the total patient days by month for fiscal year 2012 compared to the operating budget and fiscal year 2011 actual.



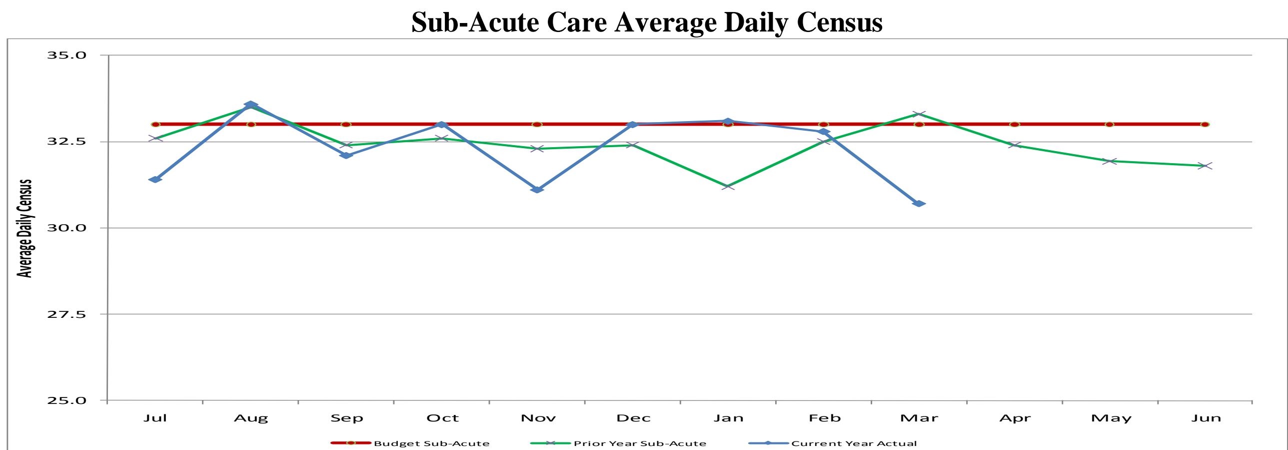
The graph below shows the average daily census for all inpatient services. The actual ADC was 80.94 versus budget of 91.65 an unfavorable variance of 12.1%.



The acute average length of stay (ALOS) decreased from the high in February of 4.15 to 3.69 in March, back below 4.0. Budgeted acute ALOS is 4.0, and YTD is still under that target. The overall acute ALOS for FY 2011 was 4.13. The graph below shows the ALOS by month compared to the budget.

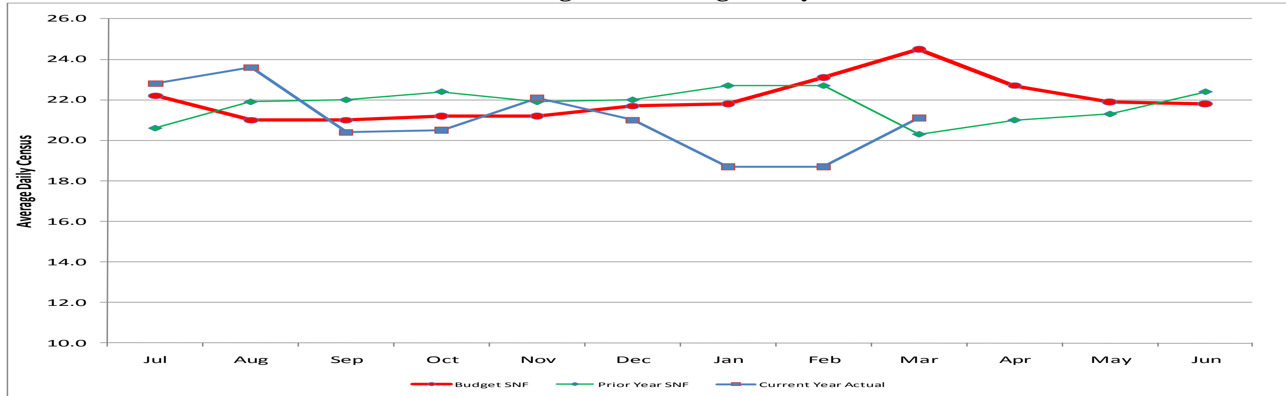


The Sub-Acute programs average daily census of 30.68 in March was below budgeted projections by 7.3%. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.



The Skilled Nursing Unit (South Shore) patient days were 14.0% or 106 patient days lower than budgeted for the month of March. YTD days are also down compared to both budget and the prior year. However, efforts to improve census have been fruitful as census has climbed back up from the lows of the prior few months. The graph, below, shows the Skilled Nursing Units monthly average daily census as compared to budget and the prior year.

Skilled Nursing Unit Average Daily Census

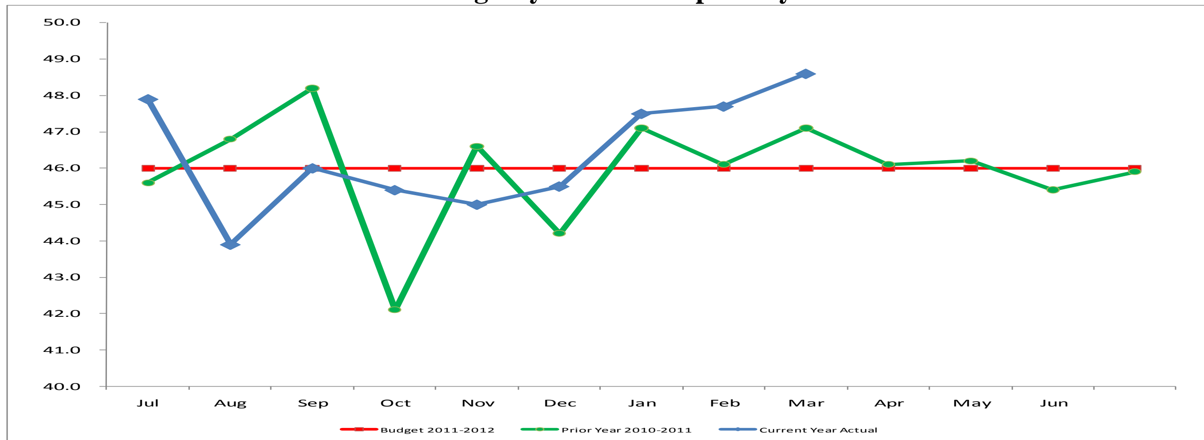


ANCILLARY SERVICES

Outpatient Services

Emergency Care Center visits in March were 1,506. This is 80 visits (5.6%) over the budget of 1,426. 17.3% of ECC visits resulted in inpatient admissions versus 19.2% in February. On a per day basis, the total visits represent an increase of 1.9% from the prior month daily average. In March, there were 315 ambulance arrivals versus 267 in the prior month. Of the 315 ambulance arrivals in the current month, 224 or 71.1% were from Alameda Fire Department (AFD) ambulances.

Emergency Care Visits per Day



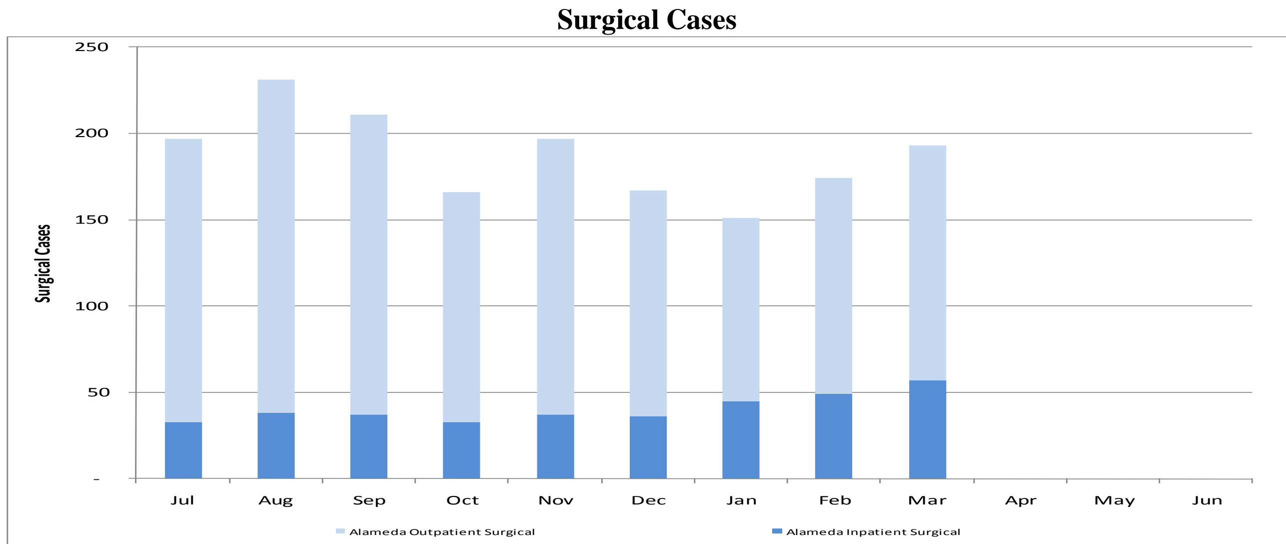
Outpatient registrations were 1,901, or 16.3% below budget. March's average daily registrations were 61.3 which was 4.07% lower than the prior month. This is in consistent with YTD outpatient registrations which are below budget by 8.5%. This month Laboratory, Radiology and Nuclear Medicine were down 247, 52 and 20 visits respectively. On the other hand visits were up in MRI (15 visits), CT Scan (20 visits), Physical Therapy (46 visits) and Occupational Therapy (17 visits). There were no Wound Care visits but visits were again budgeted as the program was expected to start in February. This equated to a total of 380 visits for the two months.

Surgery

The year-to-date surgery cases were 1,699 or 3.1% above the budget of 1,648 and also above last year. For the month, total surgery cases were just above budgeted expectations by 0.5% at 193 cases versus the budget of 192 cases. Inpatient cases were above budget 7 (14.0%) while outpatient cases were 6 (4.2%) below budget. Inpatient and outpatient cases totaled 57 and 136

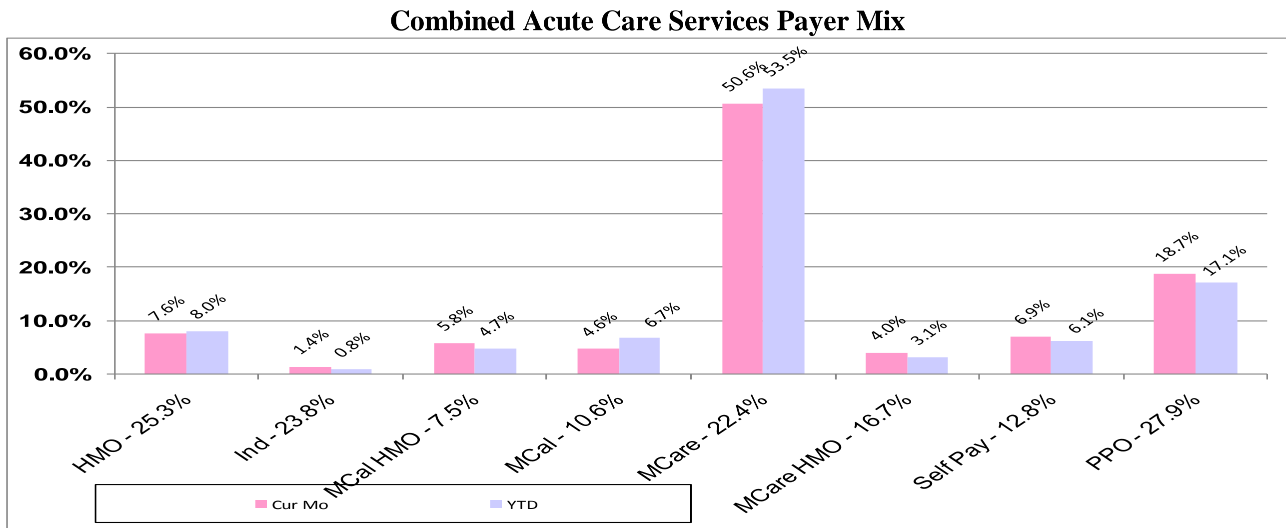
in March versus 49 and 125 during the prior month. Inpatient surgery was busy again in March.

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

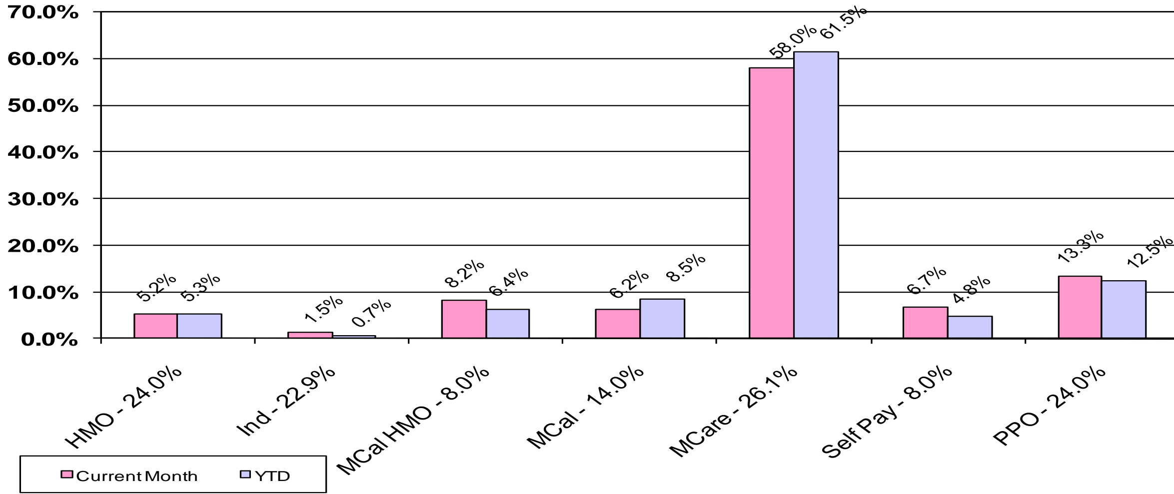


Payer Mix

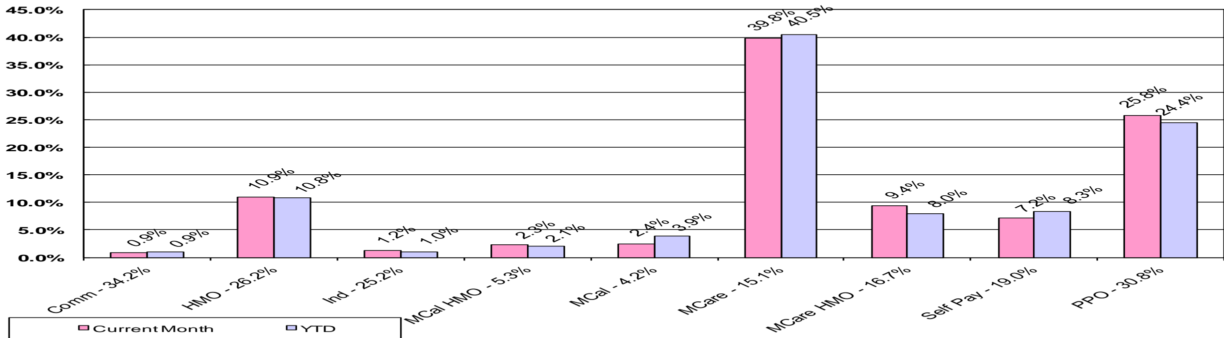
Combined acute care services, inpatient and outpatient, Medicare and Medicare Advantage total gross revenue in March made up 54.5% of the month's total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 26.3%, Medi-Cal Traditional and Medi-Cal HMO utilization at 10.4% and self pay at 6.9%. The graph below 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.



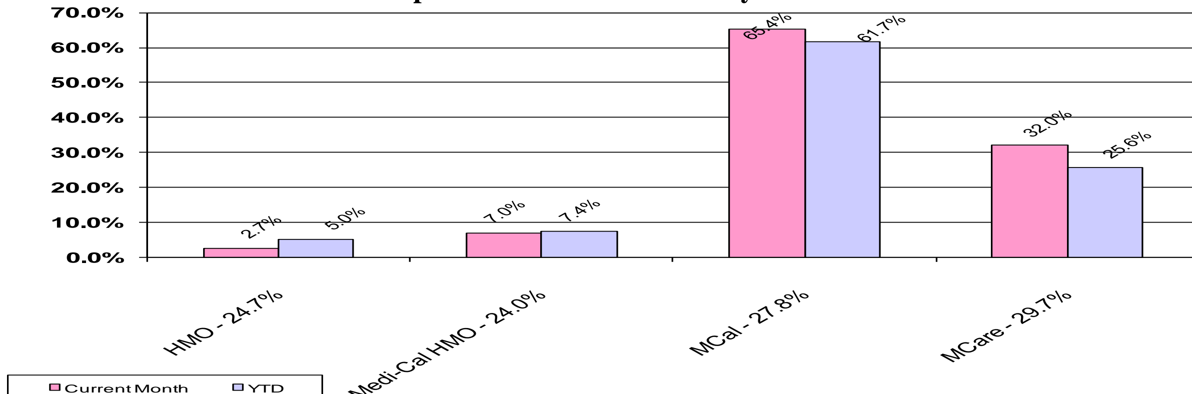
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 58.0% of our total inpatient acute care gross revenues followed by HMO/PPO at 18.5%, Medi-Cal and Medi-Cal HMO at 14.5% and Self Pay at 6.7% of the inpatient acute care revenue. The graph below shows inpatient acute care current month and year to date payer mix and current month estimated net revenue percentages for fiscal year 2012.



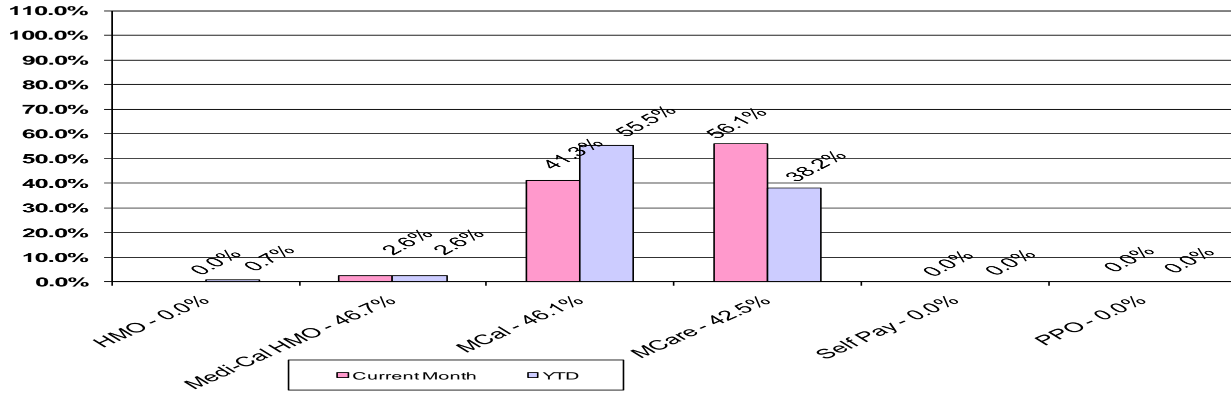
The outpatient gross revenue payer mix for February was comprised of 50.4% Medicare and Medicare Advantage, 34.5% HMO/PPO, 5.9% Medi-Cal and Medi-Cal HMO, and 8.6% self pay. The graph below shows the current month and fiscal year to date outpatient payer mix and the current months estimated level of reimbursement for each payer.



In February, the Sub-Acute care program again was dominated by Medi-Cal utilization of 67.7%, down from a high of 70% in January. Medicare was 25.7% and HMO/PPO rounds out the unit at 4.2%. 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.

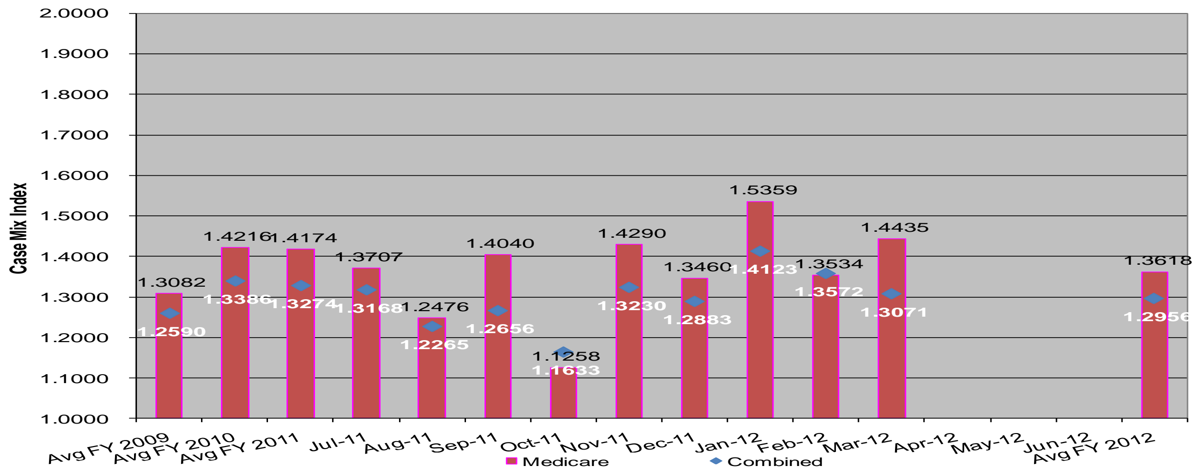


The graph below shows the current month and fiscal year to date skilled nursing payer mix and the current month's estimated level of reimbursement for each payer. Note the change in volumes between Medicare and Medi-Cal. This reflects the successful placement of an increasing volume of post-acute skilled patients (Medicare).



Case Mix Index

The hospital's overall Case Mix Index (CMI) for March was 1.3071, down from the prior months of 1.3572, and below the March 2011 of 1.4580. The Medicare CMI increased from 1.3534 in February to 1.4435 in March. The graph below shows the Medicare CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.



The CMI at the time of forecasting this year's budget was 1.3758. Year-to-date March 2012 the CMI was 1.2969. This represents a 6.2% decline compared to the same time frame last year. 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.

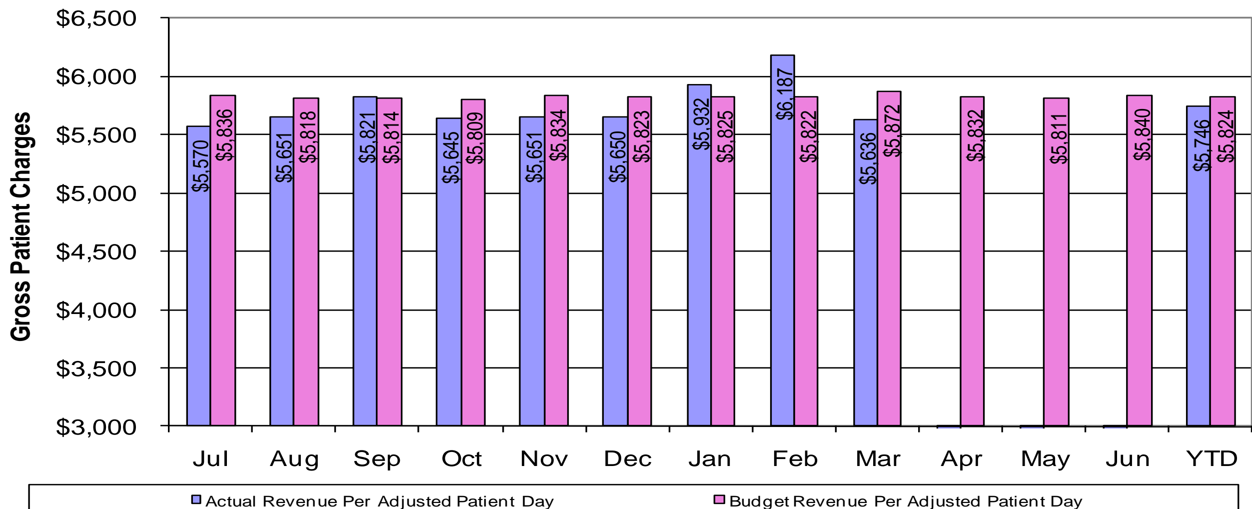
Case Mix Index Comparison

Financial Class	Jun 10 - Mar 11	Mar 11 YTD	Mar 12 YTD	Mar 12 YTD Volume
Blue Cross	0.0000	0.9873	0.0000	-
Commercial - Non-Contracted	1.9649	2.1959	1.1095	9
HMO	1.2522	1.1826	1.3154	90
Industrial	1.8373	1.6500	1.6603	9
Kaiser	1.8412	1.8890	1.8012	10
Medi-Cal HMO	1.0008	1.0069	1.0559	123
Medi-Cal	1.2724	1.2898	1.2126	108
Medicare	1.4724	1.4858	1.3690	1,121
Medicare HMO	1.3568	1.3549	1.3574	192
Personal Pay	1.0105	1.0290	1.1291	144
Medi-Cal Pending	1.8334	1.9058	2.0751	4
PPO	1.2613	1.2801	1.1050	231
VA	1.4051	1.3387	1.3925	45
Combined	**1.3758**	**1.3825**	**1.2969**	2,086

Revenue

Gross patient charges in March fell below the budget by $2.8 million, or 11.4%. Inpatient revenues were $2.5 million budget below the budget and outpatient revenues were down $277,000. Inpatient days were below budget by 11.7%, consistent with the inpatient gross revenue, yet inpatient surgeries and emergency visits were above budget. Outpatient registrations were 16.3% under budget. Outpatient revenues were lower than budget as a result of the lower volume. On an adjusted patient day basis, total patient revenue was $5,636, below the budget of $5,872 for the month of March and lower than February gross revenue per APD of $6,187. 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



Contractual Allowances

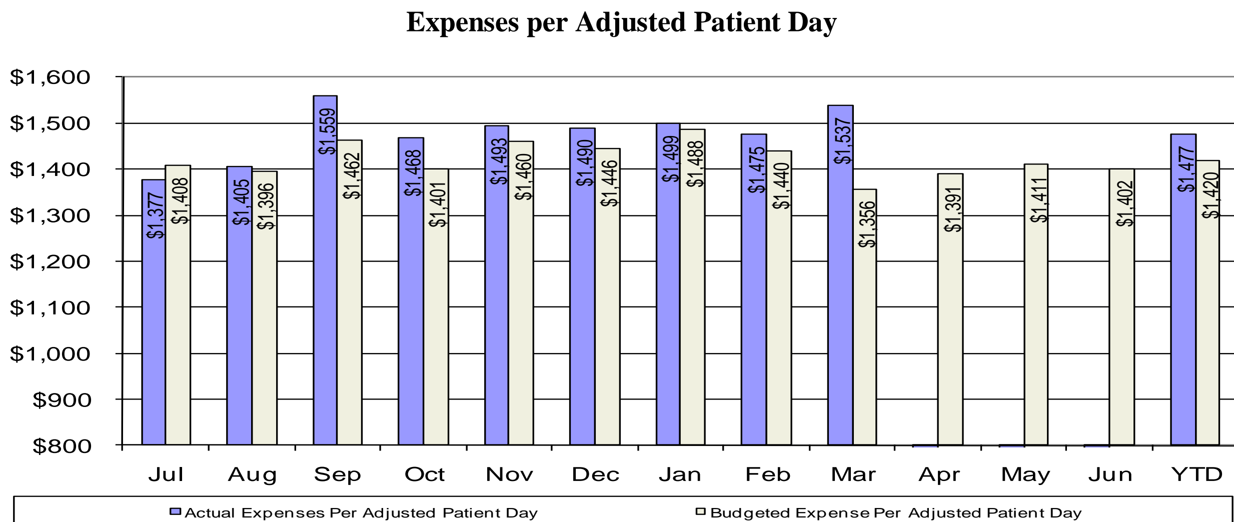
Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payers such as Blue Cross. As such net revenues as a percentage of gross revenues were very close to budget. A collection ratio of 22.2% was budgeted and 22.9% was realized.

Expenses

Total Operating Expenses

Total operating expenses were higher than the fixed budget by $270, 000 or 4.7% and YTD is above budget by just 0.3%. Salaries continue below budget however benefits were up. Non-medical professional fees were not as high this month but several areas were up as discussed below.

The graph below shows the actual hospital operating expenses on an adjusted patient day basis for the 2012 fiscal year by month as compared to budget. Note that expenses per patient day were over budget again this month which is expected with lower volume and the fixed nature of many expenses.



Following are explanations of the significant areas of variance that were experienced in the current month.

Salary and Temporary Agency Expenses

Salary and temporary agency costs combined were favorable to the fixed budget by $70,000 and yet were unfavorable to budgeted levels on a per adjusted patient day (PAPD) basis by $40 or 5.5%. Year to date salaries and agency expenses are running just above budget by 2.5% PAPD.

Benefits

Benefits were unfavorable to the fixed budget by $124,000 or 15.4%, and over budget per adjusted patient day by 24.7%. Group Health Insurance – Non Alameda Hospital contributed to this positive variance.

Professional Fees

Professional fees which had been running over budget were favorable to budget this month.

Supplies

Supplies were favorable to budget by $43,000 (5.5%). This is positive; however, the favorable supply cost variance was down from previous months. This month the favorable variance was the result of lower than budgeted patient related supplies such as medical supplies expense, pharmacy supplies associated with the IVT program (low IVT program volumes), and prosthetics.

Purchased Services

Purchased services were $214,000 above the fixed budget and $62 unfavorable PAPD. Expenses were up in Pathology, Dietary, Engineering, Information Systems, Accounting, Patient Accounting and hospital Admin.

Rents and Leases

Rents and leases were above the fixed budget by $32,000, and above budget $11 PAPD in March at $38 per adjusted patient day versus a budget of $28.

Other Operating Expense

Other operating expenses were $40,000 over the fixed budget and $12 over the budget on a per adjusted patient day basis. This variance relates to the payment of recruitment fees for two new hospital employees.

Balance Sheet

Total assets decreased almost $1.3M from the prior month, mostly due to the decrease in Cash which was partially offset by the increase in Other Receivables. The following items make up the increase in current assets:

- Total unrestricted cash and cash equivalents for March decreased by almost $1.9M and days cash on hand including restricted use funds decreased to 2.2 days on hand in March from 12.4 days on hand in February. This was largely due to the funding of the IGT program and the timing of payroll.

- Net patient accounts receivable decreased in March by $252,000 compared to an increase of $678,000 in February. Days in outstanding receivables were 64.8 at March month end, a drop from the high of 66.5 days in February. Collections in March were $5.5 million compared to $4.4 million in February. March also had 2 more business days than February.

- Other Receivables increased by almost $900,000 due to the IGT program. Third Party Settlements, Inventories and Prepaids remained fairly constant from one month to the next.

Total liabilities decreased by only $627,000 compared to an increase of $42,000 in the prior month. This decrease in the current month was the result of the following:

- Accounts payable and accrued expenses increased $57,000. This small increase is an improvement over prior month's accrued expenses.

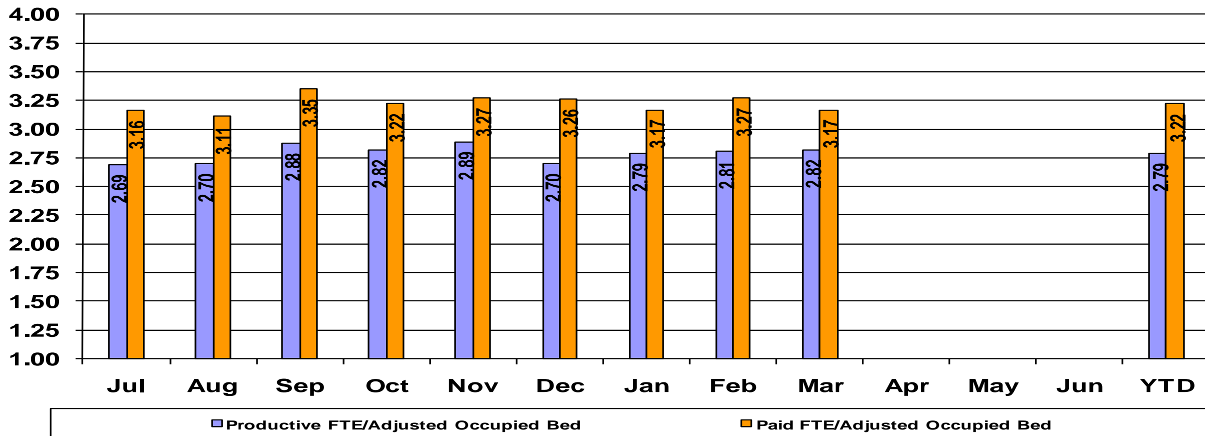
- Payroll related accruals decreased by $643,000 as a result of the timing of pay period end in relation to the month end.

- 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.

Key Statistics

FTE's per Adjusted Occupied Bed

On an adjusted occupied bed basis, productive FTE's were 2.82, above the budget of 2.63 FTE's by 6.9%, and paid FTE's were 3.17 or 5.4% above budget. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2012 by month.



Current Ratio

The current ratio for March is 1.0. This is a decrease from last month's ratio of 1.03.

A/R days

Net days in Accounts Receivable are currently at 64.8. This is down from prior month. We are working hard to bring this number down to 51, which will help our cash position.

Days Cash on Hand

Days cash on hand for March was 2.2. This has decreased from prior month of 12.4 because of IGT and payroll timing. It is expected that this will increase next month with receipt of the Districts tax monies.

The following pages include the detailed financial statements for the seven (9) months ended March 31, 2012, of fiscal year 2012.

ALAMEDA HOSPITAL
KEY STATISTICS
MARCH 2012

	ACTUAL MARCH 2012	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	MARCH 2011	YTD MARCH 2012	YTD FIXED BUDGET	VARIANCE	%	YTD MARCH 2011
Discharges:										
Total Acute	245	265	(20)	-7.5%	233	2,125	2,105	20	1.0%	1,882
Total Sub-Acute	5	2	3	150.0%	2	20	14	6	42.9%	18
Total Skilled Nursing	10	10	-	0.0%	19	79	80	(1)	-1.3%	79
	260	277	(17)	-6.1%	254	2,224	2,199	25	1.1%	1,979
Patient Days:										
Total Acute	905	1,059	(154)	-14.5%	1,085	8,215	8,422	(207)	-2.5%	8,074
Total Sub-Acute	951	1,023	(72)	-7.0%	1,032	8,887	9,075	(188)	-2.1%	8,946
Total Skilled Nursing	653	759	(106)	-14.0%	630	5,778	6,037	(259)	-4.3%	6,005
	2,509	2,841	(332)	-11.7%	2,747	22,880	23,534	(654)	-2.8%	23,025
Average Length of Stay										
Total Acute	3.69	4.00	(0.30)	-7.6%	4.66	3.87	4.00	(0.14)	-3.4%	4.29
Average Daily Census										
Total Acute	29.19	34.16	(5.13)	-15.0%	35.00	29.87	30.63	(0.75)	-2.5%	29.36
Total Sub-Acute	30.68	33.00	(2.40)	-7.3%	33.29	32.32	33.00	(0.68)	-2.1%	32.53
Total Skilled Nursing	21.06	24.48	(3.53)	-14.4%	20.32	21.01	21.95	(0.94)	-4.3%	21.84
	80.94	91.65	(11.07)	-12.1%	88.61	83.20	85.58	(1.44)	-1.7%	83.73
Emergency Room Visits	1,506	1,426	80	5.6%	1,461	12,754	12,650	104	0.8%	12,640
Outpatient Registrations	1,901	2,271	(370)	-16.3%	2,197	16,621	18,168	(1,547)	-8.5%	17,881
Surgery Cases:										
Inpatient	57	50	7	14.0%	47	377	398	(21)	-5.3%	401
Outpatient	136	142	(6)	-4.2%	139	1,322	1,250	72	5.8%	1,244
	193	192	1	0.5%	186	1,699	1,648	51	3.1%	1,645
Adjusted Occupied Bed (AOB)	125.42	135.86	(10.44)	-7.7%	126.87	276.04	126.86	149.18	117.6%	124.69
Productive FTE	353.09	357.70	(4.61)	-1.3%	386.79	344.10	344.26	(0.16)	0.0%	368.67
Total FTE	397.39	408.57	(11.18)	-2.7%	438.55	396.42	405.39	(8.97)	-2.2%	425.48
Productive FTE/Adj. Occ. Bed	2.82	2.63	0.18	6.9%	3.05	1.25	2.71	(1.47)	-54.1%	2.96
Total FTE/ Adj. Occ. Bed	3.17	3.01	0.16	5.4%	3.46	1.44	3.20	(1.76)	-55.1%	3.41

City of Alameda Health Care District
Statements of Financial Position
March 31, 2012

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 428,701	$ 2,253,861	$ 1,784,141
Patient Accounts Receivable, net	10,311,955	10,563,953	7,249,185
Other Receivables	4,569,093	3,674,460	8,090,457
Third-Party Payer Settlement Receivables	661,578	661,578	150,000
Inventories	1,146,202	1,152,120	1,183,358
Prepaids and Other	222,070	300,951	262,359
Total Current Assets	17,339,599	18,606,923	18,719,500
Assets Limited as to Use, net	35,702	24,337	483,716
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	43,405,170	43,397,622	43,383,571
Construction in progress	3,570,359	3,515,044	2,921,048
Depreciation	(39,471,735)	(39,404,854)	(38,862,494)
Property, Plant and Equipment, net	8,381,739	8,385,757	8,320,070
Total Assets	**$ 25,757,040**	**$ 27,017,017**	**$ 27,523,286**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 1,552,815	$ 1,579,531	$ 746,074
Accounts Payable and Accrued Expenses	8,937,239	8,885,354	6,987,765
Payroll Related Accruals	4,089,480	4,732,459	3,991,254
Deferred Revenue	1,432,594	1,909,641	5,725,900
Employee Health Related Accruals	629,895	629,895	343,382
Third-Party Payer Settlement Payable	631,035	368,344	(3,930)
Total Current Liabilities	17,273,058	18,105,224	17,790,445
Long Term Debt, net	806,915	845,575	1,142,109
Total Liabilities	18,079,973	18,950,799	18,932,554
Net Assets:			
Unrestricted	7,471,364	7,871,880	8,037,015
Temporarily Restricted	205,702	194,337	553,716
Total Net Assets	7,677,066	8,066,217	8,590,731
Total Liabilities and Net Assets	**$ 25,757,040**	**$ 27,017,017**	**$ 27,523,286**

City of Alameda Health Care District

Statements of Operations

March 31, 2012

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,509	2,841	(332)	-11.7%	2,747	22,880	23,534	(654)	-2.8%	23,025
Discharges	260	277	(17)	-6.1%	254	2,224	2,199	25	1.1%	1,979
ALOS (Average Length of Stay)	9.65	10.26	(0.61)	-5.9%	10.81	10.29	10.70	(0.41)	-3.9%	11.63
ADC (Average Daily Census)	80.9	91.6	(10.71)	-11.7%	88.6	84	85.9	(2.39)	-2.8%	84.0
CMI (Case Mix Index)	1.3071				1.4546	1.2951				1.3734
Revenues										
Gross Inpatient Revenues	$ 14,140	$ 16,682	$ (2,542)	-15.2%	$ 16,162	$ 131,524	$ 137,061	$ (5,537)	-4.0%	$ 126,322
Gross Outpatient Revenues	7,771	7,973	(202)	-2.5%	7,206	62,526	65,667	(3,141)	-4.8%	61,083
Total Gross Revenues	21,912	24,655	(2,743)	-11.1%	23,368	194,050	202,728	(8,678)	-4.3%	187,405
Contractual Deductions	16,775	18,223	1,448	7.9%	17,161	145,414	149,392	3,979	2.7%	134,157
Bad Debts	(17)	765	782	102.2%	891	3,365	6,429	3,063	47.6%	5,845
Charity and Other Adjustments	136	187	51	27.1%	190	1,505	1,551	47	3.0%	1,447
Net Patient Revenues	5,017	5,480	(462)	-8.4%	5,127	43,766	45,355	(1,589)	-3.5%	45,957
Net Patient Revenue %	22.9%	22.2%			21.9%	22.6%	22.4%			24.5%
Net Clinic Revenue	51	30	21	69.5%	45	336	177	159	90.1%	303
Other Operating Revenue	15	10	5	49.0%	10	239	91	148	163.3%	91
Total Revenues	**5,084**	**5,520**	**(436)**	-7.9%	**5,182**	**44,341**	**45,623**	**(1,282)**	-2.8%	**46,351**
Expenses										
Salaries	2,869	2,904	35	1.2%	3,048	25,614	25,502	(113)	-0.4%	26,756
Temporary Agency	127	163	35	21.8%	271	1,051	1,342	291	21.7%	1,876
Benefits	927	803	(124)	-15.4%	948	7,697	7,168	(529)	-7.4%	7,255
Professional Fees	321	339	18	5.3%	342	3,373	2,688	(685)	-25.5%	2,715
Supplies	740	783	43	5.5%	744	5,520	6,788	1,268	18.7%	6,589
Purchased Services	588	374	(214)	-57.3%	369	3,471	3,320	(151)	-4.5%	3,331
Rents and Leases	148	116	(32)	-27.9%	74	847	833	(14)	-1.7%	618
Utilities and Telephone	53	65	12	17.8%	64	589	584	(5)	-0.8%	566
Insurance	25	17	(8)	-45.1%	31	246	152	(94)	-62.2%	285
Depreciation and amortization	67	77	10	13.4%	77	646	642	(4)	-0.6%	719
Other Opertaing Expenses	111	71	(40)	-55.7%	58	823	692	(131)	-19.0%	763
Total Expenses	**5,977**	**5,713**	**(264)**	-4.6%	**6,026**	**49,876**	**49,710**	**(166)**	-0.3%	**51,472**
Operating gain (loss)	**(894)**	**(193)**	**(701)**	-363.1%	**(844)**	**(5,535)**	**(4,087)**	**(1,448)**	35.4%	**(5,122)**
Non-Operating Income / (Expense)										
Parcel Taxes	478	478	0	0.0%	479	4,324	4,302	22	0.5%	4,307
Investment Income	1	0	0	177.0%	0	5	(114)	119	-104.4%	9
Interest Expense	(12)	(12)	1	4.5%	(9)	(138)	(13)	(126)	985.3%	(80)
Other Income / (Expense)	26	22	4	16.6%	1,473	233	201	31	15.6%	1,648
Net Non-Operating Income / (Expense)	**493**	**488**	**5**	**1.0%**	**1,943**	**4,423**	**4,376**	**47**	**1.1%**	**5,884**
Excess of Revenues Over Expenses	**$ (401)**	**$ 295**	**$ (696)**	**-235.6%**	**$ 1,099**	**$ (1,112)**	**$ 289**	**$ (1,401)**	**-484.5%**	**$ 762**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

March 31, 2012

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,637	$ 3,973	$ (336)	-8.5%	$ 4,069	$ 3,896	$ 3,937	$ (41)	-1.0%	$ 3,698
Gross Outpatient Revenues	1,999	1,899	100	5.3%	1,814	1,852	1,886	(34)	-1.8%	1,788
Total Gross Revenues	5,636	5,872	(236)	-4.0%	5,883	5,748	5,824	(76)	-1.3%	5,486
Contractual Deductions	4,315	4,340	25	0.6%	4,321	4,308	4,292	(16)	-0.4%	3,927
Bad Debts	(4)	182	187	102.4%	224	100	185	85	46.0%	171
Charity and Other Adjustments	35	45	9	21.3%	48	45	45	(0)	0.0%	42
Net Patient Revenues	1,291	1,305	(15)	-1.1%	1,291	1,297	1,303	(6)	-0.5%	1,345
Net Patient Revenue %	22.9%	22.2%			21.9%	22.6%	22.4%			24.5%
Net Clinic Revenue	13	7	6	83.1%	11	10	5	5	96.1%	9
Other Operating Revenue	4	2	1	60.9%	3	7	3	4	171.5%	3
Total Revenues	**1,308**	**1,315**	**(7)**	-0.5%	**1,305**	**1,314**	**1,311**	**3**	0.2%	**1,357**
Expenses										
Salaries	738	692	(46)	-6.7%	767	759	733	(26)	-3.6%	783
Temporary Agency	33	39	6	15.6%	68	31	39	7	19.3%	55
Benefits	239	191	(47)	-24.7%	239	228	206	(22)	-10.7%	212
Professional Fees	83	81	(2)	-2.3%	86	100	77	(23)	-29.4%	79
Supplies	190	187	(4)	-2.1%	187	164	195	31	16.1%	193
Purchased Services	151	89	(62)	-69.9%	93	103	95	(7)	-7.8%	98
Rents and Leases	38	28	(11)	-38.1%	19	25	24	(1)	-4.9%	18
Utilities and Telephone	14	15	2	11.2%	16	17	17	(1)	-4.0%	17
Insurance	6	4	(2)	-56.7%	8	7	4	(3)	-67.2%	8
Depreciation and Amortization	17	18	1	6.5%	19	19	18	(1)	-3.7%	21
Other Operating Expenses	29	17	(12)	-68.2%	15	24	20	(5)	-22.7%	22
Total Expenses	**1,537**	**1,361**	**(177)**	-13.0%	**1,517**	**1,477**	**1,428**	**(49)**	-3.5%	**1,507**
Operating Gain / (Loss)	**(230)**	**(46)**	**(184)**	-400.1%	**(213)**	**(164)**	**(117)**	**(47)**	39.7%	**(150)**
Non-Operating Income / (Expense)										
Parcel Taxes	123	114	9	8.0%	121	128	124	5	3.6%	126
Investment Income	0	0	0	199.1%	0	0	0	0	175.5%	0
Interest Expense	(3)	(3)	(0)	-3.1%	(2)	(4)	(3)	(1)	24.8%	(2)
Other Income / (Expense)	7	5	1	26.0%	371	7	6	1	19.2%	48
Net Non-Operating Income / (Expense)	**127**	**116**	**11**	**9.1%**	**489**	**131**	**126**	**5**	**3.9%**	**172**
Excess of Revenues Over Expenses	**$ (103)**	**$ 70**	**$ (173)**	-246.5%	**$ 277**	**$ (33)**	**$ 9**	**$ (42)**	-465.4%	**$ 23**

City of Alameda Health Care District
Statement of Cash Flows
For the Nine Months Ended March 31, 2012

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ (400,517)	$ (1,111,656)
Items not requiring the use of cash:		
Depreciation and amortization	66,881	$ 645,550
Write-off of Kaiser liability	-	$ -
Changes in certain assets and liabilities:		
Patient accounts receivable, net	251,998	(3,062,770)
Other Receivables	(894,633)	3,521,364
Third-Party Payer Settlements Receivable	262,691	123,387
Inventories	5,918	37,156
Prepaids and Other	78,881	40,289
Accounts payable and accrued liabilities	51,885	1,949,474
Payroll Related Accruals	(642,979)	98,226
Employee Health Plan Accruals	0	286,513
Deferred Revenues	(477,047)	(4,293,306)
Cash provided by (used in) operating activities	(1,696,922)	(1,765,773)
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(11,365)	448,014
Additions to Property, Plant and Equipment	(62,863)	(707,219)
Other	1	546,005
Cash provided by (used in) investing activities	(74,227)	286,800
Cash flows from financing activities		
Net Change in Long-Term Debt	(65,376)	471,547
Net Change in Restricted Funds	11,365	(348,014)
Cash provided by (used in) financing and fundraising activities	(54,011)	123,533
Net increase (decrease) in cash and cash equivalents	(1,825,160)	(1,355,440)
Cash and cash equivalents at beginning of period	2,253,861	1,784,141
Cash and cash equivalents at end of period	$ 428,701	$ 428,701

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results			Unaudited Results	
	FY 2008	FY 2009	FY 2010	FY 2011	YTD 3/31/2012
Profitability Ratios					
Net Patient Revenue (%)	22.48%	22.69%	24.16%	23.58%	22.55%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	-0.72%	3.62%	4.82%	-1.01%	-0.74%
EBIDAP[Note 5]	-10.91%	-5.49%	-3.66%	-13.41%	-10.49%
Total Margin	-3.75%	1.03%	2.74%	-2.61%	-2.51%
Liquidity Ratios					
Current Ratio	0.98	1.15	1.23	1.05	1.00
Days in accounts receivable ,net	51.70	57.26	51.83	46.03	64.79
Days cash on hand (with restricted)	30.6	13.6	21.6	14.1	2.4
Debt Ratios					
Cash to Debt	187.3%	115.3%	249.0%	123.3%	19.68%
Average pay period	58.93	58.03	57.11	62.68	76.07
Debt service coverage	(0.14)	3.87	5.98	(0.70)	(0.19)
Long-term debt to fund balance	0.26	0.20	0.14	0.18	0.24
Return on fund balance	-29.59%	8.42%	18.87%	-19.21%	-14.48%
Debt to number of beds	20,932	13,481	10,482	11,515	14,657

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2008	Audited Results FY 2009	Audited Results FY 2010	Unaudited Results FY 2011	Unaudited Results YTD 3/31/2012
Patient Care Information					
Bed Capacity	135	161	161	161	161
Patient days(all services)	22,687	30,463	30,607	30,270	22,880
Patient days (acute only)	11,276	11,787	10,579	10,443	8,215
Discharges(acute only)	2,885	2,812	2,802	2,527	2,125
Average length of stay (acute only)	3.91	4.19	3.78	4.13	3.87
Average daily patients (all sources)	61.99	83.46	83.85	82.93	83.20
Occupancy rate (all sources)	45.92%	52.94%	52.08%	51.51%	51.68%
Average length of stay	3.91	4.19	3.78	4.13	3.87
Emergency Visits	17,922	17,337	17,624	16,816	12,754
Emergency visits per day	48.97	47.50	48.28	46.07	46.38
Outpatient registrations per day[Note 1]	84.54	82.05	79.67	65.19	60.44
Surgeries per day - Total	14.78	16.12	13.46	6.12	6.18
Surgeries per day - excludes Kaiser	5.54	5.14	5.32	6.12	6.18

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.

DATE: April 19, 2012

FOR: April 25, 2012 Finance and Management Committee

TO: City of Alameda Health Care District, Finance and Management Committee

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Recommendation to Enter into an Agreement with Select Therapies for Long Term Care Rehabilitation Services Management and Recommendation for Reorganization of the Rehabilitation Services

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Recommendation:

Management recommends that the District Board of Directors authorize entering into a contract with Select Therapies to provide management and rehabilitation personnel for the rehab services provided at South Shore and the subacute unit (LTC Services).

Secondly, management also recommends that our outpatient and acute inpatient rehab services continue to be provided by hospital employees and a Department Manager is hired to be responsible for the operational activities of the rehab department and to help grow and develop these service lines. We will encourage any qualified internal candidates to apply for this position.

The total overall financial opportunity associated with this recommendation at current outpatient rehab volumes and current Medicare A Average Daily Census (ADC) at South Shore is $460,227 per year.

With the incorporation of outpatient rehab volumes from the Orthopedic Program and an increasing the Medicare ADC at South Shore the financial results will increase to $632,000 per year. This is discussed in more detail under the Financial Analysis section starting on page 5.

Background:

Over the past month, management has had continued discussions about our current and future needs for Rehabilitation Services. The addition of Waters Edge Skilled Nursing Facility to the hospital, together with our interest in enhancing our acute inpatient and outpatient rehab programs, are driving our approach on how to best structure and manage the department going forward.

Under the direction of Richard Espinoza, our new Long Term Care Administrator, we are implementing policies & procedures and clinical protocols that are consistent throughout our Long Term Care (LTC) units (Subacute, South Shore and now Waters Edge). This consistency is especially important now that LTC services have become such a significant part of our overall patient population. In addition, all three facilities will be surveyed as one unit by the California

Department of Public Health and having standardized clinical and administrative policies & procedures are required.

Waters Edge recently contracted with Select Therapy, a professional Rehab management firm specializing in long term care therapy, to provide Physical Therapy, Occupational Therapy and Speech Therapy services to the residents at that facility. In meeting with Select Therapy, we believe they can provide the types of comprehensive clinical programs and services necessary for the success of our LTC units, which differ from the acute care setting. By retaining Select Therapies as the contracted rehab company, we will maintain the continuity and high quality of care provided at the facility during the transition to the hospital.

Discussion:

Needs and Benefits of a Strong LTC Rehab Program:

A strong rehab program is critical to the success of our LTC service lines. The positive affects of a well managed LTC Rehab program include:

- Effective and efficient communication & coordination of care with physicians and nursing personnel.
- Well documented plans of care that lead to successful outcomes, both clinically and financially, for monitoring both skilled and custodial residents at all three LTC facilities. This includes Quality Assurance monitoring, Prospective Payment System (PPS), MDS 3.0 reimbursement & regulatory requirements and performance improvement activities that are consistent throughout our LTC service lines.
- Quality of life for the custodial nursing and Subacute residents to prevent decline in function and to assess / assist in developing plans and treatment to increase overall function for the resident.
- Facility specific programs based upon their unique resident needs such as – homeward bound and community reentry programs, wheelchair and bed positioning, contracture management & splinting, pain management, behavior and dementia management, falls prevention & post falls intervention, environmental adaptations, continence improvement, cognitive function and wound care.
- Financial management: this requires up to date understanding of Medicare (PPS), MDS 3.0, detailed understanding of Medicare part B caps, Medi-cal and other third party reimbursement contracts to ensure that we are appropriately reimbursed for the care that is provided and contracted for, which requires daily monitoring.
- Marketing and community / physician outreach: long term care programs that have a quality and innovative rehab program is a very important factor that prospective residents, families and other referring acute care hospitals when choosing a facility.
- State surveys and regulatory compliance: Waters Edge, South Shore and the subacute unit comprise our skilled nursing services within the hospital. It will be expected that the policy & procedures, education/training, and ancillary services provided be consistent in each of these units.

Given the above factors, we feel that it is important to have all of our LTC rehab services be provided by Select Therapy who can provide a spectrum of programs and resources that are

needed to make all of our LTC service lines successful. Although we acknowledge that our hospital based rehab staff have done a respectable job working with the residents in the Subacute unit and at South Shore, we continue to receive feedback that there is a need for improved communication with nursing personnel, coordination of scheduling of resident therapy sessions, processes for managing resident plans of care and modifying those plans when there is a change in condition in conjunction with changes in the residents insurance benefits. Furthermore, the addition of Waters Edge will increase our skilled nursing capacity by over 100 residents, many of whom will be high rehab utilizing residents. We do not currently have the capability to manage this in-house.

Needs and Benefits of a Strong Outpatient and Acute Inpatient Rehab Program:

Rehabilitation Services (Speech Therapy, Occupational Therapy and Physical Therapy) are core service lines of any acute care hospital and nearly every physician specialty refers patients for rehab services and our ability to provide timely access to a quality /comprehensive rehab program is an essential component of the hospital's future growth and success.

For patients in the acute care setting, rehab services are integral part of the patient care plan. Physicians rely on timely assessments by the rehab staff in order to understand the physical needs and capabilities of the patients they are caring for and to modify their orders accordingly. Physicians and discharge planners rely on these assessments to help determine when the patient is physically ready for a safe discharge from the hospital.

The need for a comprehensive and well managed inpatient and outpatient rehab program will be even more essential as we develop an orthopedic program here at the hospital, as was presented at the April 2nd Board Meeting. Not only will orthopedic surgeons use physical and occupational therapy after surgical procedures, they will also recommend therapy on a conservative basis for those patients experiencing other types of injury or chronic health problem, strength training, continued physical fitness, or pre-surgical treatment. As such, our rehab services program will be promoted in conjunction with our orthopedics program throughout Alameda and our greater service area. Rehab Services address a key component of the Hospital's strategic plan to increase outpatient services that will better serve the community and the Hospital.

Service Expectations:

At a minimum these management recommendations should accomplish the following:

- First and foremost, implement the clinical programs and establish best practices to meet the needs of our patients resulting in improved clinical outcomes. This applies to LTC as well as the Outpatient / Inpatient programs.
- Increased utilization of rehab services based upon the patients needs and abilities. Work with other clinical staff and physicians in a team effort to create best practices to improve clinical outcomes.
- Improved financial performance through increased rehab service utilization, increased physician referrals and operational efficiencies.

- Improved overall productivity of the Rehab Services department by allowing staff to focus on specific service areas and patient types (e.g. LTC, acute inpatient and outpatient) based upon industry benchmarks.
- More timely access for initial outpatient rehab assessments and more efficient scheduling of follow up visits.
- Additional training, education and skill development of the rehab personnel.
- Develop a comprehensive rehab services program to support the needs of quality Orthopedics program.
- Participate in marketing and community awareness of our rehab services programs.

Staffing Model:

The staffing model for this recommendation was developed based upon the actual amount of paid time associated with services provided in each service area (inpatient, outpatient, subacute and South Shore). It also takes into consideration both core staffing needs of the department as well as staffing/productivity benchmarks in the industry.

The following is a summary of the hospital based staffing needs to support both recommendations. Please see Attachment A for a more detailed breakdown of current staffing allocation. Further discussion regarding the suggested change in staffing levels is included in the Financial Analysis section that follows as it coincides with assumptions on patient volumes.

	Current Staffing	Outpatient	Inpatient/ Outsource LTC	New
Speech	0.5			.5
OT	1.6		(.4)	1.2
PT/PT Assist	5.4	(1.5)	(1.0)	2.9
Manager (PT)		1.0		1.0
Receptionist	1.0			1.0
Total	8.5	(.5)	(1.4)	6.6

All of our current rehab staff, other than the receptionist work less than full time, most are .64 or .48 status. One of the initial tasks of the Rehab Manager will be to determine what modifications will need to be made to the staff work schedule and ensure that the rehab personnel are properly aligned with the patient care activity.

Speech Therapy is currently considered at a "core" staffing level. Even though the staffing model on Attachment A indicates that .13 FTE is associated with care in LTC services and could be reduced with outsourcing this service to Select Therapies, Speech Therapy is an essential component of the hospital's stroke certification program and timely swallow assessments and dysphasia training make it necessary to maintain current staffing levels.

With this model Occupational Therapy be reduced by .4 FTE for time allocated to LTC services. Even though the total inpatient & outpatient staffing need is .76, our Occupational Therapist provide a valuable employee ergonomics program that has resulted in fewer and less severe workers compensation lost time and expense. This service is very valuable and is recommended

to remain at 1.2 FTE's. The 1.2 FTE's will also provides a solid core staffing level to support our inpatient and outpatient service as needs.

Physical Therapist / PT Assistants will be most affected by this recommendation. Do to recruiting challenges we have been using a full time registry physical therapist for the past year. This has been a needed but more expense resource and will be the first position to be reduced. It is expected that the new Rehab Manager for the Inpatient/Outpatient program will be a working manager and spend about half of their time performing direct patient care.

The Manager will also assess and determine what the appropriate staffing requirements will be for physical therapists and PT Assistants. In addition to the registry therapist, a 1.0 FTE of staff therapy hours (PT /PT Assistants) will be reduced to achieve the outpatient productivity benchmarks at our current visit volumes.

Lastly, with the Manager working half time providing patient care, there would be no additional reductions if this person is an internal candidate, however, if a Manager is brought in from the outside, and additional .5 FTE would need to be reduced. A summary of the industry productivity benchmarks for outpatient rehabilitation programs is outlined on Attachment B.

Select Therapy has committed to interview and offer employment to any interested rehab staffs that are affected by the staffing reductions associated with this recommendation.

Financial Analysis:

The incremental financial opportunity of this recommendation is derived primarily from the Outpatient program and Medicare A patients at South Shore skilled nursing.

Acute Inpatient:
The acute inpatient and subacute units require core staffing to ensure that assessments and treatments are completed on a timely basis; however the reimbursement for these programs is included in the DRG or per diem payment. For these nursing units, we want to provide additional rehab services as needed to achieve the desired clinical outcomes and quality of life for our patient's, meet the expectations of our physicians and enhance our ability to promote these services to physicians and the community. However, there is no incremental reimbursement projected for these services.

The acute inpatient staffing levels will need to be monitored and adjusted accordingly based upon fluctuations in inpatient census and the number of patient assessments. This will most likely increase with an active orthopedic surgical program at the hospital. Having a dedicated inpatient therapy team will allow the outpatient program to schedule patients more effectively resulting in staffing efficiency and our ability to facilitate a greater number of outpatient visits while maintaining the service level expected of our inpatient services.

Outpatient:
Outpatient rehab care is reimbursed based upon the number of patients treated and the amount of time, measured in 15 minute billable units, spent with each patient. Both the number of visits and the amount of time spent with each patient are determined by the clinical needs of the patient as indicated in the physician orders. It is expected that post orthopedic patients will require more rehab than other medical patients and this will increase revenues for the department. In addition,

the orthopedic program is projected to about 4,100 new outpatient visits per year. As previously mentioned, there are established industry productivity benchmarks for outpatient rehab programs that are applied on the financial analysis.

Attachment C demonstrates that the current staffing, visits, revenues, expenses and contribution margin for our outpatient services. It then demonstrates a waterfall financial affect of implementing appropriate staffing levels based upon the industry standards and the financial impact of adding an orthopedics program. The anticipated affect on the Contribution Margin is as follows:

FY 2012	Benchmark Staffing	Orthopedics	With Changes
($145,367)	$53,144	$63,530	($28,693)

Implementing the appropriate staffing levels and compliment of Physical Therapists / PT Aides will improve the contribution margin by $53,144 per year.

With the addition of the Orthopedic Program, outpatient rehab is projected to improve the contribution margin by an additional $63,530 and even more importantly, serve as an essential component of a much larger Orthopedics Program that is estimated to net $793,504 in year one. It is essential to establish a comprehensive rehab component in order for the orthopedic program to be successful.

As previous discussed, it is necessary to have a dedicated working Rehab Services Manager who can work with nursing services and administration to implement the acute inpatient and outpatient clinical programs that will be required to grow this service line. The manager will also need to implement patient scheduling, staff scheduling, and to help market and promote the rehab services to physicians and the community.

Even though we can significantly improve the financial performance of the outpatient program through these changes, we have learned that we need to focus on rehab service reimbursement in our future third party payor contract negotiations to yield greater reimbursement per visit. The greatest revenue opportunity associated with this recommendation will come from enhanced and carefully managed rehab services provided in our LTC service areas.

Outpatient Rehab Space and Equipment Needs:
The existing rehab department has five treatment bays and a small equipment area. Although there is capacity in this area to treat an increased number of patients, additional exercise and rehab equipment space will be needed to support the Orthopedic Program once ramped up. There is space within the hospital where the Cardiofit program once was that could possibly be used for expansion of our rehab service area. Longer term, we may want to relocate the outpatient program to Marina Village, where our Wound Care program is located.

Much of the equipment in rehab is old and needs to be replaced. Fortunately, rehab equipment is modestly priced compared to other Hospital equipment. In the FY 2013 capital budget we will allow for $10,000 - $15,000 to replace old monitoring equipment, exercise bikes, and other needed rehab equipment.

Long Term Care Service Lines:
South Shore patients, like those at Waters Edge, can greatly benefit from a more comprehensive rehab program as discussed previously. From a financial perspective, the short term Medicare A patients require more rehab care than the long term custodial residents since many of these patients will be discharged once their level of function has improved to the highest practicable level. Reimbursement for the Medicare A patient is based upon established Resource Utilization Group (RUG) scores which are determined in large part, by the amount of therapy services provided. For the current fiscal year to date, South Shore has been operating at a 2.16 Medicare A ADC. Under the direction of our new Long Term Care Administrator, we believe this average census can increase to 4.0. Together with a dedicated and LTC focused rehab program managed by Select Therapy, the amount of rehab care will also increase, resulting not only in improved clinical outcomes for the patients, but also higher RUG scores and increased reimbursement. See Attachment D.

Rehab care provided in the subacute unit, like acute inpatient, is included in the per diem rate paid to the hospital. However, because we have received feedback from our clinical staff that our subacute patients could benefit from additional rehab care, the Select Therapy proposal includes staffing to double the amount of therapy time provided.

The following is a summary of the financial opportunity at South Shore. The complete financial analysis is on Attachment E.

FY 2012 (2.16 ADC)	Select Therapies (2.16 ADC)	Select Therapies Increase in ADC – 4.0
$226,920	$407,083	$515,417

There will be some Part B therapy services provided to the long term custodial resident; however, this reimbursement is capped at $3,760. We have not fully monitored or maximized this potential in the past. The financial opportunity is about $23,500 per year.

The most significant opportunity is with our Medicare A patients. As noted on the financial analysis, even with the current Medicare A days at South Shore, it is conservatively estimated that under Select Therapies management, this program will produce $180,164 additional revenue each year. The current average reimbursement per Medicare A day is $481, only $96 higher than the per diem Medi-Cal rate of $385 per day. This rate is lower in part, because about 28% of Medicare A patient days did not get any rehab and were paid solely based upon nursing services; this provides an opportunity not only for better patient care but also better financial results.

Having a more comprehensive LTC rehab program will allow us to take care of a greater number of post acute rehab patients, many being post surgical patients. We are budgeting a 4.0 Medicare A average daily census at South Shore which will result in reimbursement of $1,034,583, an increase of $515,417 over the current performance.

The opportunity for a positive financial contribution is much greater for the LTC programs than for the outpatient program if it is properly staffed and managed. From a financial management perspective, this is the driving force behind outsourcing this component to Select Therapy and they have a proven track record in this area.

Key Terms of recommended Select Therapy Contract:

The Select Therapy contract is a one year contract that will automatically renew for successive one year terms unless terminated by either party by providing 90 days notice after the initial one year term. The fee schedule is variable, based solely on the Medicare A days at each RUG levels. Therefore, Select's fee is based upon billable time that we will get reimbursed for. The Select fee for Part B services is 70% of the Part B fee. Rehab services provided in the subacute unit is $30 per billable unit (time actually spend treating residents). It is our expectation that Select Therapies will bring creative programs to the subacute unit to enhance the quality of life of these residents. Select will participate in Quality Assurance / Performance Improvement and other hospital committees as do other management staff.

Select will also utilize Casamba, a rehab specific software application that helps document the patients care plan, but also tracks the patient's progress and coordination with billing and reimbursement. Select Therapy provides rehab service in over 100 skilled nursing facilities in California and around the county with approximately 20 facilities in Central and Northern California. Providing rehab services to LTC residents is what they do.

If approved, we would like to implement the recommended changes effective July 1, 2012, to coincide with the new fiscal year. We will monitor performance throughout the year and report actual results against expectations.

Rehebilitation Department

Staffing and Time allocation at each Service Location

Based upon actual time spent YTD thru January 2012

Atttachment A

		Hours associted with providing patient care services in each Service Area						
		Outpatient	Inpatient	Total	South Shore	Subacute	Total	Grand Total
Staffing FTE's								
	ST	0.13	0.24	0.37	0.03	0.10	0.13	0.50
	OT	0.20	0.56	0.76	0.31	0.13	0.44	1.20
	PT	2.66	1.36	4.02	0.75	0.23	0.98	5.00
Total Staffing FTE's		3.00	2.15	5.15	1.10	0.45	1.55	6.70

Other budget Staffing Hours	OT	0.40	Hospital Ergonomics training and assessment program
	Receptionist	1.00	Department scheduling, phones, clerical duties.
	PT	0.40	PT staff out on leave part year
	Total Budget	8.50	

Note: Other than the receptionist, all staff are less than full time (.64 or .48)

Attachment B

Industry Productivity Benchmark for Outpatient Rehabilitation Programs

1 - 60-70% of time spend on billable patient care activity.
2 - We will use 63%. For and 8 hour day, this is 5.0 hours per day
3 - At Alameda Hospital, the dept currently averages 30 minutes billable time with each patient
4 - This would equate to (300 min. per day / 30 min per patient = 10.0 patients per therapist per day
5 - OP Physical Therapy visits currently average 12.34 visits per day / 2.66 PT FTE's = 4.6 visits per day each.
6 - At Productivity benchmark (at 10 pat/day): we would need 1.23 FTE plus non-productive coverage .4 = 1.6 FTE, a reduction of 1.0 FTE.

** Much of this lower activity is associated with scheduling and the need for our therapists to move between LTC and Inpatient services areas throughout the day. Outpatient, if not interupted and well managed, could achieve these industry benchmarks. In addition, employee FTE status will need to be evaluated.

Rehab Services Analysis
For Outpatient Program at Alameda Hospital
(using actual data thru January 2012 annualized)

Attachment C

		FY 2012 Annualized Outpatient Acitivity	Benchmark Productivity/ plus Add Working Manager	Orthopedics Program	Total Opportunity
Staffing FTE's					
	ST	0.13			
	OT	0.20			
	PT	2.66	(1.50)	1.6	
	Manager		1.00		
Total Staffing FTE's		3.00	(0.50)	1.6	4.10
Visits					
	ST	64			
	OT	301			
	PT	3,123		4,100	
		3,488		4,100	7,588
Gross Revenue					
	ST	23,115			
	OT	95,083			
	PT	722,566		948,613	
Total Gross Revenue		840,764		948,613	1,789,377
Net Revenue %		24%		24%	24%
Net Revenue					
	ST	5,548			
	OT	22,820			
	PT	173,416		227,667	
Total Net Revenue		201,783	0	227,667	429,450
Expenses:					
Salary & Wages					
	ST	12,654			
	OT	21,113			
	PT	237,359	(72,800)	124,800	
Total Salary & Wages		271,126	(72,800)	124,800	323,126
Benefits @ 27%		73,204	19,656	33,696	126,556
Other Operating Expenses		2,820		5,641	8,461
Total Operating Expenses		347,150	(53,144)	164,137	458,143
Contribution Margin		(145,367)	53,144	63,530	(28,693)

Notes:
1 - Assumes working manager will spend half time (.5) providing patient care
2 - Assumes 1.0 FTE reduction assumes the Registry PT that we have used this past year. No effect on benefits for this position.
Also assumes an additional .5 PT/PT Aide position reduction if working manager is a new external candidate.
3- The growth assumptions are conservative. With more complex rehab patients with the Orthopedic program, more billable time may be needed with each patient resulting in more billable units per visit and thus higher net revenue than our historical rate.
*** (amount of rehab to be provided is based upon needs of patient as perscribed by physician order)*

4- Even with higher productivity, we need to establish better reimbursement rates from thrid party payors

South Shore Skilled Nursing
Medicare A RUG level distribution and reimbursement

Attachment D

Fiscal Year 2012 Annualized Medicare A Days at South Shore
(using acutal data thru March 2012)

RUG Level	Medicare A Days	RUG Rate	Expected Reimbursement
SE2	5	550.00	2,512
SE3	6	450.00	2,878
CA1	59	316.41	18,789
CB1	103	371.06	38,306
CC1	15	400.66	5,857
HB1	28	471.26	13,347
RHA	109	469.20	51,010
RHB	62	532.97	33,110
RHC	67	586.23	39,096
RMA	111	401.81	44,784
RMB	107	488.34	52,198
RMC	26	520.21	13,307
RML	11	709.21	7,775
RMX	51	772.96	39,545
RVA	3	662.37	1,815
RVB	26	588.51	15,592
RUB	-	792.17	
	789		379,922
ADC	2.16	Avg per day	481

Select Therapy expected RUG utilization
conservative based on history at other Skilled Nursing Facilities
Assuming the current ADC of 2.16

RUG Level	Medicare A Days	RUG Rate	Expected Reimbursement
SE2			
SE3			
CA1			
CB1			
CC1			
HB1			
RHA			
RHB	118	469.20	55,530
RHC			
RMA			
RMB	95	488.34	46,236
RMC			
RML			
RMX			
RVA			
RVB	181	588.51	106,797
RUB	395	792.17	312,511
	789		521,074
ADC	2.16	Avg per day	660

Select Therapy expected RUG utilization
conservativebased upon history at other Skilled Nursing Facilities
With anticipated increase in Medicare A Avg. Daily Census of 4.0

RUG Level	Medicare A Days	RUG Rate	Expected Reimbursement
SE2			
SE3			
CA1			
CB1			
CC1			
HB1			
RHA			
RHB	219	532.97	116,720
RHC			
RMA			
RMB	175	488.34	85,557
RMC			
RML			
RMX			
RVA			
RVB	336	588.51	197,622
RUB	730	792.17	578,284
	1,460		978,183
ADC	4.00	Avg per day	670

Distributed for April 25, 2012
Finance and Management COmmittee

Rehab Services Analysis
for Long Term Care Service Lines
(using actual data thru January 2012 annualized)

Attachment E

	Current - FY2012 Annualized South Shore/subacute	Forcast with Select Therapy South Shore/subacute at current Medicare A ADC	Forcast with Select Therapy South Shore/subacute with increase in Medicare A ADC
Medicare A - Days	789	789	1,460
Medicare A - ADC	2.16	2.16	4.0
Revenues			
South Shore Net Revenue	379,922	521,074	978,183
Avg. Net Rev per A day	481	660	670
Subacute / South Shore Part B Net Revenue	32,940	56,400	56,400
Total Net Revenue	412,862	577,474	1,034,583
Operating Expenses			
Salary Wages & Benefits	145,128		
Benefits @ 27%	39,185		
Total SW&B	184,313	-	
Professional Service Contract	-	168,762	235,846
Other Operating Exp	1,629	1,629	2,500
Total Operating Expenses	185,942	170,390	238,346
Contribution with Rehab participation	226,920	407,083	742,337
Incremental Contribution Margin		180,164	515,417
Staffing			
Speech Therapy	0.13	0.20	0.30
Occupational Therapy	0.44	0.80	0.20
Physical Therapy	0.98	0.80	2.00
Total	1.55	1.80	2.50

Notes:

1 - Medicare A reimbursement includes payment for room and borad and all care provided. The amount of rehab minutes provided increase the RUG level and the amount of Medicare A reimbursement for skilled patients.

2 - Current Medicare A Revenue is based upon acutal billings and payments for current fiscal year.

3- Subacute reimbursement is an estimate based upon number of billed units up to annual CAP. (Part B reimbursement is caped for each beneficiary at $3,760 per year.)

4- Select Therapy Physical Therapy staffing includes working manager position.

5- Speech Therapist is part of hospital core staffing and also part of Stroke team. No reduction to this position. Reduce OT .4 FTE and reduce PT/PT Aide 1.0 FTE.

6 - The Select RUG utilization and reimbursement is much more conservative than their experience in other skilled nursing facilities (50% RUB vs. 77%)

City of Alameda Health Care District
Work Plan for Business Office and Revenue Cycle
Updates as of 4/18/12

#	Task	Responsibility	Updates as of 1/27/12	Updates as of 2/26/12	Updates as of 3/22/12	Updates as of 4/18/12	Status
1	Call Emdeon about the 4 ED levels splitting the gross amount	Becky Pavone	Continue to work on this issue Meditech was able to resolve this issue on some but not all claims. Continue to look for what the outstanding claims have in common.	Continue to work on this issue Meditech was able to resolve this issue on some but not all claims. Continue to look for what the outstanding claims have in common. The task is with Alameda IT	B.Pavone to review ED charge issues with Queen of the Valley/Napa - they are on Meditech 5.64	90% complete. Identifying remaining payers at this time	In process
2	Review claim scrubber	Teresa Jacques, Gwynn Smith, Becky Pavone	Contact has been made with DSG about a demonstration and proposal	Parties decided late last week to set up a demo and ask for a proposal in the 2nd or 3rd week in March. Teresa has left a message with Scott and expects to hear from him early this week to confirm a date.	DSG was at Alameda to Demo on 3/8/12. Not a top priority at this time	No update	In process
3	**Review what Kaiser pays fo**r. Special focus on LTC and ancillary charges.	Diane Gramse			Task deferred to D.Gramse at Fresno Office	HFS has found a workaround for the Kaiser ancillary billing and will bill any prior claims within the timely filing limit and claims going forward as of today	Complete
4	**Review credit balance reports**. Recommend repayment strategy if necessary.	Teresa Jacques	One staff is working some credits and additional staff have been identified and training is expected to start in the next 10 days.	Still looking to train some additional staff to be able to process credit balances. This was given to a returning staff member but more back up is still needed.	No Update	No update	In process
5	**Day-to-day management of the business office**. The goals are to expedite cash collections, correct system problems, and make recommendations for the long term organization and staffing of the department. A time frame and budget needs to be submitted.	Becky Pavone	In the process of interviewing for a Business Office Manager. An offer for the Financial Counselor will be offered by Feb 1.	The new Financial Counselor started mid-February. As a former employee the transition has been seamless. All candidates for the Business Office Manager have been interviewed no offers were made.	R.Pavone began Interim Director engagement on 3/4/12 .All areas of registration being evaluated: Meeting with HR on 3/26 to review staffing issues to assist in formulating go forward staffing plan. Daily quality checklists have been implemented to review department data integrity. Expectations have been presented regarding POS collections in Admitting and ED. Department Huddles have been established to meet 3 times weekly to discuss department updates/concerns and status. Created a weekly Self Pay Meeting with Case Mgmt/Social Services/Heath Advocates/Financial counselors to discuss uninsured patient status. Met with HFS Billing Office to review daily issues log to insure timely response and resolution to outstanding issues and utilize info obtained as a teaching tool within department.	Working with HR and Finance on department reorganization.After meeting on 3/26 we are drafting a staffing model for dept. Finalizing review of department productivity to meet staffing needs. Met with ED staff regarding POS and will be creating visuals for both ED and Main Admitting. Xtrained Pre Admit/Verification staff.. Continue to coach department supervisor in QA, Collections and Staffing	On-going
6	**Assess current functions** including registration, billing, cash posting, and billing follow-up. Provide final recommendations for organization and staffing levels.	Teresa Jacques	Additional 1 on 1 training will be completed by 2/17/12 to include proper registration of Medicare and Medi-Cal patients vs. Managed Medicare and Medi-Cal. All clerks will be required to sign off that they received and understand the material. Additionally, we are going to review last quarter's registration errors with January's With respect to the organization and staffing plan we are waiting to incorporate the new Business Office Director for support of the reorganization.	Registration remains an area of concern. Starting on March 5th Rebecca Pavone will be onsite to work with the Admissions staff and cover the Business Office Director position.	Refer to Line 9	Refer to item 5	In process

#	Task	Responsibility	Updates as of 1/27/12	Updates as of 2/26/12	Updates as of 3/22/12	Updates as of 4/18/12	Status
7	**Redesign the cash posting system**. Incorporate appropriate checks and balances, reassign to staff member who possesses understanding of third party contracts.	Teresa Jacques	Cash Posting was been addressed in a temporary fashion. Accounting is waiting for an additional staff member that will take on some of the banking and deposit responsibilities, in the interim we have separated the duties amongst the business office staff.	The Business Office is still waiting for Accounting to take over some of the banking and deposit responsibilities.	No Update		In process
8	**Review relationships between business office and operating departments.** Affirm functions are being covered. Evaluate certain registration functions as being more effective if handled by operating departments.	Teresa Jacques	Met with Janet Dike and Julie Green to understand where coding issues are originiating. We are going to develop algorithms for communicating coding issues and quality assurance. Additionally, thus far we have met with the Directors of ED and Medical Imaging meeting to start this process. Alameda will provide the staff to produce the algorithms and we expect that this project will be completed in the next 6 weeks.	This relationship and communication has smoothed out. With staff in the last month working to get the RAC processes defined there has been no update on the meetings with the Department Directors.	Reviewing process for late add on and walk in ancillary services to insure appropriate authorizations obtained	HFS Billing Office representative was on-site the week of 4/9 and worked with HIM, Admitting, verification, and billing to work out and streamline issues and communications between AH and HFS.	In process
9	**Determine the duties of verification clerks**. How does this relate to Health Advocates? How are authorizations and TARs obtained? Does the system work well?	Becky Pavone, Gwynn Smith, Teresa Jacques	HFS is working with IP Verification clerks on authorizations and TARS. A new TAR log has been developed and training on maintaining the log. Electronic TARS has been put on hold for now and will be revisited in March.	Our next step with the TAR process is to see how we can incorporate ETAR into the system. The TAR log has been added to again this month and is being used for both tracking and communication now.	No Update	Meeting scheduled for week of 4/23/12 with Health Advocates to evaluate contract.	In process
10	**Determine who will assume supervisory business office responsibilities**. AH Administration?	Becky Pavone	Interviews are in process	No offers were made to the Business Office Director candidates.	On 3/4/12 R.Pavone began as Interim Business Office Director	No update	In process
11	**Reports.** Which ones will be provided daily to monitor progress? Schedule weekly update meetings.	Gwynn Smith, Teresa Jacques, Diane Gramse	Cash projection log has been built, reviewing how billing information can be reported in a format that will work for cash projection.	No update	Daily review of Meditech Revenue Generation reports including individual productivity.	Ongoing review of current reports available and those NPR reports needed for analysis and review	In process

#	Task	Responsibility	Updates as of 1/27/12	Updates as of 2/26/12	Updates as of 3/22/12	Updates as of 4/18/12	Status
12	**Eligibility and authorization process**. Recommendations for improvement. Check Assist being used? TAR process?	Teresa Jacques, Becky Pavone	HFS will recommend that the Check Assist be turned off do to its unreliable information. HFS will get into place the necessary website access and training in the next month. HFS has developed a new TAR log and trained Alameda IP Intake staff. HFS is evaluating the Intake/Verification clerk duties to determine the needs of the facility.	This task was handed to Alameda staff and there is no update.	Met with Anita Mayo-Green to obtain individual staff sign on to WebSites. Anticipated implementation and training by April 1	Spoke with Emdeon Acct Mgr Jason Zitt who will arrange for hospital/HFS Webinar inservice.	In process

#	Task	Responsibility	Updates as of 1/27/12	Updates as of 2/26/12	Updates as of 3/22/12	Updates as of 4/18/12	Status
13	**Coordination of authorizations**. Surgery, imaging.	Becky Pavone, Teresa Jacques	1/27/12 HFS has will be meeting with Imaging Director the week of Jan 30th to discuss the authorization process. A meeting with the Lab Director has not yet been scheduled.	The meeting with John did not occur due to the RAC issues, contractual allowance reviews and tearing down the AR.	See #13	No update	In process
14	**Workflow for PBX.**	Diane Gramse, Teresa jacques	We have assigned some cash posting duties to this position and are going to evaluate further after the Financial Counselor has been hired.	This will be looked at in March when Teresa is back onsite.	On Teresa Jacques task list for week of 3/26/12	No update	In process
15	**Interdepartmental Procedures**	Gwynn Smith		No update this period.	Gwynn Smith working on Policies/Procedures and Flow charts	No update	In process
16	**Develop Cash projection model**	Teresa Jacques	Have built the model no data available to differentiate government billings from commercial to estimate cash.	If Alameda goes to DSG the issue of estimating cash by payor will work since the model is based on reporting from DSG. Otherwise I will need to see if we can get zero balance information in another form and change the model.	No Update	No update	In process
18	**CDM and revenue usage report.**	Teresa Jacques, Gwynn Smith	A contract has been signed for an outside vendor to perform a CDM review.	The CDM team will be onsite the first week in March.	Completed March 9,2012. Report from Panacea due April 2012	Awaiting outcome of Panacea report.	In process
19	**Bad Debt -** Evaluate BD contracts, review BD contractors collections, choose contracts, evaluate BD write offs, campaign for charity care, campaign for additional one-time discounts starting in Feb 2012. Goal to get self pay to manageable level	Teresa Jacques	CFO has received requested information and is now looking for additional information from Analyst staff in order to evaluate. We are still waiting for the report to be built on our side, credit card contract to be signed, and Emdeon to make the necessary corrections on the statements.	Work was done on the contractual assesment this last month but no decision has been made. The Early Out program has started. The file was sent mid February over 5,000 claims. The credit card virtual terminal is up and running and the statements have been changed by Emdeon. Teresa reviewed the statements that are now going out and there is still one phone number that was changed correctly by Emdeon. We are also looking to offer "check by phone" for patients.	Contractual assessment was decided to reserve an additional $400,000 for Feb-June 2012. The discount campaign for Bad Debt has begun at Rash Curtis and ARM. We expect to start Early Out in the first week of April. We corrected the phone numbers on the Emdeon Statements and spelling errors were corrected on the Rash Curtis statements.Received access to Check by Phone on 3/21/12 and will begin training and implementing within the next week.	Meeting with Rash Curtis set for 4/20 to review current status of Early Out Campaign	In process
21	**Compliance**	Diane Gramse, Teresa jacques, Gwynn Smith			Complete	Two compliance issues were identified and addressed during the month.	On-going
22	**Review contracts** with outside vendors that provide revenue cycle related functions. Make recommendations for continuation or modification of services.	Teresa Jacques	Rash Curtis contract has been signed. We are still in the process of developing a report to transmit the self pay accounts on a weekly basis. All self pay will be turned over and worked before going to bad debt. A discount will be offered in late February on all self pay and bad debt balances with Rash Curtis.	The report is complete and has been transmitted. The discount will be offered for accounts in collections in the first part of March and the Early Out will be offered in the end of March. We are also looking at splitting the bad debt between Rash Curtis and a local company.	In process	Currently reviewing HA contract terms and meeting set for week of 4/23. Discount Campaign on early out accts and BD accts with Rash Curtis and ARM is in effect through the end of April/2012	In process
23	**Contract payments** - assess P & P for identifying 3rd party shortfalls	Mahera	The long term solution is to set up and use the proration module in Meditech. This task is assigned to Mahera.	No update	No Update	Mahera has identified an additional $200,000+ in United underpays and B.Pavone has identified Kaiser underpaymentto be determined and D.Gramse has identified Alameda Alliance underpays. All of which will be pursued for additional monies	In process

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25	**Unbilled** - research causes for unbilled amounts over goal by $1.5m, reduce unbilled to goal of $3.5 to $4m for all accounts except LTC	Teresa Jacques	We have identified the unbilled accounts and met again with HIM staff. All uncoded/unbilled are listed with issues. We are working to resolve issues ie physician queries, accounts with no charges, accounts with no reports.	No update	Complete (this issue primarily due to LTC patient receivables. We continue to monitor	Ongoing review of current reports available and those NPR reports needed for analysis and review	In process
26	**RAC Monitoring and Medicare takebacks** - In working Medicare claims several accounts were noted where Medicare had taken back their inpatient payment	Alameda Staff and Business Office	The RAC process has been revisited and the staff have worked diligently over the last two weeks to re-address the RAC process. It has now been noted that $457,000 has been taken back on RAC claims. These claims have been sent to E.H.R. to be appealed. There are several claims in the meantime that will be re-billed as outpatient claims. 191 claims have been audited. 40% of the claims were determined to be appropriate.	The RAC process is still in process we have started our processes in the Business Office and our preparing our policies and procedures.	Business RAC Policy and Procedure draft presented to committee for review. Business Office participates in monthly RAC Status Meetings	Scheduled meetings continue. Business Office policies are in draft form with the committee.	On-going
	Waters Edge system conversion on Point Click Care.	Teresa Jacques			Attended several meetings over the last two weeks to plan responsibilites for implementing the PCC system and various other tasks that need to be completed for Finance and Bus Ofc for the April 1 start date. Trained on PCC last week and will be updating and/or building the database the week of March 26.	On hold until start date is determined.	In process