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CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Thursday, April 11, 2013

5:30 p.m. (CLOSED) | 7:30 p.m. (OPEN)

PLEASE NOTE START TIME FOR EXECUTIVE CLOSED SESSION

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 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 **(5:30 p.m. – Dal Cielo Conference Room)** — J. Michael McCormick

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. March 7, 2013

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

1. Discussion of Hospital Trade Secrets applicable to District's Strategy for Delivery of New Programs and Services

   No action will be taken.

   Estimated Date of Public Disclosure: June 2013

G. Consultation with Legal Counsel Regarding Pending and Threatened Litigation — Gov't Code Sec. 54957.6

H. Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions — Gov't Code Sec. 54956.9(a)

I. Adjourn into Open Session

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

A. Announcements from Closed Session — J. Michael McCormick

VI. General Public Comment

VII. Regular Agenda

A. Consent Agenda — **ACTION ITEMS**

✓ 1) Approval of March 7, 2013 Meeting Minutes [enclosure] (pages 3-8)

✓ 2) Approval of Administrative Policies and Procedures [enclosure] (pages 9-10)

- No. 5 – Compliance Plan
- No. 10 – Disposal of Surplus Property
- No. 47 – Resources for Limited English Language Patients & Patients with Hearing, Vision or Other Communication Barriers
- No. 71 – Patient Billing for Clinical Studies and Investigational device Billing
- No. 76 – Expense Reimbursement
- No. 79 – Child Passenger Safety Seats
- No. 81 – Non Discrimination Policy

✓ 3) Approval of Annual Appointment to the Community Relations and Outreach Committee for 2013 [enclosure] (pages 11-12)

✓ 4) Approval of the Renewal of the Operating Engineers, Local #39 Memorandum of Understanding - October 1, 2010 – January 1, 2015 [enclosure] (PAGES 13-14)

✓ 5) Approval of Medical Staff Application for Hospice and Palliative Medicine Privileges [enclosure] (pages 15-17)

B. Action Items

✓ 1) Acceptance of February 2013 Unaudited Financial Statements and March 27, 2013 Finance and Management Committee Report [enclosure] (pages 18-41) — Elliott Gorelick, Kerry Easthope

C. District Board President's Report INFORMATIONAL — J. Michael McCormick

D. Community Relations and Outreach Committee Report INFORMATIONAL — Jordan Battani

✓ 1) Community Outreach Calendar (March – May 2013) [enclosure] (page 42)

E. Medical Staff President Report INFORMATIONAL — Emmons Collins, MD

F. Chief Executive Officer Report INFORMATIONAL — Deborah E. Stebbins

✓ 1) Monthly CEO Report [enclosure] (pages 43-49)

- Bay Area Bone & Joint Center, Capital Projects, Foundation/Community Relations and Outreach, Information Technology and Meaningful Use, Kate Creedon Center for Advanced Wound Care, Language Interpreter Program, Long Term Care, Stroke Program, DSRIP Report, Performance Improvement and Quality Management, and Key Statistics – March 2013

2) Joint Commission Survey Update

✓ 3) LAFCo Municipal Service Review (MSR) and Updated Spheres of Influence – City of Alameda Health Care District [enclosure] (pages 50-75)

VIII. General Public Comments

IX. Board Comments

X. Adjournment

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the City of Alameda Health Care District Board of Directors
Open Session
Wednesday, March 7, 2013 Regular Meeting

DRAFT

Board Members Present	Management Present	Legal Counsel Present	Guests
Jordan Battani Robert Deutsch, MD Tracy Jensen J. Michael McCormick	Deborah E. Stebbins Kerry J. Easthope Brian Jung	Thomas Driscoll, Esq.	
		Medical Staff Present	**Excused**
			Elliott Gorelick Emmons Collins, MD
Submitted by: Erica Poncé, Administrative Secretary			

Topic		Discussion	Action / Follow-Up
I.	Call to Order	The meeting was called to order at 5:40 p.m.	
II.	Roll Call	Ms. Thorson called roll noting a quorum of Directors was present.	
III.	Adjourn into Executive Closed Session	The meeting was adjourned into Executive Closed Session at 5:41 p.m.	
IV.	Closed Session Agenda		
V.	Reconvene to Public Session	The meeting was reconvened into public session at 8:05 p.m.	

A. Announcements from Closed Session
Director McCormick stated that the Executive Closed Session Minutes were reviewed and approved from the January 9, 2013 and February 6, 2013 Regular Meetings. The Board Quality Committee Report for January 2012 was reviewed and accepted as presented. The Board approved the Credentialing Recommendations of the Medical Staff as outlined below. No other action was taken.

Initial Appointments – Medical Staff

	Name	Specialty	Affiliation	

Topic		Discussion		Action / Follow-Up
	• Michael Knoll, DDS	Oral Surgery	Randall Stettler, DDS	
	• Vinod Kurupath, MD	Gastroenterology	No. CA GI Consultants	
	• William West, MD	Orthopedics (Assist Only)	Private Practice	
Reappointments – Medical Staff				
	Name	Specialty	Staff Status	Appointment Period
	• Susan Cha, MD	Teleradiology	Courtesy	04/01/13 – 03/31/15
	• Christopher Chen, MD	Orthopedics	Courtesy	04/01/13 – 03/31/15
	• Huilian Cheng, MD	Gastroenterology	Courtesy	04/01/13 – 03/31/15
	• Lisa Higa, MD	Gastroenterology	Courtesy	04/01/13 – 03/31/15
	• Ho-Yin Li, MD	Anesthesiology	Courtesy	04/01/13 – 03/31/15
	• Norman Moscow, MD	Radiology	Courtesy	04/01/13 – 03/31/15
	• Jeffrey Niccoli, DPM	Podiatry	Courtesy	04/01/13 – 03/31/15
	• Thomas Quinn, MD	Cardiology	Courtesy	04/01/13 – 03/31/15
	• Concepcion Regacho, MD	Anesthesiology	Courtesy	04/01/13 – 03/31/15
	• Ronald Rubenstein, MD	Otolaryngology	Courtesy	04/01/13 – 03/31/15
	• Thomas Sugarman, MD	Emergency Medicine	Active	04/01/13 – 03/31/15
Proctoring Proctoring reports to Lilavati Indulkar, MD were approved.				
Resignations				
	• Stephen Daane, MD	Plastic Surgery		
	• Leslie Graham, MD	Emergency Medicine		
	• General Hilliard, MD	Cardiology		
	• Herkanwal Khaira, MD	Urology		
	• Henry Turkel, MD	Emergency Medicine		
	• Julie Wiley, PA	Physician Assistant		

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Topic	Discussion	Action / Follow-Up
VI.	**General Public Comments** There were no comments.	
VII.	**Regular Agenda**	
	A. Consent Agenda 1) Approval of February 6, 2013 Meeting Minutes 2) Approval of Departmental Policies and Procedures • Diagnostic Imaging • Nuclear Medicine • Mammography • Infection Control 3) Approval of Administrative Policies and Procedures • No. 4 – Plan for Provision of Patient Care Services • No. 14 – Interdisciplinary Practice Committee • No. 21 – Patient Identification and Communications for Clinical Care and Treatment • No. 24 – Do Not Resuscitate (DNR) • No. 26a – Non Behavioral (Physical) restraint Standards • No. 26b – Behavioral Health Care Restraint Standards • No. 28 – Sedation Management • No. 32 – Transfer of Patients • No. 43 – Hand-Off Communication • No. 51 – Code Purple • No. 54 – Medical Staff Line of Responsibility • No. 64 – Code 4 Rapid Deployment Plan • No. 67 – Hospital Diversion • No. 68 – Pain Management • No. 69 – New Born Abandonment • No. 84 – Color-Coded Wristband Use • No. 90 – Universal Protocol 4) Approval of Annual Appointment to the Board Quality Committee for 2013 5) Approval of Annual Appointment to the Finance and Management Committee for 2013	Director Battani made a motion to approve the Consent Agenda as presented. Director Deutsch seconded the motion. The motion carried.
	B. Action Items 1) Acceptance of January 2013 Unaudited Financial Statement and February 27, 2013 Finance and Management Committee Report	Director Battani made a motion to accept the January 2013 Unaudited Financial Statement and February 27, 2013 Finance and Management

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Topic	Discussion	Action / Follow-Up
	In Director Gorelick's absence, Director Deutsch gave the report. He referred Board Members to pages 33 through 55 of their packet, and highlighted key points. The District recorded a loss of $395,000 for the month of January. Excluding adjustments related to prior periods and one-time payments, the loss for the month of January was $193,000 against a budgeted gain of $101,000. About one-third of this variance is on the revenue side, and two-thirds on the expense side. Much discussion was generated by three billing adjustments totaling almost $800,000. Management is taking action to report back and identify these items in a timelier manner. Of the $800,000, $485,000 was an due to a Tri-Care billing error. Money needs to be paid back, and Tri-Care is amenable to a plan. $134,000 was due to a misclassification of Hospital self-insurance claims, with no cash impact. $173,000 was because of a misclassification of Kaiser cosmetic surgery charges, no cash impact. On the positive side, DSH funds of $225,000 were booked in January and $132,000 of the cash (offsetting the booked receivable) will arrive in February for fiscal year 2010 and EMR implementation incentive for Medi-Cal of $365,000 was received in January. Kerry Easthope, CFO, added that $135,000 of this money is expected to come in during March and the remaining balance will come in installments. Alameda Hospital at Waters Edge was positive by $217,000. The Kate Creedon Center for Advanced Wound Care was close to budget with no material impact. Bay Area Bone & Joint Center lost $75,000 in direct revenue and expenses but contributed $100,000 in Hospital net revenue from referred therapy, imaging, and surgical procedures. Overall, the orthopaedic program is below budget, but not significantly. The number of imaging and therapy referrals is ramping up significantly from prior month. The appointment of Committee members passed. There is an open at-large seat. Enclosed in the Board packet on pages 32-33 is a memo for the annual appointment of Committee members.	Committee Report. Director Jensen seconded the motion. The motion carried.
C. District Board President's Report	Director McCormick conveyed his enthusiasm for the future. He thanked Director Battani for serving as District Board President for the past six years and her help to move the District forward. He welcomed Tracy Jensen as the newest Board Member.	
D. Community Relations and Outreach Committee Report	Director Battani provided an update to the Board regarding the Community Relations and Outreach Committee. At the January 27, 2013 meeting, Deborah Stebbins presented an	

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Topic	Discussion	Action / Follow-Up
	update/overview of Alameda Hospital's Strategic Plan. Marketing and communication initiatives continue to be focused on the Bay Are Bone & Joint Center. Community Stroke Risk Assessments were offered on March 1, 2013. Approximately fifty (50) free assessments were provided. These assessments will be offered each quarter in 2013. The next session is scheduled for May 17, 2013. The next Community Relations and Committee Meeting will be held on March 26, 2013. At that time, the committee will review and approve the new slate of members and will present an approved list at the April Board Meeting.	
E.	Medical Staff President Report In Dr. Collin's absence, Director Deutsch gave the Medical Staff President Report. He reported that there are twice weekly educational sessions offered. The Medical Executive Committee meets monthly. Also, regular Service Committee meetings about medicine, surgery, and critical care / emergency medicine have been well-attended. These meetings are an opportunity for Medical Staff and Hospital Management to come together in an effort to solve problems and provide the best quality care possible.	
F.	Chief Executive Officer Report Ms. Stebbins provided an overview of the information found in her written report (beginning on page 56 of the Board Packet): Employee Service Awards, Bay Area Bone & Joint Center, Foundation/Community Relations and Outreach, Information Technology and Meaningful Use, Kate Creedon Center for Advanced Wound Care, DSRIP Report, Long Term Care, Stroke Program, Pharmacy, Quality/Risk Management, Fiscal Year 2013 Financial Forecast, and Key Statistics – February 2013. Ms. Stebbins highlighted that a great deal of work is being done surrounding AB-97 which would reduce SNF reimbursement rates. For the District, the impact is approximately $450,000. For other small, rural hospitals, AB-97 may put them out of business. She will spend two days in Sacramento next week lobbying and speaking with legislators about this very important issue. Ms. Stebbins served on a panel in February, sponsored by the League of Women Voters, at a well-attended event about health care reform. This same presentation may be repeated in other venues.	

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Topic	Discussion	Action / Follow-Up
	Dr. DiStefano and Pirnia continue to do a great job at representing the Hospital, and are offering a free session regarding arthritis of the hip and knee on March 30 in Dal Cielo Conference Room. Handouts regarding the session were made available. Ms. Stebbins highlighted the Key Statistics and noted that February was a better month than January, and March looks stronger thus far. Attention was called to the Board Meeting packet beginning on page 62, regarding Joint Commission Survey Education. She asked that all Board Members review the material in preparation for the upcoming survey. Page 62 gives the methodology for "tracers" which have been occurring weekly. Each Board Member was asked to be prepared to answer questions from the Joint Commission. The involvement of specific Board Members will be discussed over the next month as Management continues preparation. Director Jensen asked when the last Joint Commission survey took place, and asked if there were outstanding findings. Mary Bond, RN, Executive Director of Nursing, replied that the last survey was in 2010 and that there were no outstanding findings. Any corrections were completed within the 30/60/90 day time frame as required.	
I. **General Public Comments** There were no comments.		
II. **Board Comments** There were no comments.		
III. **Adjournment**	Being no further business, the meeting was adjourned at 8:31 p.m.	

Attest:

J. Michael McCormick
President

Tracy Jensen
Secretary

DRAFT

1

Date: April 4, 2013

For: April 11, 2013 District Board Meeting

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

From: Deborah E. Stebbins, Chief Executive Officer
Kristen Thorson, District Clerk

Subject: Approval of Administrative Policies and Procedures

Recommendation:

Management requests approval of the following Administrative policies and procedures.

No. 5 – Compliance Plan	
Minor revisions.	
Purpose:	To ensure Hospital wide compliance in accordance with Hospital Standards of Conduct, as well as any other Hospital or payor policy and any applicable Federal and State statute, regulation, and rule.
No. 10 – Disposal of Surplus Property	
Minor Revisions.	
Purpose:	To provide for the disposal of surplus property of the City of Alameda Health Care District based on the provisions of the governing statute.
No. 47 - Resources for Limited English Language Patients and Patients with Hearing, Vision or other Communication Barriers	
Changes to reflect current regulations and services provided.	
Purpose:	To enhance effective communication between patients who are Limited English Proficient (LEP), deaf, hard of hearing, blind or visually impaired, and Alameda Hospital staff members. This policy complies with applicable Federal and State regulations.
No. 71 – Patient Billing for Clinical Studies and Investigational Device Billing	
No Changes.	
Purpose:	To establish a policy on the billing protocol for clinical studies for patients and/or insurers.
No. 76 – Expense Reimbursement	
Minor Revisions.	
Purpose:	To reimburse employees for legitimate business related expenses that they incur on behalf of Alameda Hospital

No. 79 – Child Passenger Safety Seats	
Revisions made to meet regulatory guidelines, specifically changing the age requirements from 6 to 8 years and eliminating the weight requirement for providing child passenger safety seats.	
Purpose:	To provide information regarding Child Passenger Restraint Law to all parents/guardians of children treated at or discharged from Alameda Hospital. "Health & Safety Code Sections 1204.3, 1212, and 1268 require hospitals at the time of, or before the discharge of a child under the age of eight years to provide and discuss information on the law requiring child passenger restraint systems to the parent or to the person to whom the child is released." The parents or legal guardian of infants and young children will be made aware of the law and provided with information regarding local car seat programs and risks of death/injury associated with nonuse and misuse of a child passenger safety seat.
No. 81 – Non-Discrimination Policy	
Minor revisions	
Purpose:	To state the Hospital's non-discrimination policy related to employment, treatment or participation in program, services and activities.

BACKGROUND:

The Joint Commission tri-annual accreditation survey is scheduled for Spring, 2013. In preparation for this survey, the hospital has begun its review of all Administrative Policies and Procedures. All Administrative policies and procedures will be brought to the Board of Directors for approval.

The policies and procedures are either new or have been revised to reflect current practices, regulatory language / requirements and/or other pertinent information as indicated above. Each policy and procedure has been reviewed by the appropriate Medical Staff Committees, Hospital Committees, Management Team, and Administration.

Policies and Procedures are available for review upon request from Administration.

Date: March 22, 2013

For: April 11, 2013 District Board Meeting

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

Through: Community Relations and Outreach Committee

From: Jordan Battani, Co-Chair– Community Relations and Outreach Committee
Terrie Kurrasch, Co-Chair – Community Relations and Outreach Committee
Erica Poncé, Administrative Secretary

Subject: Approval of Membership to the Community Relations and Outreach Committee for CY 2013

RECOMMENDATION:

The Community Relations and Outreach Committee recommend the following committee members be appointed for the remainder of calendar year 2013. All shall be voting members of the committee.

Name		New or Current Member
Jeptha Boone, MD	At Large Representative	Current
Shubha Fanse	At Large Representative	Current
Karen Fong	At Large Representative	New
Jim Franz	At Large Representative	Current
Terrie Kurrasch	At Large Representative, Co-Chair	Current
Mike McMahon	At Large Representative	Current
Jaseon Outlaw	At Large Representative	New
Bill Pai	At Large Representative	New
Monica Valerio	At Large Representative	Current
Bill Withrow	At Large Representative	Current
Tracy Zollinger	At Large Representative	Current

BACKGROUND:

The Board of Directors, on February 6, 2013, appointed Jordan Battani as Co-Chair of this committee. Terrie Kurrasch co-chairs with Jordan Battani, and is an active member of the community. The Committee will be reviewing potential candidates for the three open medical staff representative positions in future months.

The following structure has been approved by this committee as well as the District Board of Directors. Similar committee structures have been developed for other two board designated committees (Finance and Management Committee and Community Relations and Outreach Committee).

1. Community Relations Committee:

    a. Primary Purpose: The primary purpose of the Community Relations Committee is to develop a community engagement and outreach plan that supports the hospital's strategic plan and annual goals. The Committee advises the board on strategies and programs to enhance health care services to the community, increase the district's (hospital's) market share, effectively position the hospital for success based on information flow with the community and elected officials and support the fund-raising objectives of the Alameda Hospital Foundation.

    b. Committee Composition and Voting Rights: The committee shall be comprised of the following members:

        i. At least two members of the City of Alameda Health Care District Board of Directors all of whom shall be voting members of the committee. One of these members also shall be appointed to serve as the committee co-chair. The other co-chair will be an at large member from the community who will be elected each year.

        ii. The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-noting member, unless the President is serving as a voting member of the committee.

        iii. Up to three members of the Alameda Hospital Medical Staff all of whom shall be voting members of the committee.

        iv. Up to eleven at large members chosen for expertise needed by the district all of whom shall be voting members of the committee. At least one member at large shall also be a member of the Alameda Hospital Foundation Board.

        v. The City of Alameda Health Care District Chief Executive Officer, and other hospital management as delegated, who shall not be voting members of the committee.

        vi. The Executive Director of the Alameda Hospital Foundation and the Director of Community Relations shall serve as staff to the Committee and collaborate with the Committee co-chairs on the preparation of agenda.

    c. Terms: The committee shall be appointed annually.

    d. Meeting Frequency: The committee shall meet at least quarterly.

DATE: March 28, 2013

For: April 11, 2013 District Board Meeting

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

FROM: Kerry Easthope, Chief Financial Officer
Phyllis J. Weiss, Director Human Resources & Ancillary Services

Subject: Approval of the Renewal of the Operating Engineers, Local #39 Memorandum of Understanding - October 1, 2010 – January 1, 2015

Recommendation:

Hospital Administration is hereby recommending that the City of Alameda Health Care District Board of Directors approve the renewal of the District's Memorandum of Understanding (MOU) with the Operating Engineers, Local #39. This union represents five (5) employees who work in the maintenance department of the Hospital; one (1) Chief Engineer, three (3) Engineers and one (1) Utility Worker. The term of the agreement is October 1, 2010 through January 1, 2015 (four years and 3 months). A summary of the changes to the MOU are itemized in the "Discussion" section below and a full copy of the Tentative Agreements and the expired MOU are available for review upon request.

Background:

Hospital Management met with the Operating Engineers Union in 2010 when the MOU originally expired and mutually agreed to extend the MOU while the Union settled some of the larger contracts in the area. We then met in 2012 and reached Tentative Agreements on four (4) proposals made by the Union and once again took a break while the Union continued negotiations in the area.

We starting meeting again in late 2012 and worked creatively to reach an agreement intended to preserve the "green" status of their Pension Plan with a modest wage increase in later part of calendar year 2013 in order to reach parity with other wage rates in the market place (no retroactive wage increases).

Negotiating sessions were amicable and conducted in a professional manner. Management feels that the Operating Engineers' representatives understood the Hospital's challenges and took them very seriously as reflected in the terms of this four year and three month agreement.

Discussion:

A summary of the Tentative Agreements which modify the existing MOU are as follows:

Article II, Section 5, Sub-Section C:
Clarification of Bio-Med Engineering Supervisor position.

Article II, Section 7, Relief Chief Engineer:
Extending premium pay to the first (1st) day of coverage as the Chief Engineer.

Article II, New Section – Relief Engineer:
Clarifying the schedule in the event a Relief Engineer is hired.

Article (New) – Federal Political Action Committee:
Creating new (voluntary) deduction for members towards the Union's Federal Political Action Committee.

Article III – Wages:

10/1/10 – 9/30/13:	Wages frozen at 10/1/09 rates
10/1/13 – 9/30/14:	3.0%*
10/1/14 – 1/01/15:	2.5%

(*very low financial impact due to the small number of employees in this bargaining unit)

Article VIII, Section 4 – Retirement Program:
Increase of $1.35/hour over current pension contribution, over the life of the MOU.

Article XI – Term of Memorandum of Understanding:
October 1, 2010 – January 1, 2015 - Four years & three months.

Date: March 29, 2013

For: April 11, 2013 District Board Meeting

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

From: Emmons Collins, MD, Medical Staff President

Subject: Approval of Medical Staff Application for Hospice And Palliative Medicine Privileges

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Recommendation:

The Medical Executive Committee respectfully requests your approval of the attached ***Application for Hospice and Palliative Medicine Privileges.*** The request to add this privilege delineation has been reviewed and approved by members of the Medical Committee and the Medical Executive Committee.

Background / Discussion:

For some patients with a terminal illness, "home" is in a nursing home. In the case of Alameda Hospital, this would mean Waters Edge, South Shore or our Subacute unit on the 2nd floor of the hospital. Often times, nursing homes have contracts with agencies that provide hospice care and physicians are not required to be credentialed separately. However, because Waters Edge, South Shore and Subacute fall under Alameda Hospital's license, physicians providing hospice care must apply for Medical Staff membership and be granted privileges to provide hospice care.

The privileges set forth on the attached application represent procedures commonly provided for end-of-life care, including management of pain, emotional and spiritual support and providing medications and supplies.

Application for Hospice and Palliative Medicine Privileges

☐ Initial appointment
☐ Reappointment

An applicant applying for hospice and palliative medicine privileges must be a member in good standing of the Alameda Hospital Medical Staff with clinical privileges or be an applicant for Medical Staff membership and clinical privileges. Hospice medicine privileges are contingent upon practitioner maintaining his/her Medical Staff membership and privileges at Alameda Hospital.

NAME: ____ **SPECIALTY**: ______________________________

Hospice and palliative medicine privileges include the care, treatment and/or services listed below. I specifically acknowledge that board certification alone does not qualify me to perform all privileges or assure competence in all clinical areas. By signing this request, I believe that my specific training, experience and current competence qualify me to perform each privilege I have requested.

A HOSPICE AND PALLIATIVE MEDICINE PRIVILEGES

		Approved	Denied
☐	Performance of history and physical exam	☐	☐
☐	Direct treatment and formation of a treatment plan	☐	☐
☐	Assessment of pertinent diagnostic studies	☐	☐
☐	Administration and management of palliative sedation	☐	☐
☐	Perform pain relieving procedures	☐	☐
☐	Management of common comorbidities and complications and neuropsychiatric comorbidities	☐	☐
☐	Management of palliative care emergencies	☐	☐
☐	Management of psychological, social and spiritual issues of palliative care patients and their families	☐	☐
☐	Management of symptoms, including various pharmacologic and Non-pharmacologic modalities and pharmacodynamics of commonly used agents	☐	☐
☐	Provision of appropriate advanced symptom control techniques such as parenteral infusional techniques.	☐	☐
☐	Symptom management, including patient and family education Psychosocial and spiritual support and appropriate referrals for other modalities such as invasive procedures.	☐	☐

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform.

____ ______________________

Signature – Applicant Date

Applicant: ____

RECOMMENDATION(S)

I have reviewed the requested privileges for hospice/palliative medicine and the supporting documentation for the above named applicant and have indicated my recommendation next to each procedure.

____ _______________________________

Service Committee Chair Date

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING FEBRUARY 28, 2013

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
FEBRUARY 28, 2013

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
FEBRUARY, 2013

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 February 28, 2013 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

Overall for the month of February, the hospital experienced a combined negative net operating loss of $78,000 against a budgeted loss of $33,000. Year to date the hospital shows a loss of $1.1 million compared to a budgeted loss of $339,000. Waters Edge remains steady with a positive net contribution of $335,000 and a year to date contribution of just over $2 million. Wound Care had another busy month in January as the number of visits has increased. The program's net contribution however fell below budget by $23,000 in February but is still $17,000 better than budget year to date.

The major contributor to the higher Net Revenue in February is the high census.

February discharges were 32 or 13.1% above budget and total patient days were 348 or 6.5% greater than budget. The acute ALOS back increased to 4.5 in the month. Total patient days for inpatient acute services were up 28.9%; subacute days were down 4.0%, skilled nursing days were up at South Shore by 9.6% and Waters Edge were up by 2.6%.

Overall outpatient activity was mixed again this month. Outpatient registrations were down 15% but emergency room visits were 109 or 8.5% above budget and Wound Care visits were up 129 or 51.6% above budget, the budget number of wound care visits does increase by 50 in March. Outpatient surgeries were below budget for the month by 43 or 29.9%, consistent with the trend year-to-date.

The Wound Care program had 379 visits in February compared to a budget of 250, or 51.6% above budget. In February there were 95 HBO treatments compared to 57 in January.

Total gross and net revenue in February was generally in line with activity. The overall inpatient component was above budget by 17.5% and outpatient was down 4.0%.

The overall Case Mix Index (CMI) in February was 1.3611; higher than last month's of 1.2999 and above the FY 2013 year-to-date of 1.3493.

However, off setting the increase in acute volume and revenues, total expenses were almost $6.9 million in February, $355,000 or 5.4% above budget.

Salaries, temporary agency fees, professional fees, supplies and purchased services were over budget while other categories were close to or just under budget. These variances will be discussed in more detail later in the narrative. As previously discussed, the FY2013 temporary agency budget was understated by about $40,000 per month and we will strive to overcome this variance with positive revenue and/or expense reductions as the year progresses.

Cash and cash equivalents were steady at $5 million at the end of February consistent with the prior month end. Cash collections in February were almost $6 million. Net accounts receivable increased by almost $350,000 to $11.5 million.

Accounts payable and other accrued expenses increased by $150,000 from $10.8 million to just over $10.9 million.

Lastly, the current ratio dropped slightly to .93 just below the required 1.0 of our bank covenants. Total Assets have remained stable at approximately $6.0 million consistent with the prior month end.

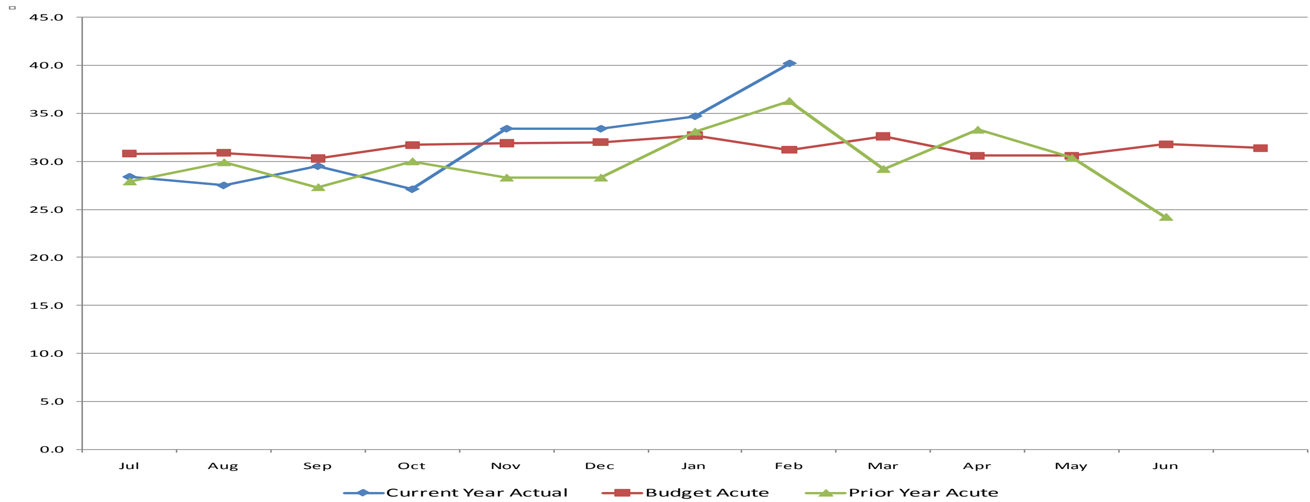
ACTIVITY

ACUTE, SUBACUTE AND SNF SERVICES

Overall, patient days were 6.5% above budget for the month and also above February of last year. This month's acute days were above budget by 28.9%, Subacute was down 4.0%, South Shore was up 9.6% and Waters Edge was up 2.6%.

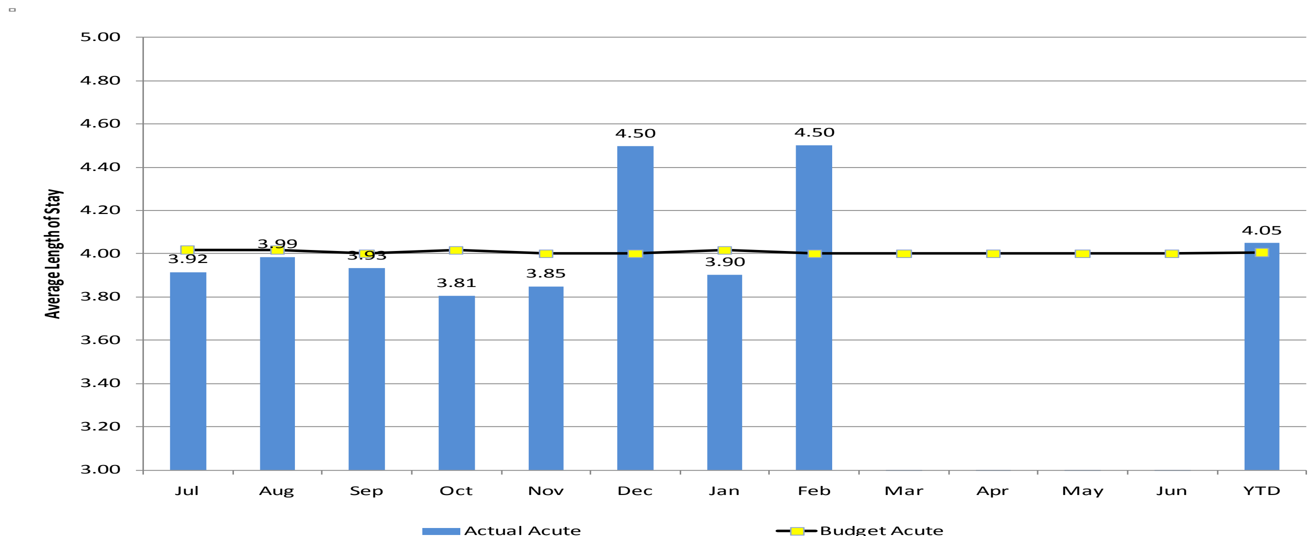
February's acute patient days were 252 days or 28.9% higher than budget for the month and 12.1% higher than February 2012. The acute care program is comprised of the Critical Care Unit (4.9 ADC, 24.3% above budget), Telemetry / Definitive Observation Unit (17.7 ADC, 63.2% above budget) and Med/Surg Unit (17.5 ADC, 7.2% above budget).

Acute Average Daily Census



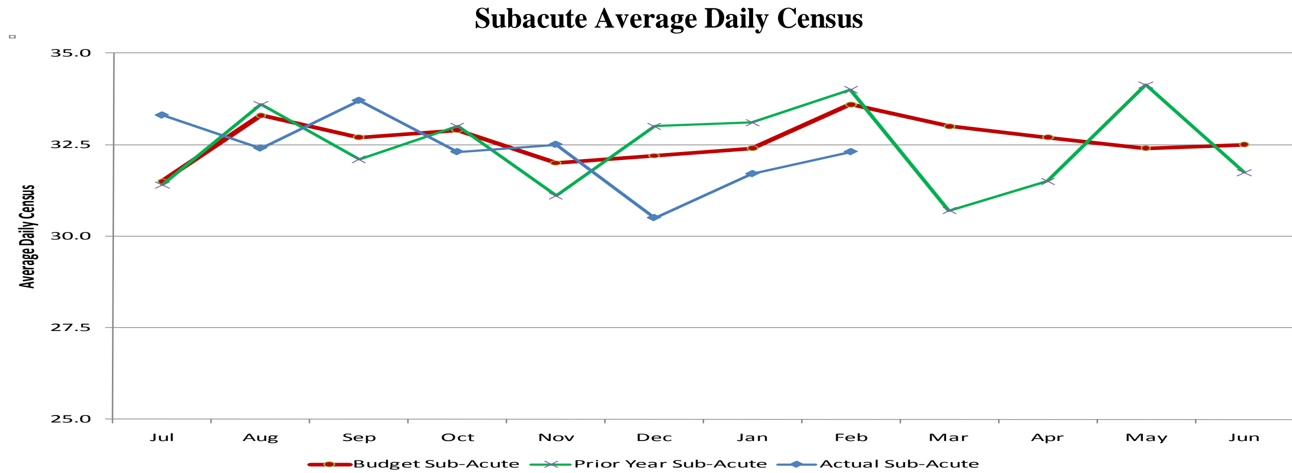
The acute Average Length of Stay (ALOS) increased from 3.9 in January to 4.5 in February and is above the budget of 4.00. The YTD acute ALOS for FY 2013 is 4.05. The graph below shows the ALOS by month compared to the budget.

Acute Average Length of Stay

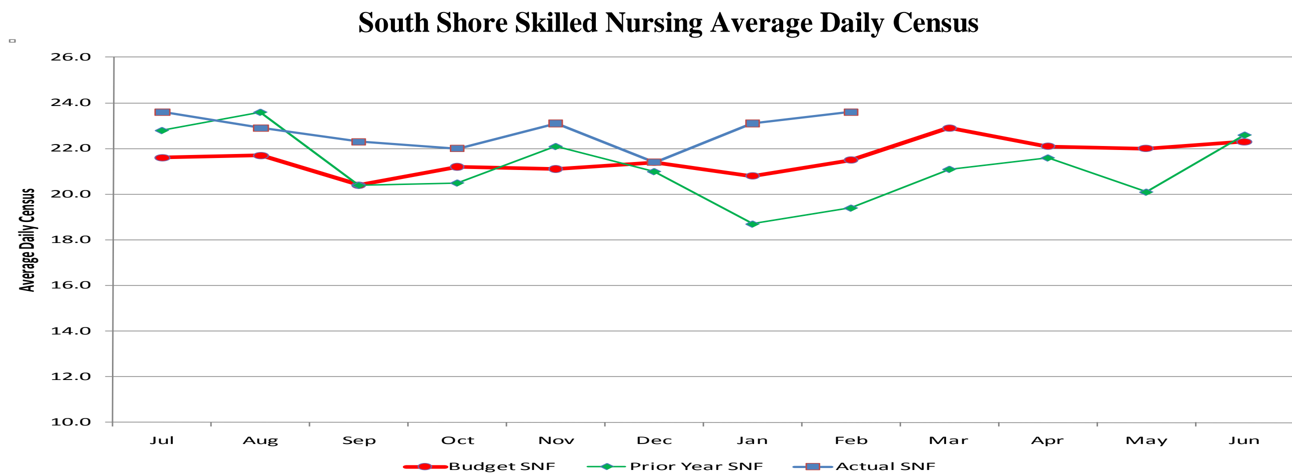


The Subacute program ADC of 32.25 was below budget by 1.36 ADC or 4.0%. The graph below shows the Subacute ADC for the current fiscal year as compared to budget and the prior year. We purposely postponed new admissions to the subacute unit

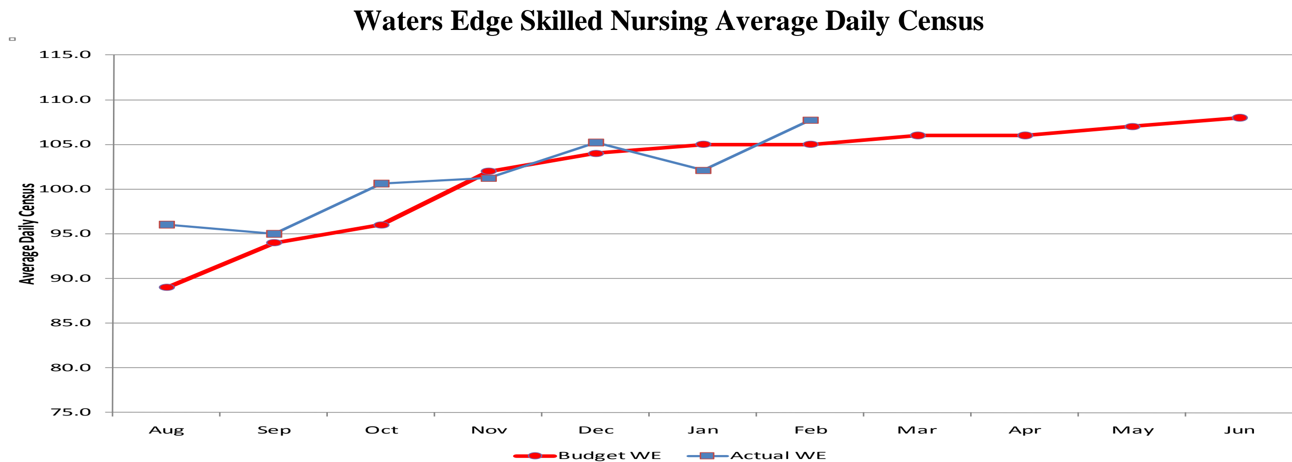
during our week long annual State survey. Census is now coming close to previous levels.



The South Shore ADC was above budget by 58 patient days (9.6%) for the month of February. The graph below shows the South Shore monthly ADC as compared to budget and the prior year. In February the number of Medicare A skilled patients was 2.14 ADC, down from 2.35 ADC in January and still lower than budget of 4.09.



Waters Edge census was 107.7 ADC or 2.6% above the budget of 105 in February. The Medicare census was 16.3 ADC up from 10.5 ADC in the prior month, and slightly above the Medicare ADC budget of 15.0.



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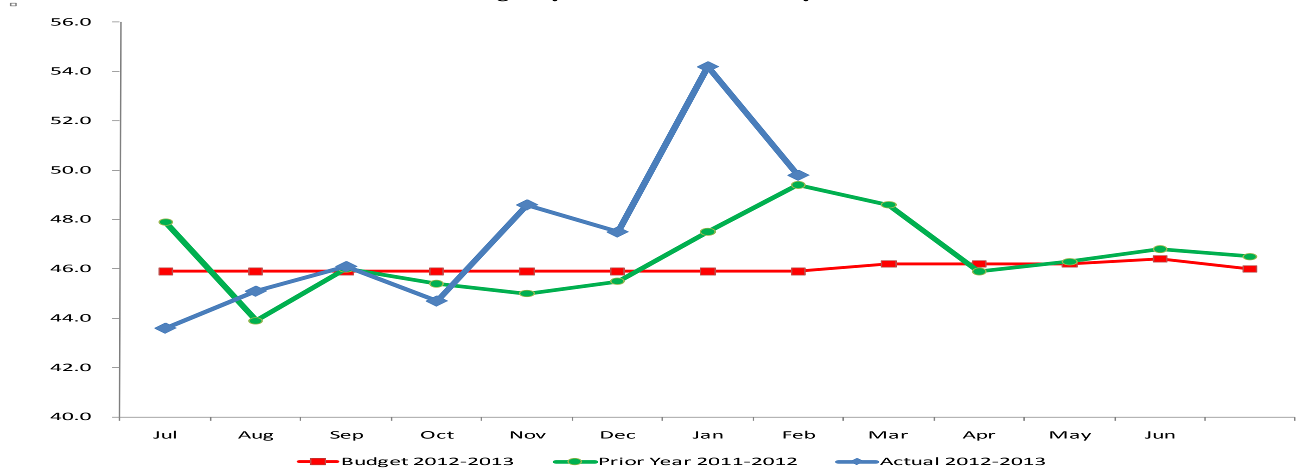
ANCILLARY SERVICES

Outpatient Services

Emergency Care Center (ECC) visits in February were 1,394, and 109 visits (8.5%) above the budget of 1,285. The inpatient admission rate from the ECC was 20.2% up from the 16.8% admit rate in January. On a per day basis, the total visits represent a decrease of 8.1% from the prior month high daily average. In February, there were 326 ambulance arrivals versus 384 in the prior month. Of the 326 ambulance arrivals in the current month, 212 or 65.0% were from Alameda Fire Department (AFD).

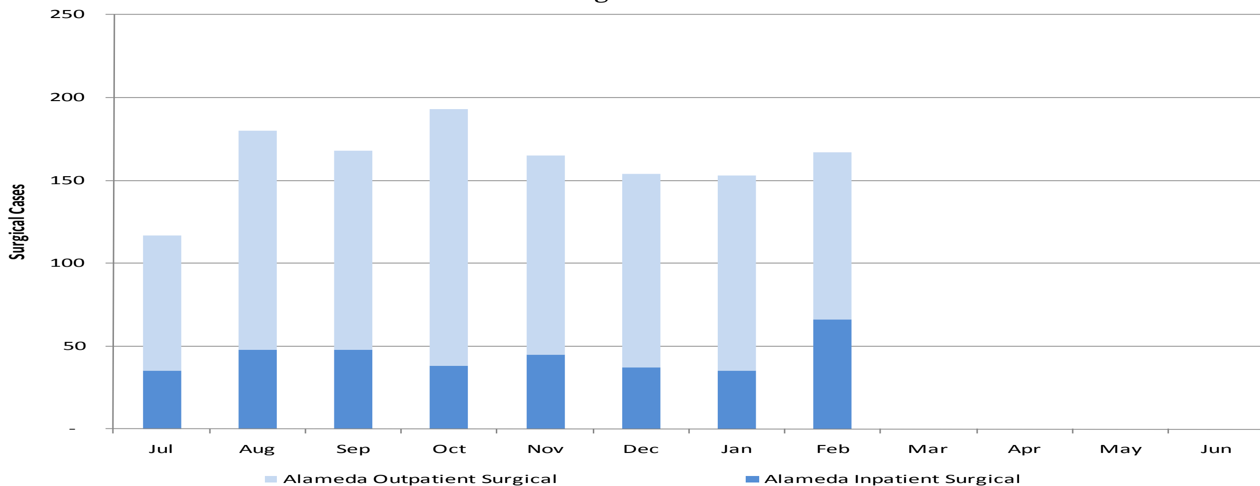


Outpatient registrations totaled 1,806 or 15.0% below budget. This month the number of patient visits were downw in Physical Therapy (132), CT (22), MRI (39), Radiology (254), Ultrasound (28) and Laboratory (83). However, visits were up in Occupational Therapy (26 visits), and Wound Care (129 visits). Starting in December and going forward, the budget for Physical Therapy and Radiology Services assumes significant increases from referrals by our two new orthopedic physicians. Work is being done to help streamline the referral and registration process of orthopedic clinic patients needing follow up ancillary services at the hospital. In February there were 147 Therapy referrals and 108 Imaging referrals from the new orthopedic clinic, compared to 249 and 101 respectively in January. MRI was budgeted to increase the number of service days from 2 days per week to 3 days per week and this did not begin until mid March.

In February, Wound Care again exceeded the budget of 250 with 379 visits, or 51.6% over budget. Hyperbaric Oxygen treatments accounted for 95 of those visits, compared to 57 in December.

Surgery

The total number of surgery cases in February were 167 or 17.7% below the budget of 203 and below last year's case volume of 174. Inpatient cases were above budget by 7 (11.9%) cases at 66 and outpatient was below budget by 43 (29.9%) at 101 cases.



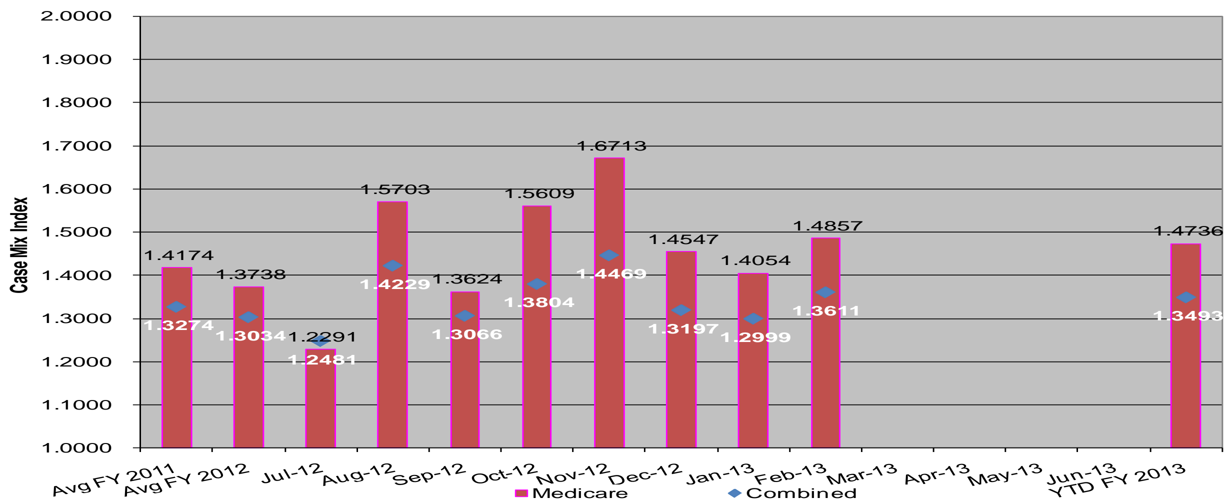
Payer Mix

The Hospital's overall payer mix compared to budget is illustrated below. This is inclusive of the Waters Edge revenue.

	Feb Actual	Feb Budget
Medicare	49.1%	46.2%
Medi-Cal	27.2%	27.2%
Managed Care	14.7%	16.2%
Other	3.6%	3.0%
Commerical	1.3%	3.0%
Self-Pay	4.0%	4.4%
Total	100.0%	100.0%

Case Mix Index

The Hospital's overall Case Mix Index (CMI) for February was 1.3611, up from the prior month of 1.2999. The Medicare CMI was 1.4857 in February. This is also above last month's and above the FY 2013 YTD. The graph below shows the Medicare CMI for the Hospital during the current fiscal year as compared to the prior two years.



Revenue

Gross patient charges in February were over budget by $2.7 million or 10.8%. Inpatient gross revenues were $3 million above budget and outpatient gross revenues were down $314,000. Acute inpatient days were above budget by 28.9% and acute gross revenue was up 29.8%. Acute nursing revenue was half of the inpatient revenue variance. Inpatient ancillary service charges above budget as would be expected with higher census, in Laboratory, Pharmacy, Respiratory and Supplies.

Waters Edge gross and net revenue were above budget in February consistent with the volume. The ancillary revenue was lower than budget by (11.1%) but the routine daily room and board revenue was above budget by 5%. Net revenue came in above budget due to the higher census overall and in particular for the Medicare patient activity being slightly above budget.

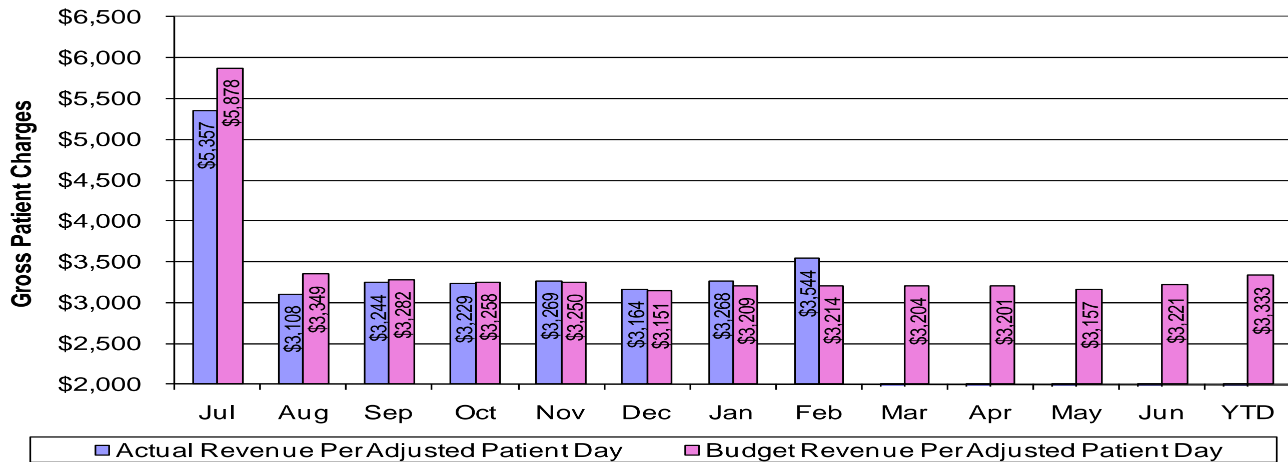
Outpatient gross revenues were lower than budget by $314,000 (4.0%). Pharmacy, Imaging and Surgery were again below budget while the clinics (Wound Care in particular), Emergency and Laboratory were above budget. The new orthopedic practice anticipated increases in Imaging, Rehab Services and Surgery, these volumes and referral patterns are increasing.. However, these

areas have started a little slower than we have projected in the budget, but they are growing steadily as the year progresses.

Wound Care volume was above budget with the gross revenue exceeding budget by $98,000 due to another busy month, resulting in Net Revenue coming in again better than budget by $10,400 for the month, and $169,000 year to date.

On an adjusted patient day basis, total patient revenue was $3,544 above the budget of $3,214 for the month of February. The table below shows the Hospital's monthly gross revenue per adjusted patient day by month and year-to-date for Fiscal Year 2013 compared to budget. Note the overall revenue per day dropped in August with the addition of Waters Edge days and revenue in the mix. Waters Edge provides a significant amount of days (almost double) yet these patients have primarily room and board charges and very little ancillary services compared to acute patients.

Gross Charges per Adjusted Patient



Contractual Allowances and Net 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 payers such as Blue Cross. A Net Revenue percentage of 23.8% was budgeted and 22.7% was realized. Year to date net revenue percentage is 23.2% of gross versus a budget of 23.3%. Medi-Cal reimbursement at both South Shore and Waters Edge were calculated at a per diem rate of $316 which is consistent with budget and AB97 rate reduction.

Overall, Net Revenue was $6.37 million, $332,000 above the budget of $6.04 million. Net Patient Revenue was above budget mainly due to the higher acute census.

Waters Edge had Net Revenues of $1.14 million, $29,000 above the budget of $1.11 million. Higher than budgeted overall and medicare A census are driving this variance. Year to date, Waters Edge Net Revenue is $155,000 (2.1%) above budget, and consistent with patient census (1.9%) above budget.

The Wound Care program also resulted in a positive net revenue contribution of $10,400 for the month. However there are additional expenses associated with providing this additional revenue.

The hospital did receive about $320,000 additional payment for the "tentative" FY 2012 medicare cost report in the month of Februay. Net Revenue was kept neutral from this tentative settlement as there were other medicare and medi-cal adjustments that needed to be made.

Based on prior year experience and to be conservative, we have established a liability reserve for FY 2012 of $40,000 until the audit is complete (3 to 4 year lag). We also received notification of the final Medicarecost report audit findings for FY 2008 that resulted in a $42,000 payable which will be made in March. However, because the hospital had a receivable in the amount of $101,000 for FY 2008, this is a $143,000 negative impact. The additional $137,000 was recorded to increase our acute medi-cal liability reserve for FY 2013, as opposed to taking it in as income, until we know more about how and when the new district hospital reimbursement model will go into effect. The net of these are reflected in Third-Party Payer Settlements under the Balance Sheet.

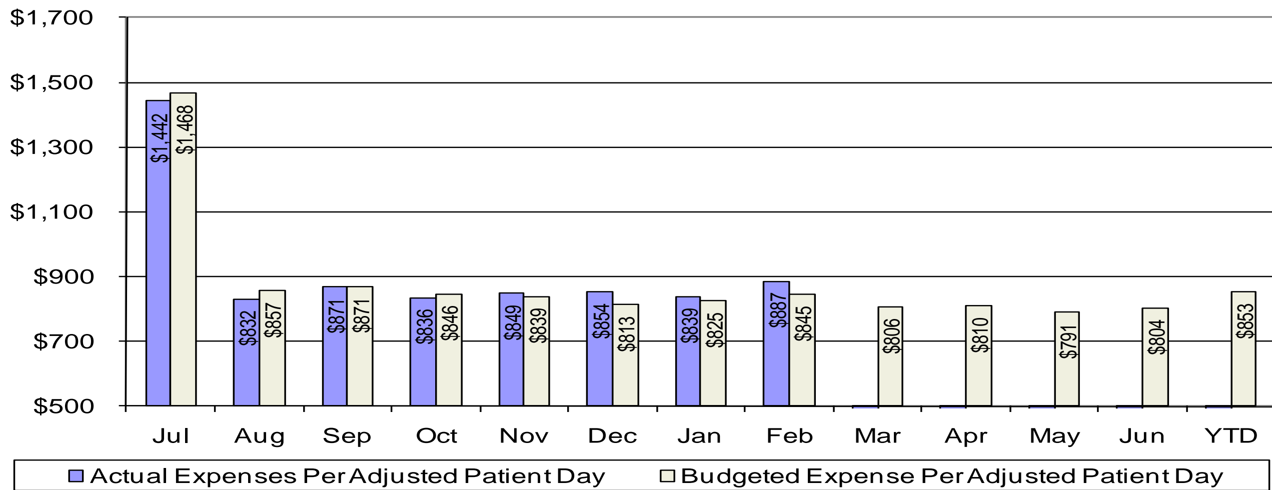
Expenses

Total Operating Expenses

Total operating expenses were $6.9 million which was higher than the fixed budget by $355,000 or 5.4%. Salaries, temporary agency fees, professional fees, supplies and purchased services were all above budget while benefits and other expenses were under budget. All other expense categories were reasonably close to budget. As mentioned at the July meeting the temporary agency budget is understated by $40,000 per month.

We are currently drilling down on those expense categories where we have a material year to date variance from budget to determine what changes can be made to mitigate these variances for the remainder of the fiscal year.

The graph on the next page shows the actual Hospital operating expenses on an adjusted patient day basis for the fiscal year by month as compared to budget. Note that expenses per patient day were very close to budget this month and last.



The 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 unfavorable to the fixed budget by $253,000.

While the temporary agency expenses were budgeted lower than they should have been, there are still several areas using temporary staff to replace vacant positions. The departments still utilizing temporary staff to replace budgeted vacant positions are Laboratory, Rehab Services, Waters Edge and General Accounting. In addition again the acute inpatient volume was high in CCU (24.3% above budget) and DOU (63.2% above budget) requiring more staffing including registry staffing.

Temporary agency expense in the month was $77,000 higher than prior month and $57,000 higher than the year to date average

To cover for the higher acute census, it required additional use of premium pay hours to help cover shifts. Overtime pay was $60,000 higher than prior month and about $100,000 higher than the year-to-date average. The amount paid for double time was an additional $30,000 higher than prior month and $61,000 higher than the year to date average. It is difficult to have available staff on hand for dramatic increases in censuses as we experienced in February. We are in the process of hiring more short hour and on-call nursing personnel as it seems that censuses continues to remain higher than anticipated and we must staff these beds in a more cost effective manner.

We did have additional salary expense in pharmacy, as we have hired and are training new pharmacists. We have also expanded the

pharmacy service hours so there could be some additional salary expense in pharmacy going forward. However, this change will reduce the amount paid for our contracted after hour pharmacy service.

Benefits

Benefits were below the fixed budget by $27,000. Year to date is still above budget by $122,000. These numbers fluctuate from month to month as employees take non-productive time off and variations in health benefit utilization. In the month, health care claims expense was below budget resulting in this positive budget variance.

Professional Fees

Professional fees were over budget by $44,000 or 11.1% mostly due to the fees associated with the Interim Director in Information Systems. These fees were unanticipated and are offset partially by savings in salaries. In addition, there were higher management fees for the Wound Care program associated with the higher volumes and revenue. Legal fees were also slightly higher in February as we engage legal council in various business matters.

Supplies

Supplies expense was $64,000 over budget and year to date, supply expense is $361,000 higher than budget. Supply expense is up consistent with the higher revenue due to the census. Departments using more supplies than anticipated were Surgery, Outpatient Clinics (Wound Care and Ortho Clinic) and Blood Bank.

Purchased Services

Purchased services were just $6,000 over budget for the month of February and year to date are $152,000 over budget. Most departments were very clost to budget in February. MRI purchased service for the trailer was budgeted to increase to three days per week on January 1st, however the increase to add the third day started on March 13th, resulting in a positive budget variance. However, the positive budget variance was offset by increased fees from our dialysis service provider that was up in the month, but is not expected to recur every month.

Rents and Leases

Rents and lease expense was $27,000 over budget in themonth. This variance is assicated with the additional bed and equipment rentals to accommodate the needs of the higher census. There was also an additional $5,000 for ultrasound equipment lease accrual missed in prior month and the new ortho clinic space $2,500 that was not budgeted.

Other Operating Expense

Other operating expenses were under budget this month by just $18,000. Year to date other expenses are under budget by $112,000; about half from Waters Edge and half from hsoptial based travel and training budget.

Balance Sheet

Total assets increased by almost $420,000 from the prior month. The following items make up the increase in current assets:

- Total unrestricted cash and cash equivalents for February decreased by only $24,000 and days cash on hand including restricted use funds decreased to 21.0 days cash on hand in February from the 22.5 days cash on hand in January. Patient collections in February averaged $214,000 per day, much higher than prior month. Please note there is extra cash that is being held for repayment of LTC over payments since August 2012 and the addition of Waters Edge. Year to date, this overpayment amount is estimated at $1.6 million. The State of California is in the process of having this rate adjusted to mitigate this issue going forward, but as of January has not been corrected.

- Net patient accounts receivable was almost $11.5 million, up almost $350,000 from $11.1 million at the end of January. This is expected to come back down in March as January and February strong revenue continue to be collected.

- Days in outstanding receivables were 58.3 at February month end, an increase from January of 57.6 days. Cash collections in January were almost $6.0 million compared to $5.4 million in January. The holiday delays have ceased and cash collections were getting back on track in February. Collections per day were $211,000 which consistent with expectations.

- Inventories increased by almost $40,000 during the month during the normal course of business. This also fluctuates slightly

from month to month.

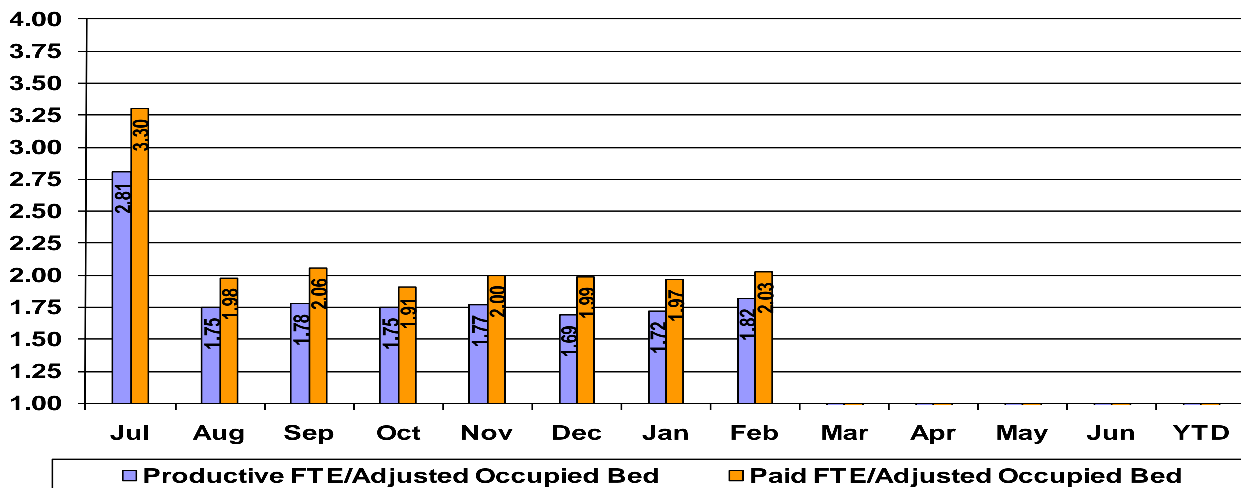
Overall, total liabilities increased by about $484,000 as well from prior month.

- Accounts payable increased by almost $150,000 in February to approximately $10.9 million which equates to 137 AP Days, down from from 153 days in January.
- Payroll related accruals increased by $207,000 due to the timing the the pay periods in the month.
- Deferred revenues decreased by $477,000 due to the recognition of one-twelfth of the 2012/2013 parcel tax revenues.
- Current Portion of Long Term Debt in the month of February decreased by about $54,000 as we continue to reduce short term liability to the State that ends this year.
- Third Party Settlement increase by $683,000. About $143,000 is associated with completion of the Medicare FY 2008 cost report audit. The net audit resulted in a payable of $42,000 that will be paid in March, however the hospital had a receivable fromMedicare of $101,000 for this fiscal year. In addition,based on prior year Medicare audit experience and to be slightly conservative, a reserve of $40,000 was established for FY 2012. The acute Medi-cal reserve for FY 2013 was increase by $137,000 with a total liability reserve of $250,000. The remaining increase is for the ongoing LTC medi-cal overpayment reserve associated with Waters Edge and South Shore as we have been accruing each month.

Key Statistics

FTE's Per Adjusted Occupied Bed

For the month of February Productive FTE's per Adjusted Occupied Bed were 1.82, above the budget of 1.69 FTE's by 7.7%. Paid FTE's per Adjusted Occupied Bed were 2.03 or 3.6% above the budget. The graph below shows the productive and paid FTE's per Adjusted Occupied Bed for FY 2013 by month.



Current Ratio

The current ratio for February is 0.93, down from .94 in January. We have met with representatives from the Bank of Alameda regarding these loan covenant ratios and other matters. We will be providing them with a loan covenant waiver request along with fiscal year end projections.

A/R days

Net days in net accounts receivable (A/R) are currently at 58.3. This is up from the prior month of 57.6. Net A/R days are up as the

result of lower than normal cash collections in the month. We are taking actions to help ensure that A/R balances and cash flows to remain more constant in the weeks and months to come.

Days Cash on Hand

Days cash on hand for February were 21.0, a decrease from prior month of 22.5. While cash collections have improved, cash is also needed to pay down vendor balances as the property tax proceeds will be used to subsidize operations over the course of the fiscal year as well as other capital project commitments.

The following pages include the detailed financial statements for the eight (8) months ended February 28, 2013, of Fiscal Year 2013.

ALAMEDA HOSPITAL
KEY STATISTICS
FEBRUARY 2013

	ACTUAL FEBRUARY 2013	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	FEBRUARY 2012	YTD FEBRUARY 2013	YTD FIXED BUDGET	VARIANCE	%	YTD FEBRUARY 2012
Discharges:										
Total Acute	250	218	32	14.5%	245	1,901	1,907	(6)	-0.3%	1,880
Total Sub-Acute	3	3	-	0.0%	3	21	17	4	23.5%	15
Total South Shore	4	9	(5)	-55.6%	9	45	67	(22)	-32.8%	69
Total Waters Edge	18	13	5	38.5%	-	104	87	17	19.5%	-
	275	243	32	13.1%	257	2,071	2,078	(7)	-0.3%	1,964
Patient Days:										
Total Acute	1,125	873	252	28.9%	1,017	7,697	7,642	55	0.7%	7,310
Total Sub-Acute	903	941	(38)	-4.0%	951	7,850	7,915	(65)	-0.8%	7,936
Total South Shore	660	602	58	9.6%	543	5,523	5,155	368	7.1%	5,125
Total Waters Edge	3,016	2,940	76	2.6%	-	21,426	21,034	392	1.9%	-
	5,704	5,356	348	6.5%	2,511	42,496	41,746	750	1.8%	20,371
Average Length of Stay										
Total Acute	4.50	4.00	0.50	12.5%	4.15	4.05	4.01	0.04	1.1%	3.89
Average Daily Census										
Total Acute	40.18	31.18	9.00	28.9%	36.32	31.67	31.45	0.23	0.7%	30.08
Total Sub-Acute	32.25	33.61	(1.36)	-4.0%	33.96	32.30	32.57	(0.27)	-0.8%	32.66
Total South Shore	23.57	21.50	2.07	9.6%	19.39	22.73	21.21	1.51	7.1%	21.09
Total Waters Edge	107.71	105.00	2.71	2.6%	-	101.07	99.22	1.85	1.9%	-
	203.71	191.29	12.43	6.5%	89.68	187.77	184.45	(0.04)	0.0%	83.83
Emergency Room Visits	1,394	1,285	109	8.5%	1,384	11,521	11,154	367	3.3%	1,384
Wound Care Clinic Visits	379	250	129	51.6%	-	1,824	1,200	624	52.0%	-
Outpatient Registrations	1,806	2,124	(318)	-15.0%	1,854	15,026	16,053	(1,027)	-6.4%	14,720
Surgery Cases:										
Inpatient	66	59	7	11.9%	49	353	350	3	0.9%	310
Outpatient	101	144	(43)	-29.9%	125	948	1,259	(311)	-24.7%	1,186
	167	203	(36)	-17.7%	174	1,301	1,609	(308)	-19.1%	1,496
Adjusted Occupied Bed (AOB)	277.88	278.01	(0.12)	0.0%	125.47	249.39	249.04	0.35	0.1%	122.09
Productive FTE	506.97	470.85	36.11	7.7%	360.31	454.69	449.39	5.30	1.2%	342.51
Total FTE	562.93	543.82	19.11	3.5%	410.63	517.32	513.58	3.75	0.7%	395.85
Productive FTE/Adj. Occ. Bed	1.82	1.69	0.13	7.7%	2.87	1.82	1.80	0.02	1.0%	2.81
Total FTE/ Adj. Occ. Bed	2.03	1.96	0.07	3.6%	3.27	2.07	2.06	0.01	0.6%	3.24

City of Alameda Health Care District
Statements of Financial Position
February 28, 2013

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 4,995,909	$ 5,019,811	$ 3,327,884
Patient Accounts Receivable, net	11,487,583	11,140,157	8,835,256
Other Receivables	3,435,872	3,428,917	6,488,283
Third-Party Payer Settlement Receivables	-	-	-
Inventories	1,011,420	971,887	1,045,311
Prepaids and Other	679,227	692,317	416,371
Total Current Assets	21,610,011	21,253,089	20,113,105
Assets Limited as to Use, net	153,386	141,504	64,183
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	44,558,908	44,541,685	43,470,520
Construction in progress	3,856,883	3,752,486	4,102,468
Depreciation	(40,246,981)	(40,175,214)	(39,670,499)
Property, Plant and Equipment, net	9,046,755	8,996,902	8,780,434
Total Assets	**$ 30,810,152**	**$ 30,391,495**	**$ 28,957,722**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 1,028,051	$ 1,054,889	$ 1,724,249
Accounts Payable and Accrued Expenses	10,928,989	10,779,597	7,848,673
Payroll Related Accruals	5,891,902	5,684,717	4,307,924
Deferred Revenue	1,912,806	2,390,458	5,726,305
Employee Health Related Accruals	655,694	650,317	691,942
Third-Party Payer Settlement Payable	2,726,397	2,043,843	601,233
Total Current Liabilities	23,143,840	22,603,821	20,900,326
Long Term Debt, net	1,682,933	1,738,539	1,022,152
Total Liabilities	24,826,773	24,342,360	21,922,478
Net Assets:			
Unrestricted	5,619,993	5,697,631	6,761,061
Temporarily Restricted	363,386	351,504	274,183
Total Net Assets	5,983,379	6,049,135	7,035,244
Total Liabilities and Net Assets	**$ 30,810,152**	**$ 30,391,495**	**$ 28,957,722**

City of Alameda Health Care District

Statements of Operations

February 28, 2013

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	5,704	5,356	348	6.5%	2,511	42,496	41,746	750	1.8%	20,371
Discharges	275	243	32	13.1%	257	2,071	2,078	(7)	-0.3%	1,964
ALOS (Average Length of Stay)	20.74	22.02	(1.28)	-5.8%	9.77	20.52	20.09	0.43	2.1%	10.37
ADC (Average Daily Census)	203.7	191.3	12.43	6.5%	86.6	174.9	171.8	3.09	1.8%	83.8
CMI (Case Mix Index)	1.3611				1.3331	1.3493				1.3476
Revenues										
Gross Inpatient Revenues	$ 20,216	$ 17,212	$ 3,004	17.5%	$ 15,535	$ 144,136	$ 142,251	$ 1,885	1.3%	$ 117,383
Gross Outpatient Revenues	7,490	7,803	(314)	-4.0%	6,977	61,808	60,875	933	1.5%	54,755
Total Gross Revenues	27,706	25,015	2,691	10.8%	22,512	205,944	203,126	2,818	1.4%	172,139
Contractual Deductions	20,483	18,210	(2,272)	-12.5%	17,031	148,253	148,757	504	0.3%	128,639
Bad Debts	575	691	116	16.7%	361	8,775	5,634	(3,140)	-55.7%	3,382
Charity and Other Adjustments	361	168	(193)	-114.7%	113	1,045	1,363	318	23.3%	1,369
Net Patient Revenues	6,287	5,945	341	5.7%	5,006	47,870	47,371	500	1.1%	38,749
Net Patient Revenue %	22.7%	23.8%			22.2%	23.2%	23.3%			22.5%
Net Clinic Revenue	75	42	33	79.6%	36	350	334	16	4.8%	285
Other Operating Revenue	8	50	(42)	-84.5%	8	448	402	45	11.3%	224
Total Revenues	**6,369**	**6,037**	**332**	5.5%	**5,050**	**48,668**	**48,107**	**561**	1.2%	**39,257**
Expenses										
Salaries	3,369	3,271	(98)	-3.0%	2,723	26,950	27,176	226	0.8%	22,745
Temporary Agency	234	79	(155)	-197.1%	173	1,485	525	(960)	-182.7%	924
Benefits	1,002	1,029	27	2.6%	765	7,722	7,600	(122)	-1.6%	6,770
Professional Fees	438	394	(44)	-11.1%	379	3,347	3,136	(211)	-6.7%	3,051
Supplies	797	734	(64)	-8.7%	611	6,159	5,798	(361)	-6.2%	4,779
Purchased Services	562	556	(6)	-1.0%	426	4,392	4,241	(152)	-3.6%	2,883
Rents and Leases	232	205	(27)	-13.2%	120	1,589	1,556	(33)	-2.1%	699
Utilities and Telephone	91	87	(4)	-4.6%	73	628	681	53	7.8%	535
Insurance	41	42	0	0.9%	29	304	316	12	3.8%	221
Depreciation and amortization	72	68	(4)	-5.5%	68	580	544	(36)	-6.6%	579
Other Opertaing Expenses	95	113	18	16.3%	60	814	926	112	12.1%	712
Total Expenses	**6,933**	**6,577**	**(355)**	-5.4%	**5,428**	**53,972**	**52,500**	**(1,471)**	-2.8%	**43,898**
Operating gain (loss)	**(563)**	**(540)**	**(23)**	-4.3%	**(378)**	**(5,304)**	**(4,393)**	**(910)**	20.7%	**(4,641)**
Non-Operating Income / (Expense)										
Parcel Taxes	477	500	(23)	-4.6%	477	3,837	3,999	(162)	-4.1%	3,846
Investment Income	1	-	1	0.0%	1	8	-	8	0.0%	4
Interest Expense	(21)	(8)	(12)	-155.4%	(13)	(99)	(64)	(34)	53.4%	(127)
Other Income / (Expense)	28	15	13	89.5%	28	423	120	303	253.6%	206
Net Non-Operating Income / (Expense)	**486**	**507**	**(21)**	**-4.2%**	**492**	**4,169**	**4,054**	**115**	**2.8%**	**3,930**
Excess of Revenues Over Expenses	**$ (78)**	**$ (33)**	**$ (45)**	**134.5%**	**$ 115**	**$ (1,135)**	**$ (339)**	**$ (796)**	**234.6%**	**$ (711)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

February 28, 2013

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 2,586	$ 2,211	$ 375	17.0%	$ 4,269	$ 2,374	$ 2,386	$ (13)	-0.5%	$ 3,929
Gross Outpatient Revenues	958	1,002	(44)	-4.4%	1,917	1,018	1,021	(3)	-0.3%	1,833
Total Gross Revenues	3,544	3,214	331	10.3%	6,187	3,392	3,408	(16)	-0.5%	5,762
Contractual Deductions	2,620	2,339	(281)	-12.0%	4,681	2,442	2,495	54	2.2%	4,306
Bad Debts	74	89	15	17.1%	99	145	95	(50)	-52.9%	113
Charity and Other Adjustments	46	22	(25)	-113.8%	31	17	23	6	24.7%	46
Net Patient Revenues	804	764	40	5.3%	1,376	788	795	(6)	-0.8%	1,297
Net Patient Revenue %	22.7%	23.8%			22.2%	23.2%	23.3%			22.5%
Net Clinic Revenue	10	5	4	78.9%	10	6	6	0	2.9%	10
Other Operating Revenue	1	6	(5)	-84.5%	2	7	7	1	9.2%	8
Total Revenues	**815**	**776**	**39**	5.1%	**1,388**	**802**	**807**	**(5)**	-0.7%	**1,314**
Expenses										
Salaries	431	420	(11)	-2.6%	748	444	456	12	2.6%	761
Temporary Agency	30	10	(20)	-195.9%	48	24	9	(16)	-177.5%	31
Benefits	128	132	4	3.0%	210	121	127	7	5.1%	227
Professional Fees	56	51	(5)	-10.6%	104	55	53	(3)	-4.8%	102
Supplies	102	94	(8)	-8.2%	168	101	97	(4)	-4.3%	160
Purchased Services	72	71	(0)	-0.6%	117	72	71	(1)	-1.7%	97
Rents and Leases	30	26	(3)	-12.7%	33	26	26	(0)	-0.3%	23
Utilities and Telephone	12	11	(0)	-4.1%	20	10	11	1	9.5%	18
Insurance	5	5	0	1.3%	8	5	5	0	5.6%	7
Depreciation and Amortization	9	9	(0)	-5.1%	19	10	9	(0)	-4.6%	19
Other Operating Expenses	12	15	2	16.6%	16	13	16	2	13.7%	24
Total Expenses	**887**	**845**	**(42)**	-5.0%	**1,492**	**883**	**881**	**(2)**	-0.2%	**1,469**
Operating Gain / (Loss)	**(72)**	**(69)**	**(3)**	-3.9%	**(104)**	**(81)**	**(73)**	**(7)**	10.1%	**(155)**
Non-Operating Income / (Expense)										
Parcel Taxes	61	64	(3)	-5.0%	131	63	67	(4)	-5.8%	129
Investment Income	0	-	0	0.0%	0	0	-	0	0.0%	0
Interest Expense	(3)	(1)	(2)	-154.3%	(4)	(2)	(1)	(1)	50.6%	(4)
Other Income / (Expense)	4	2	2	88.7%	8	7	2	5	247.2%	7
Net Non-Operating Income / (Expense)	**62**	**65**	**(3)**	**-4.6%**	**135**	**69**	**68**	**1**	**1.0%**	**132**
Excess of Revenues Over Expenses	**$ (10)**	**$ (4)**	**$ (6)**	133.5%	**$ 32**	**$ (12)**	**$ (5)**	**$ (7)**	124.0%	**$ (24)**

Wound Care - Statement of Operations
February 28, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Clinic Visits	379	250	129	51.6%	1,824	1,200	624	52.0%
Revenue								
Gross Revenue	624,792	525,980	98,812	18.8%	3,491,959	2,524,704	967,255	38.3%
Deductions from Revenue	493,586	405,215	88,371		2,743,100	1,945,032	798,068	
Net Revenue	131,206	120,765	10,441		748,858	579,672	169,186	
Expenses								
Salaries	15,080	15,232	152	1.0%	101,693	119,932	18,239	15.2%
Benefits	4,313	4,311	(2)	-0.1%	27,273	33,941	6,667	19.6%
Professional Fees	75,608	61,379	(14,229)	-23.2%	410,195	304,217	(105,978)	-34.8%
Supplies	25,652	7,532	(18,120)	-240.6%	131,601	60,256	(71,345)	-118.4%
Purchased Services	1,635	2,083	448	21.5%	31,951	16,665	(15,286)	-91.7%
Rents and Leases	6,024	5,080	(944)	-18.6%	43,864	40,640	(3,224)	-7.9%
Depreciation	8,685	4,900	(3,785)	-77.2%	52,590	39,200	(13,390)	-34.2%
Other	2,952	5,917	2,965	50.1%	15,169	47,336	32,167	68.0%
Total Expenses	139,949	106,434	(33,515)	-31.5%	814,337	662,187	(152,150)	-23.0%
Excess of Revenue over Expenses	(8,743)	14,331	(23,074)	-161.0%	(65,479)	(82,515)	17,036	-20.6%

Note: Of the 379 visits, 95were hyberbaric oxygen treatment visits.

City of Alameda Health Care District
Waters Edge Skilled Nursing - Statement of Operations
February 28, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Patient Days								
Medicare	456	420	36	8.6%	2,292	2,475	(183)	-7.4%
Medi-Cal	2,310	2,184	126	5.8%	17,201	16,169	1,032	6.4%
Managed Care	49	84	(35)	-41.7%	321	880	(559)	-63.5%
Self Pay/Other	201	252	(51)	-20.2%	1,612	1,510	102	6.8%
Total	3,016	2,940	76	2.6%	21,426	21,034	392	1.9%
Revenue								
Routine Revenue	2,408,229	2,293,986	114,243	5.0%	16,734,299	16,486,154	248,145	1.5%
Ancillary Revenue	351,286	395,364	(44,078)	-11.1%	2,113,970	2,987,822	(873,852)	-29.2%
Total Gross Revenue	2,759,515	2,689,350	70,165	2.6%	18,848,269	19,473,976	(625,707)	-3.2%
Deductions from Revenue	1,619,896	1,578,648	(41,247)	-2.6%	11,157,136	11,937,473	780,337	6.5%
Net Revenue	1,139,619	1,110,702	28,918	2.6%	7,691,133	7,536,503	154,630	2.1%
Expenses								
Salaries	420,006	472,136	52,130	11.0%	2,979,195	3,434,360	455,165	13.3%
Temporary Agency	15,551	-	(15,551)	-100.0%	34,672	-	(34,672)	-100.0%
Benefits	95,807	155,600	59,793	38.4%	660,746	1,044,267	383,521	36.7%
Professional Fees	(1,660)	8,999	10,659	118.4%	48,865	82,993	34,128	41.1%
Supplies	54,842	94,323	39,481	41.9%	454,426	682,509	228,083	33.4%
Purchased Services	105,201	128,772	23,571	18.3%	734,708	918,243	183,535	20.0%
Rents and Leases	77,028	76,552	(476)	-0.6%	539,163	535,864	(3,299)	-0.6%
Utilities	20,814	14,999	(5,815)	-38.8%	93,703	104,992	11,289	10.8%
Insurance	5,000	12,165	7,165	58.9%	19,098	85,155	66,057	77.6%
Other	11,189	20,031	8,842	44.1%	98,380	144,930	46,550	32.1%
Total Expenses	803,778	983,577	179,799	18.3%	5,662,956	7,033,313	1,370,357	19.5%
Excess of Revenue over Expenses	335,841	127,125	208,716		2,028,177	503,190	1,524,987	

City of Alameda Health Care District
Orthopedic Clinic - Statement of Operations
February 28, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Clinic Visits	182	178	4	2.2%	431	595	(164)	-27.6%
Revenue								
Gross Revenue	106,664	108,890	(2,226)	-2.0%	183,963	871,120	(687,157)	-78.9%
Deductions from Revenue	74,665	76,223	(1,558)		124,404	609,784	(485,380)	
Net Revenue	31,999	32,667	(668)		59,559	261,336	(201,777)	
Expenses								
Salaries	29,344	31,608	2,264	7.2%	151,216	181,373	30,157	16.6%
Benefits	8,392	8,945	553	6.2%	43,196	51,329	8,132	15.8%
Professional Fees	31,615	25,000	(6,615)	-26.5%	121,071	154,500	33,429	21.6%
Supplies	13,625	2,105	(11,520)	-547.3%	35,270	11,580	(23,690)	-204.6%
Purchased Services	4,928	3,895	(1,033)	-26.5%	34,439	21,420	(13,019)	-60.8%
Rents and Leases	131	2,632	2,501	95.0%	19,823	14,472	(5,351)	-37.0%
Depreciation	-	-	-	0.0%	-	-	-	0.0%
Other	2,917	3,261	344	10.5%	27,882	57,948	30,066	51.9%
Total Expenses	90,952	77,446	(13,506)	-17.4%	432,897	492,622	59,724	12.1%
Excess of Revenue over Expenses	(58,953)	(44,779)	(14,174)	-31.7%	(373,338)	(231,286)	(142,052)	-61.4%
Hospital Based Activity:								
Inpatient Days	15	35	(20)	-57.4%	34	132	(98)	-74.2%
Inpatient Surgeries	3	8	(5)	-62.5%	6	30	(24)	-80.0%
Outpatient Surgeries	7	5	2	40.0%	23	21	2	9.5%
							-	
Therapy Referred Visits	147	350	(203)	-58.0%	315	1,200	(885)	-73.8%
Imaging Referred Procedures	108	174	(66)	-37.9%	301	586	(285)	-48.6%
Inpatient Gross Charges	269,721	495,200	(225,479)	-45.5%	572,606	1,857,000	(1,284,394)	-69.2%
Inpatient Net Revenue	59,361	111,200	(51,839)	-46.6%	107,108	417,000	(309,892)	-74.3%
Outpatient Gross Charges	329,331	325,680	3,651	1.1%	944,942	1,192,920	(247,978)	-20.8%
Outpatient Net Revenue	55,986	72,966	(16,980)	-23.3%	172,952	266,266	(93,314)	-35.0%
Total Gross Charges	599,052	820,880	(221,828)	-27.0%	1,517,548	3,049,920	(1,532,372)	-50.2%
Total Net Revenue	115,347	184,166	(68,819)	-37.4%	280,060	683,266	(403,206)	-59.0%

City of Alameda Health Care District
1206b Clinic - Statement of Operations
February 28, 2013

	Current Month				Year-to-Date			
	Actual	Budget	Variance	%	Actual	Budget	Variance	%
Clinic Visits								
Primary Care	123				983			
Surgery	40				413			
Neurology	22				229			
Total Visits	185				1,625			
Revenue								
Gross Revenue	97,267	142,006	(44,739)	-31.5%	845,134	1,136,047	(290,913)	-25.6%
Deductions from Revenue	61,528	93,724	(32,196)		555,011	749,791	(194,780)	
Net Revenue	35,739	48,282	(12,543)		290,123	386,256	(96,133)	
Expenses								
Salaries	20,580	17,642	(2,938)	-16.7%	195,351	143,738	(51,613)	-35.9%
Benefits	5,886	4,993	(893)	-17.9%	55,870	40,678	(15,193)	-37.3%
Professional Fees	21,127	21,708	581	2.7%	189,544	173,666	(15,878)	-9.1%
Supplies	88	954	866	90.8%	5,983	7,631	1,648	21.6%
Purchased Services	6,352	4,783	(1,569)	-32.8%	78,129	38,266	(39,863)	-104.2%
Rents and Leases	12,661	11,606	(1,055)	-9.1%	88,630	92,851	4,221	4.5%
Depreciation	494	207	(287)	-138.6%	1,944	1,657	(287)	-17.3%
Other	3,133	2,292	(841)	-36.7%	31,125	18,334	(12,791)	-69.8%
Total Expenses	70,321	64,185	(6,136)	-9.6%	646,576	516,821	(129,756)	-25.1%
Excess of Revenue over Expenses	(34,582)	(15,903)	(18,679)	117.5%	(356,453)	(130,565)	(225,889)	173.0%

Note:

Clinic Hours by Physician

Dr. Celada - M,W,F Mornings only

Dr. Brimer - M & Th full days, plus T Mornings

Dr. Dutaret - T & W full days

City of Alameda Health Care District
Statement of Cash Flows
For the Eight Months Ended February 28, 2013

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ (77,641)	$ (1,134,666)
Items not requiring the use of cash:		
Depreciation and amortization	71,767	$ 579,760
Write-off of Kaiser liability	-	$ -
Changes in certain assets and liabilities:		
Patient accounts receivable, net	(347,426)	(2,652,327)
Other Receivables	(6,955)	3,052,411
Third-Party Payer Settlements Receivable	682,554	2,125,164
Inventories	(39,533)	33,891
Prepaids and Other	13,090	(262,856)
Accounts payable and accrued liabilities	149,392	3,080,316
Payroll Related Accruals	207,185	1,583,978
Employee Health Plan Accruals	5,377	(36,248)
Deferred Revenues	(477,652)	(3,813,499)
Cash provided by (used in) operating activities	180,159	2,555,925
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(11,882)	(89,203)
Additions to Property, Plant and Equipment	(121,620)	(846,082)
Other	3	(6,402)
Cash provided by (used in) investing activities	(133,500)	(941,687)
Cash flows from financing activities		
Net Change in Long-Term Debt	(82,444)	(35,417)
Net Change in Restricted Funds	11,882	89,203
Cash provided by (used in) financing and fundraising activities	(70,562)	53,786
Net increase (decrease) in cash and cash equivalents	(23,902)	1,668,024
Cash and cash equivalents at beginning of period	5,019,811	3,327,884
Cash and cash equivalents at end of period	$ 4,995,911	$ 4,995,909

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	FY 2009	FY 2010	FY 2011	FY 2012	YTD 2/28/2013
	Audited Results				
Profitability Ratios					
Net Patient Revenue (%)	22.69%	24.16%	23.58%	22.90%	23.24%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	3.62%	4.82%	-1.01%	-1.48%	-1.48%
EBIDAP[Note 5]	-5.49%	-3.66%	-13.41%	-11.22%	-8.82%
Total Margin	1.03%	2.74%	-2.61%	-3.21%	-2.33%
Liquidity Ratios					
Current Ratio	1.15	1.23	1.05	0.96	0.93
Days in accounts receivable ,net	57.26	51.83	46.03	55.21	58.31
Days cash on hand (with restricted)	13.6	21.6	14.1	17.7	21.0
Debt Ratios					
Cash to Debt	115.3%	249.0%	123.3%	123.56%	189.94%
Average pay period (includes payroll)	58.03	57.11	62.68	72.94	79.39
Debt service coverage	3.87	5.98	(0.70)	(0.53)	(0.41)
Long-term debt to fund balance	0.20	0.14	0.18	0.28	0.31
Return on fund balance	8.42%	18.87%	-19.21%	-27.35%	-18.96%
Debt to number of beds	13,481	10,482	11,515	16,978	9,728

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2009	FY 2010	FY 2011	FY 2012	YTD 2/28/2013
Patient Care Information					
Bed Capacity	161	161	161	161	281
Patient days(all services)	30,463	30,607	30,270	30,448	42,496
Patient days (acute only)	11,787	10,579	10,443	10,880	7,697
Discharges(acute only)	2,812	2,802	2,527	2,799	1,901
Average length of stay (acute only)	4.19	3.78	4.13	3.89	4.05
Average daily patients (all sources)	83.46	83.85	82.93	83.19	174.88
Occupancy rate (all sources)	52.94%	52.08%	51.51%	51.67%	62.24%
Average length of stay	4.19	3.78	4.13	3.89	4.05
Emergency Visits	17,337	17,624	16,816	16,964	11,521
Emergency visits per day	47.50	48.28	46.07	46.35	47.41
Outpatient registrations per day[Note 1]	82.05	79.67	65.19	60.67	61.84
Surgeries per day - Total	16.12	13.46	6.12	6.12	5.35
Surgeries per day - excludes Kaiser	5.14	5.32	6.12	6.12	5.35

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.

March 2013

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1 Stroke Assessments	2
3	4	5	6	7	8	9
10	11	12	13 Chamber Mixer Bay Area Bone & Joint Center	14	15 Blood Pressure Screening	16 Girls Inc. Women Who Dare
17	18 Auxiliary East Bay Regional Meeting	19	20 Chamber of Commerce Luncheon Arthritis Community Lecture	21	22	23 ARPD Egg Scramble
24	25	26 CR Committee Meeting	27	28	29	30 Orthopaedic Q & A Session
31						

April 2013

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10 District Board Meeting	11	12	13
14	15	16	17	18	19 BP Screening	20 Earth Day
21	22	23	24 Low Back Pain Community Lecture	25	26	27 Orthopaedic Q & A Session
28	29 Volunteer Celebration	30				

May 2013

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1 District Board Meeting	2	3	4 Fitness Park Opening
5	6	7	8 Mastick Center Community Walk Wound Center	9	10	11 Park Street Spring Festival
12 Park Street Spring Festival	13 AUSD TB Clinic	14 AUSD TB Clinic	15 AUSD TB Clinic	16 AUSD TB Clinic	17 BP Screening Stroke Assessments	18
19 Alameda Heritage Festival at South Shore	20	21	22 Shoulder Pain Community Lecture	23	24	25 Orthopaedic Q & A Session
26	27	28 CR Committee Meeting	29	30	31	

DATE: April 4, 2013

FOR: April 11, 2013 District Board Meeting

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

FROM: Deborah E. Stebbins, Chief Executive Officer

SUBJECT: CEO Report to the Board of Directors

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1. **Bay Area Bone & Joint Center**

All orthopedic activity metrics continue on an upward trajectory, with monthly patient visits exceeding 200 for the first time. The 211 visits achieved in March represent a 20% increase over the previous month and 19% over the monthly pro-forma budget expectation. The Bay Area Bone & Joint Center performed 14 surgeries in March, which was 2 more than the previous month, and 2 more than the budgeted pro-forma. Assisted surgeries totaled 12, which was also an increase from the previous month of 11.

Drs. DiStefano and Pirnia remain active in the community. Dr. DiStefano spoke to a group at Mastick Senior Center in early March. Their second community lecture in mid-March on the topic of “Arthritis of the Hip and Knee” was well attended. Community lectures have been scheduled at the Hospital monthly, through July. The April topic will be “Lower Back Pain”.

Their Marina Village office was the site of a Chamber of Commerce Ribbon Cutting Ceremony on March 13. Vice-Mayor Marilyn Ezzy-Ashcraft officiated over the ceremony which was followed by a Chamber of Commerce mixer attended by many of its members.

Drs. DiStefano and Pirnia participated in a “Meet the Orthopaedist” Saturday morning event on March 30, which was publicized in the media and at the Hospital’s presence at the Lunar New Year Festival at Harbor Bay Isle earlier in the month.

2. **Capital Projects**

a) Seismic Anchoring

Construction on the NPC-2 compliance of emergency lighting in the original hospital is complete and signed-off with OSHPD approval.

Construction of the emergency communications NPC-2 compliance project, which entailed anchoring of existing systems is complete and is awaiting sign-off approval from OSHPD.

b) Bulk Oxygen Tank

The public bid process to select a construction vendor has begun, now that OSHPD has issued it's first set of back check comments on the structural plans for the bulk oxygen tank replacement. Completion and submission of the hospital's response is expected to be completed shortly. Completion of the project is still projected to be July 2013. Construction permits from the City of Alameda have been secured.

c) SB90/SB499 Extension Report

OSHPD has approved an administrative extension for SPC2 compliance of the Original Hospital and Stephens Wing to be January 1, 2015. Our SB 90 Extension application continues to be under review, and if approved could extend the deadline beyond that date to January 1, 2020.

d) CMS Sprinkler Mandate Report

This project is on schedule to be completed before the August 18, 2013 deadline. Management is working on plans to temporarily transfer existing patients to beds that are currently in suspension with the State of California Department of Public Health. The move is anticipated in May at the earliest. Completed plans were submitted to OSHPD and were officially logged into the state's project tracking system on January 2, 2013. A public bid process should allow the estimated 100 days or less of construction to be finished by the mandated deadline.

3. Foundation/Community Relations and Outreach Update

Community Stroke Risk Assessments are being offered once each quarter for 2013. 50 assessments were provided on March 1 with the next session scheduled for May 17.

We continue to spearhead the "Let's Move Alameda" community-wide initiative to prevent childhood obesity. We participated in the Alameda Recreation and Parks Egg Scramble on March 23 and provided healthy nutrition information for the children.

The AH Foundation provided the funding for 12 Hospital employees to participate in a special dual-role interpreter training program. The Saturday, March 9 program was provided by Accent on Languages, a Berkeley-based business, and meets Joint Commission requirements for this service. Each participant also received a $100 stipend for their time.

The Hospital Auxiliary hosted the East Bay Council, a group of Hospital Volunteers, on Monday, March 18. The 28 participants were delighted by a presentation from Pat Finnegan, owner, and Sadie, our special volunteer therapy dog. No other hospital in the group has such a volunteer. Sadie comes to Alameda Hospital every Monday and has been a member of our Auxiliary for three months.

4. Information Technology Update and Meaningful Use

a) Meaningful Use

The Information Technology Department continues to focus efforts toward the attainment of Meaningful Use Stage I. We are still on track for attestation beginning in mid-2013. The IT Steering Committee is scheduled to meet on April 10.

b) Replacement of Existing NetFax System

Both laboratory and diagnostic imaging reports are live and being distributed by the new system. Medical records reports will be scheduled for a later date based on department availability.

c) New Electronic EKG Workflow

Hardware and network issues have been resolved and training for go-live is scheduled for April.

d) Waters Edge Infrastructure

A contractor has been selected to perform the wiring upgrade Waters Edge. The installation is being coordinated with the Long Term Care Director.

e) Staffing

A new network admininstrator has been hired and began work on April 3. A vacated Data Analyst position remains open. We are also recruiting for a second hardware maintenance person to assist with maintaining devices in good working conditions.

5. Kate Creedon Center for Advanced Wound Care

Since the inception of the program in mid July of 2012, we've seen 241 patients. These patients were referred by a total of 111 physicians. This resulted in 2201 clinic visits. 690 ancillary referrals, including laboratory and surgery, were made to Alameda Hospital departments. Seventy-seven (77%) of the patients were non-Alameda residents.

Month to date through March 20, 2013, there are 115 active patients. Weekly visits continue to rise:

- Week of February 25 - 107 visits
- Week of March 17th - 117 visits

Month to date through March 20th: 69 HBOT treatments were administered and there are six patients on the waiting list.

Overall, the variance from the patient volume forecasted in the original pro forma is a favorable 70.3%. The healing rate is 82.50% for 100% healing at 20 weeks of treatment.

Kate Creedon Center for Advanced Wound Care was introduced as a strategic partner with Alta Bates Medical Group (a division on Brown and Toland Physicians) at their Specialist Physician Forum and Dinner on March 26.

6. Language Interpreter Program

In January 2010, The Joint Commission released a set of new and revised standards for patient-centered communication. One of these standards requires that anyone who performs language interpretation be qualified to act as an interpreter (e.g. through classes, training, testing, etc). To comply with Joint Commission standards, the Dual Role Interpreter Committee (Irene Pakel, Alice Cheng and Pat Reynolds) developed a Dual-Role Interpreter Program for Alameda Hospital. Irene Pakel also updated Administrative Policy #47 to comply with the new standards.

A Dual-Role Interpreter is defined as "a bi-lingual clinical staff member who is qualified to act as an interpreter by having completed both interpreter and language proficiency testing". Ten employees successfully completed the Syntex Dual-Role Interpreter Training Class; five have also successfully completed the telephonic language proficiency test to date. This program not only ensures our compliance with Joint Commission standards, but also contributes to improving quality nursing care and to decreasing safety risks for people who have language or communication barriers.

We would like to thank the Alameda Hospital Foundation for funding this program.

7. Long Term Care

Marketing efforts continue for Waters Edge, South Shore, and the Sub Acute Unit to ensure for a broad referral base. Waters Edge and South Shore continue to surpass budget expectations while the Sub Acute Unit is slightly below budget. We continue to look for third-party payor contracts and have several credentialing appointments to review our facilities.

All facilities are participating in the National Culture Change Coalition. Culture Change is a fairly recent movement to help create an environment for residents which follows the residents' daily routines and encourages a team-focused approach to make deep culture change possible. A focus is made on residents making their own decisions, allowing for spontaneous activity opportunities and allowing the residents to be recognized and treated as individuals.

This focus on Culture Change deempahsizes the facility as an institution and creates an environment to refocus on resident centric care. It promotes a shift in thinking from the long term care facility being an institution that delivers care to a place people can call their home while receiving great care.

8. Stroke Program

Alameda Hospital's Stroke Program received the Get with the Guidelines Silver Plus Award from the American Stroke Association for meeting five quality measures at 75% or above for 12 consecutive months.

The award was presented by Laura King-Hahn from the American Stroke Association, our "Get With The Guidelines" representative. It was presented to Medical Director Dr. Claudine Dutaret, Stroke Coordinator Michaele Baxter, several members of the Stroke Team, and Hospital staff on Thursday, March 21 during a reception held to honor the Hospital's achievements.

The five Quality Measures that our Stroke Program met at 75% or above are:

Measure	% Compliance
Stroke Education	88%
Rehabilitation Considered	100%
LDL Documented	94%
IV TPA (Arrive by 3.5 hrs, Treat by 4.5 hrs)	94%
NIHSS Reported	94%

Alameda Hospital Stroke Program Comparison Data:

	Baseline (Before Certification)	Current (After Certification)
IV TPA (arrive by 2hr, treat by 3hr)	0%	100%
Early Antithrombotics	90%	100%
VTE Prophylaxis	64%	100%
Antithrombotics at Discharge	100%	100%
Anticoagulation for Afib/Flutter	50%	100%
Smoking Cessation	100%	100%
Measure LDL & Discharge On Statin	50%	100%

The Targeted Stroke Initiative is to have the “Door to Drug” times (for giving thrombolytics) of 60 minutes or less at least 50% of the time.

- Alameda Hospital’s “Door to Drug” times were less than 60 minutes 67% of the time.
- The California average for this Initiative is 43.6%
- Alameda Hospital is one of three top hospitals in the area with “Door to Drug” times that met and exceeded the Initiative requirements, joining San Ramon Regional Medical Center and Eden Medical Center.
- Alameda Hospital is ahead of Alta Bates Summit and John Muir Medical Center with our “Door to Drug” times.

9. DSRIP Report

The hospital successfully submitted the requested criteria for two Category IV projects and continues to await a CMS decision on all criteria previously submitted regarding a three-year proposal for delivery system reform under California's Section 1115 Waiver's Delivery System Reform Incentive Pool (DSRIP) Program. DSRIP is designed to promote a higher quality of care and improved health of patients and families served by the California's non-designated public hospitals. DHCS has recommended to CMS that district hospitals not submit any projects for Category III: Population Focused Improvement, but that a minimum of two projects be submitted for Category IV: Patient Safety. Management is in the process of setting these proposed criteria, which were submitted in mid-January.

10. Performance Improvement and Quality Management

Alameda Hospital continues to be successful in completing appeals for payment from Medicare and Medicaid with the assistance of our vendor, Executive Health Resources (EHR). Education of physicians and clinical staff continue to be a priority in ensuring that claims meet appropriate documentation guidelines.

Quality and Risk Management will evaluate several electronic incident reporting systems over the next several months to identify the best fit for Alameda Hospital. This will assist us in evaluating risk and identifying areas of patient safety improvements. Improvements in efficiency and reduction in risk insurance cost can also be a benefit of the electronic incident reporting systems.

Alameda Hospital hopes to complete contract discussions soon with the Alameda Fire Department to expand the services they provide to hospital patients to Basic Life Support (BLS) transport services in addition to the current provision of Advanced Life Support services.

11. Key Statistics – March 2013

	March Preliminary	March Budget	% Δ compared to Budget	% Δ compared to February	February Actual
Average Daily Census	202.23	194.55	3.9%	-0.7%	203.71
Acute	34.13	32.65	4.5%	-15.1%	40.18
Subacute	31.77	33.00	-3.7%	-1.5%	32.25
South Shore	24.42	22.90	6.6%	3.6%	23.57
Waters Edge	111.90	106.00	5.6%	3.9%	107.71
Patient Days	6,269	6,031	3.9%	9.9%	5,704
ER Visits	1,466	1,423	3.0%	5.2%	1,394
Wound Care Visits	432	250	72.8%	14.0%	379
OP Registrations (excl WC)	2,179	2,220	-1.8%	20.7%	1,806
Total Surgeries	172	202	-14.9%	3.0%	167
Inpatient Surgeries	49	56	-12.5%	-25.8%	66
Outpatient Surgeries	123	146	-15.8%	21.8%	101
Case Mix Index	1.3073				1.3611

CITY OF ALAMEDA HEALTHCARE DISTRICT MUNICIPAL SERVICE REVIEW FINAL

January 10, 2013

Prepared for the
Local Agency Formation Commission of Alameda County
by
Baracco and Associates,
Policy Consulting Associates, LLC

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1. AGENCY OVERVIEW

The City of Alameda Healthcare District (AHD) provides hospital, surgical, emergency room (ER), and other healthcare services. The most recent municipal service review for AHD was adopted in September 2004.

FORMATION

AHD was formed on July 1, 2002 after approval by over two-thirds (69 percent) of voters. AHD was formed to take on operations of the Alameda Hospital, which was at the time operated as a 501(c)3 nonprofit and was facing ongoing operating losses.

AHD was formed as an independent special district under the State's Local Healthcare District Act.[1] The principal act empowers healthcare districts to provide medical services, emergency medical, ambulance, and any other services relating to the protection of residents' health and lives.[2] Districts must apply and obtain LAFCo approval to exercise services authorized by the principal act but not already provided (i.e., latent powers) by the district at the end of 2000.

BOUNDARY

AHD encompasses the territory of the City of Alameda. No annexations or detachments have occurred since formation.

AHD's boundaries comprise 10.8 square miles.[3]

Extra-territorial Services

Services are provided to both residents and non-residents alike. AHD charges all patients equally, regardless of residency, based on its established pricing structure for the services rendered.

A majority of AHD's patients reside in the City of Alameda. AHD's secondary service area includes parts of Oakland and San Leandro, which are not within AHD's bounds. Eden

[1] Health and Safety Code §32000-32490.9.

[2] Health and Safety Code §32121(j).

[3] Land area refers to the total area within the agency's boundaries excluding submerged areas, such as those lying in the San Francisco Bay. Land area is expressed in units of square miles.

Township Hospital District is the primary healthcare service provider of San Leandro and a small part of Oakland. The remainder of Oakland is not served by a healthcare district.

Unserved Areas

There are no areas within AHD's bounds where healthcare services are unavailable.

SPHERE OF INFLUENCE

AHD's SOI was established in 2003 as coterminous with its boundaries. During the 2004 SOI updates, the Commission reaffirmed the coterminous SOI, since no reorganizations or changes in service area were proposed by the District. AHD's bounds and SOI are shown in Figure 1-1.

Figure 1-1: City of Alameda HD Boundaries and SOI

*Agency sphere equals the service area boundary

Created for Alameda LAFCo by the Alameda County Community Development Agency

ACCOUNTABILITY AND GOVERNANCE

Accountability of a governing body is signified by a combination of several indicators. The indicators chosen here are limited to 1) agency efforts to engage and educate constituents through outreach activities, in addition to legally required activities such as agenda posting and public meetings, 2) a defined complaint process designed to handle all issues to resolution, and 3) transparency of the agency as indicated by cooperation with the MSR process and information disclosure.

AHD is governed by a five-member board that meets on the first Wednesday of each month at the Alameda Hospital. Closed sessions take place at six in the evening and open sessions at 7:30 pm. AHD's initial members were appointed by the Alameda County Board of Supervisors; however, beginning in 2004, board members were elected. Current board member names, positions, and term expiration dates are shown in Figure 1-2.

Figure 1-2: City of Alameda Healthcare District Governing Body

City of Alameda Healthcare District				
District Contact Information				
Contact:	Deborah E. Stebbins, CEO			
Address:	2070 Clinton Avenue, Alameda, CA 94501			
Telephone:	(510)814-4001			
Fax	(510)814-4005			
Email/website:	www.alamedahospital.org			
Board of Directors				
Member Name	**Position**	**Term Expiration**	**Manner of Selection**	**Length of Term**
Jordan Battani	President	November 2016	Elected	4 years
Robert Deutsch	Vice President	November 2014	Elected	4 years
Vacant	Director	November 2014	Elected	4 years
J. Michael McCormick	Treasurer	November 2016	Elected	4 years
Elliot Gorelick	Secretary	November 2014	Elected	4 years
Meetings				
Date:	First Wednesday of each month at 6pm (closed session) and at 7:30pm (open session)			
Location:	Meetings are held at Alameda Hospital, 2070 Clinton Avenue, Alameda, CA.			
Agenda Distribution:	Posted on hospital website, in the main lobby and in local press as requested.			
Minutes Distribution:	Available on hospital website.			

AHD conducts public outreach efforts by posting its agendas on the hospital website and in the main lobby, and by circulating them to the local press. Public outreach also includes a newsletter posted on the AHD's website. Most public documents such as budgets, plans, and other financial statements are not posted on AHD's website; however, minutes of the meetings are made available. AHD's community activities include health screening, CPR risk assessment, free stroke risk assessment, community health fairs, wellness and education programs, blood drives, outreach programs and charity care. AHD's 2011 annual financial disclosure report to Office of Statewide Health Planning and Development (OSHPD) indicated that charity cases accounted for nearly three percent of operating expenses in 2011.

If a customer is dissatisfied with AHD services, complaints may be submitted via email or over the phone. Complaints that are received or forwarded to administration or quality resource management are tracked. There were 60 such complaints filed in 2011. Generally, complaints involved concerns about patient care, customer service, billing, and wait times.

AHD demonstrated accountability in its disclosure of information and cooperation with the LAFCo questionnaires and other requests.

MANAGEMENT AND STAFFING

While public sector management standards vary depending on the size and scope of the organization, there are minimum standards. Well-managed organizations evaluate employees annually, track employee and agency productivity, periodically review agency performance, prepare a budget before the beginning of the fiscal year, conduct periodic financial audits to safeguard the public trust, maintain relatively current financial records, conduct advanced planning for future service needs, and plan and budget for capital needs.

AHD employed 421 full-time equivalents (FTEs) in 2011, which is an increase of 31 employees (or eight percent) since 2002.

AHD operations are divided into eight departments: Financial, Business Development, Human Resources and Ancillary Services, Clinical Services, Quality Resource Management, Long Term Care, Information Systems, and the Foundation. These departments are further divided into sub-departments. The chief executive officer is accountable to the Board of Directors and oversees all the departments, executive assistant, and medical staff.

AHD evaluates its employees' performance annually.

AHD evaluates its performance through ongoing quality assurance and patient safety reports, monthly financial reports and annual financial audits. AHD performance is also gauged by benchmarking with other providers on the OSHPD website.

AHD monitors its workload and productivity through personnel timesheets and tracking of facility usage (i.e., number of hours surgery rooms are in use) and daily census. In order to maximize productive work hours, the hospital evaluates the proportion of work activity that is productive versus non-productive (vacation, holiday, sick). In 2011, it was determined that 86 percent of employee total reimbursable time was productive and 14 percent was non-productive time off.

AHD has been the recipient of multiple awards and recognitions over the last few years. In 2011, Alameda Hospital was one of 167 hospitals nationwide to receive the American College of Cardiology Foundation's National Cardiac Data Registry – Get With the Guidelines Gold Performance Achievement Award. The award recognizes Alameda Hospital's commitment and success in implementing a higher standard of care for heart attack patients. In 2010, Alameda Hospital received the American Heart Association's Get With The Guidelines –Coronary Artery Disease Gold Performance Achievement Award. The award recognizes Alameda Hospital's commitment and success in implementing a higher

standard of cardiac care that effectively improves treatment of patients hospitalized with coronary artery disease. In 2008, the American Heart Association and the American Stroke Association awarded Alameda Hospital a performance achievement award for excellence in the care and treatment of coronary artery disease.

AHD is accredited for hospital services by the Joint Commission. This voluntary accreditation signifies that the hospital engages in performance measurement and evaluation, follows standards on safety, infection control, quality of care and ethics. Alameda Hospital also received National Certification as a Primary Stroke Center by the Joint Commission.

AHD's mission is to be a general acute care hospital; to provide quality and personalized care; to attract and retain outstanding physicians, employees and volunteers; to grow consistent with community need and financial feasibility; to remain financially stable; and to be an effective health care district.

AHD's financial planning efforts include an annually adopted budget and audited financial statements. AHD adopts a strategic plan and plans for capital improvement projects through a capital improvement plan with a planning horizon of two to three years, updated annually.

All special districts are required to submit annual audits to the County within 12 months of the completion of the fiscal year, unless the Board of Supervisors has approved a biennial or five-year schedule.[4] In the case of AHD, the District must submit audits annually. AHD has submitted its audit to the County for FY 10-11 within the required 12 month period.

GROWTH AND POPULATION PROJECTIONS

This section discusses the factors affecting service demand, such as land uses, and historical and anticipated population growth.

Land Use

AHD's boundary area is approximately 0.61 square miles. The City of Alameda is the land use authority for the territory within the District and land uses encompass all land use designations within the City, including but not limited to residential, commercial, industrial, institutional and open space.

[4] Government Code §26909.

Existing Population

As of 2010, the population of the area in AHD was 73,847. Its population density—6,838 residents per square mile—is significantly higher than the countywide density of 1,840 people per square mile.

Projected Growth and Development

Based on Association of Bay Area Governments (ABAG) growth projections and AHD's estimated 2010 Census population, the population of the area within the District is anticipated to reach 84,185 by 2035, with an average annual growth rate of 0.5 percent.[5] Per ABAG population projections, the rate of growth in the City of Alameda and consequently in AHD is expected to be 14 percent, while the entire County is anticipated to grow by 27 percent.

AHD reported that growth patterns have not been affecting service demand in the last few years. Slow or no growth is anticipated within the AHD boundary area in the next several years; however, no formal projections were made. AHD reports that service needs have been consistent over the past five years.

The City of Alameda is essentially built out, and growth would be limited to infill and reuse development. An inventory of vacant land shows that there is just over 100 acres of land within the City that is presently undeveloped. However, there are several opportunities for new residential uses as part of pending redevelopment uses over the next five years. The Alameda Landing project is a former naval base on 77 acres that is entitled for 300 housing units, 300,000 square feet of retail, and 400,000 square feet of office space. The Neptune Point project is a three-acre site that is planned for 40 residential units. Encinal Terminal is 16 acres planned for mixed uses. The Del Monte Building is a 250,000 square foot historic warehouse planned for mixed use adaptive reuse. Lastly, the Chipman project is 4.5 acres zoned for 80 residential units.

FINANCING

The financial ability of agencies to provide services is affected by available financing sources and financing constraints. This section discusses the major financing constraints faced by AHD and identifies the revenue sources currently available to the District.

AHD reported that current financial levels were adequate to deliver services. However, some challenges to financing were identified by AHD. The primary challenge has been the reduction in state and federal reimbursements for the Medicaid and Medicare programs.

[5] Association of Bay Area Governments, Projections 2009, August 2009.

The recession also took its toll on AHD's finances. AHD had to modify budgeted annual expenditures to better align with anticipated revenues. In addition, certain services have been downsized. AHD continues to experience the negative effects of the expiration of the Kaiser Outpatient Surgery Services contract which occurred a few years ago in 2010. The new federal healthcare law is expected to further have negative effect on the District's financing.

Revenues

AHD's most recent financial report to OSHPD was filed in 2011. In that year, the hospital ran a net operating loss.

In 2001, the non-profit Alameda Hospital applied to LAFCo for formation of a district and imposition of a special tax levied at $298 per parcel. The financial pressures cited by the hospital prior to formation of AHD included lower reimbursement rates from the federal and state governments, growing popularity of HMOs, the recent loss of ten primary care physicians to Kaiser, and reduced revenue related to shorter patient visits. The proceeds of the special tax continue to be used to repay hospital indebtedness and to defray operating and capital improvement expenses of AHD.

In FY 10-11, AHD's revenues totaled $64 million, which consists of operating (90 percent) and non-operating (10 percent) revenue sources. A majority of the operating revenue came from charges for services. Non-operating revenue included district tax revenue, investment income, rent and other income, and grants and contributions. Patients covered by Medicare and MediCal were the most significant source of revenue, constituting about 40 percent of AHD's net patient revenues. AHD does not receive a portion of the one percent ad valorem property tax.

AHD appears to have significantly less revenue per patient day when compared to other providers statewide, particularly for inpatient services. Net inpatient revenue per patient day was $1,281, compared with $2,777 statewide. Net outpatient revenue per visit was $405 at Alameda Hospital, compared with $475 statewide.

AHD has agreements with third-party payors that provide for payments at amounts different from established rates. Payments for inpatient acute care services rendered to Medicare program beneficiaries are based on prospective determined rates, which vary accordingly to the patient diagnostic classification system. Outpatient services are paid under an outpatient classification system subject to certain limitations. AHD receives payments for inpatient services from MediCal based on an established rate. Outpatient payments are based on a pre-determined fee schedule. AHD charges all patients equally based on its established pricing structure for the services rendered. Medicare and MediCal make payments at amounts different from the hospital's established rates, depending on specific payment arrangements.

AHD maintains the Alameda Hospital Foundation, which was established as a nonprofit public benefit corporation to solicit contributions on behalf of the hospital. The Foundation's funds, which represent the Foundation's unrestricted resources, are

distributed to AHD in amounts and in periods determined by the Foundation's Board of Trustees, who may also restrict the use of funds for hospital property and equipment replacement or expansion, reimbursement of expenses, or other specific purposes. Donations in FY 10-11 amounted to $162,576. The Foundation is not considered a component unit of the hospital or AHD.

Expenditures

Total expenditures in FY 10-11 were $67 million, of which over 99 percent were operating expenditures and less than one percent were considered non-operating expenditures. The most significant operating expense was salaries and wages (52 percent). Other significant expenses were employee benefits, supplies, purchased services, professional fees, and registry.

In FY 10-11, AHD total charity care and community benefit foregone collections amounted to $89 million, out of which benefits to the poor were about $9 million and benefits to the broader community in the form of unpaid Medicare program charges—$80 million. Traditional charity care constituted only two percent of all community benefits.

Total expenditures exceeded total revenue in FY 10-11 by nearly $3 million. Operating expenditures exceeded operating revenues by $9 million in the same fiscal year. This operating loss may indicate that AHD is facing significant financing challenges.

Liabilities and Assets

Currently, AHD has two active loans. One is a loan from a bank with 4.8 percent interest. Payments are due in monthly installments of $42,460 through February 15, 2014. The second note payable is to the State of California for a cost report settlement with interest of 4.56 percent. Monthly installments of $26,869 are due through May 2013. AHD has a bank line of credit available at year end with a variable interest rate. Any advances on this line are due at the time of maturity and interest is due and payable monthly. There were no borrowings under this line of credit agreement as of June 30, 2011.

AHD's goal is to maintain sufficient cash and cash equivalent balances to pay all short-term liabilities and to be able to expand services available to the community. At the end of FY 10-11, AHD had a balance of $454,848 in unrestricted net assets.

As mentioned in the Management and Staffing section of this report, AHD conducts capital improvement planning with a planning horizon of about two to three years. Planned projects are updated annually. At the end of FY 10-11, the amount of money dedicated to construction-in-progress was close to $3 million.

Financing Efficiencies

AHD participates in one joint financing arrangement; the District receives professional liability insurance through the BETA Risk Management Authority.

2. MUNICIPAL SERVICES

HEALTHCARE SERVICES

Service Overview

AHD provides cardiology, clinical laboratory, diagnostic imaging, infusion center, cancer services, pulmonary and respiratory care, rehabilitation services, stroke services, the Asian Health Outreach Program, inpatient services, specialty care, 24-hour emergency care, sub-acute and skilled nursing, surgical services and a short-stay surgery center, advanced wound care, and community wellness programs. AHD also provides charity care, community services and services to medically indigent patients under certain government public aid reimbursement programs.

Demand for Services

In 2011, AHD had 47,255 outpatient visits, including emergency room visits. In the same year, there were 2,600 hospital discharges (excluding the nursery). In 2011, 51.5 percent of the hospital's beds were occupied on an average day. To compare, in 2002, the hospital received visits from 31,949 individuals as outpatients or emergency room visits. In 2002, 37 percent of the hospital's beds were occupied on an average day.

AHD's 2011 *Annual Utilization Report of Hospitals* reported that the Alameda Hospital received 16,816 patients in its emergency room, of which 97 percent were urgent or critical cases and only three percent were classified as not being urgent. The hospital performed 2,375 surgical operations in 2011, 25 percent of which were performed on an in-patient basis. The Alameda Hospital's 2002 *Annual Utilization Report of Hospitals* reported that the hospital received 16,817 patients in its emergency room, of which 96 percent were urgent or critical cases and four percent were classified as not being urgent. The hospital performed 2,541 surgical operations in 2002, 35 percent of which were performed on an in-patient basis.

Infrastructure and Facilities

After AHD was formed, the Alameda Hospital assets were transferred to the newly formed district. AHD's facilities include seven buildings which comprise the Alameda Hospital.

The Alameda Hospital is located on 4.3 acres of land at 2070 Clinton Avenue in Alameda. The hospital was established in 1894.

The Alameda Hospital has an emergency room and eight operating rooms. The facility includes 161 beds (an increase of 26 beds since 2005), of which 100 are used for general

acute care, and the remaining 61 are used for long-term care purposes (26 are skilled nursing beds and 35 are sub-acute nursing beds).

AHD also leases various equipment and facilities under operating leases.

Healthcare facilities, for comparison purposes, are measured based on what is termed the "average age of plant." The average age of plant is a measurement determined by assessing the average age of the hospital including capital improvements and major equipment purchases less accumulated depreciation. In the case of the Alameda Hospital, the facility "average age of plant" is approximately 41 years according to the 2011 annual financial data.[6] By comparison, national healthcare providers in the first quartile have an average age of plant of 3.63 years, those in the second quartile are 7.7 years, those in the third quartile are 10.59 years, and finally those in the fourth quartile are 15.39 years.[7] The first quartile contains the top 25 percent of the best performing hospitals in an applicable peer group. The fourth represents those falling below 76 percent.

In addition to the Alameda Hospital, AHD operates Waters Edge Skilled Nursing Facility (SNF) as a composite. Waters Edge has 120 licensed beds, 130 employees, and operates at an average daily census of a 100. As reported by the City of Alameda Healthcare District, this addition was an important advancement in the District's development of continuum of services for seniors and other long-term care patients, while allowing for enhanced services for the community and being consistent with the AHD's mission.

In July 2012, AHD also opened the Kate Creedon Center for Advanced Wound Care that provides state-of-the-art technologies and techniques through a multi-disciplinary approach to promote wound healing. The center provides an array of treatments including hyperbaric oxygen therapy (HBOT) and access to patients with non-healing wounds from surrounding communities.

Infrastructure Needs or Deficiencies

There are three key projects that need to be completed by the end of FY 12-13 that relate to seismic compliance for the SB 90 Seismic Extension, CMS regulations and Bay Area Air Quality Management District regulations.

- Bulk oxygen tank replacement, anchoring of emergency lighting, emergency communication and nitrous oxide canister anchoring: 1/1/2013

[6] OSHPD defines the facility average age of plant based on the ratio of accumulated depreciation to current-year depreciation.

[7] Healthcare Management Partners' HMP Metrics Quarterly Report, 2010.

- Installation of sprinkler system within the Sub-acute Unit: 8/2013
- Boiler burner replacement project: 1/1/2013

Funding of these mandated projects will come from cash flow from operations in FY 12-13 and through support from the Alameda Hospital Foundation. Master planning and funding for 2030 seismic standards has not yet been determined.

According to OSHPD, the seven Alameda Hospital buildings meet the 2008 seismic requirements; however, two of the seven buildings do not meet the 2013 seismic requirements. These two buildings must be seismically retrofitted by January 2013 to ensure that they would function following a strong earthquake. However, AHD is applying for an extension of the 2013 deadline as provided for under SB 90.

Shared Facilities and Regional Collaboration

Prior to forming a district, the hospital explored a number of organizational options, including affiliation with a major healthcare system, consolidation with other hospital districts, affiliation with other governmental agencies, private ownership, and hospital closure. According to AHD, none of these options proved feasible, at the time of formation. However, as part of AHD's strategic plan, leadership, including the Board of Directors, continues to explore partnership and affiliation opportunities with other healthcare systems and organizations in the Bay Area to meet the mission of the District, serve the healthcare needs of the community and be financially viable.

Service Adequacy

This section reviews indicators of service adequacy and patient outcomes, including heart attack mortality rates, ER closure rates, occupancy rates, and the number of district residents using the AHD hospital. Other indicators of service adequacy, which were previously discussed, include number of annual complaints, accreditation and revenues per patient day.

Inpatient Mortality Indicators (IMIs) for the AHD hospital are available for acute myocardial infraction, congestive heart failure, acute stroke, gastro-intestinal hemorrhage, hip fracture, and pneumonia for 2009.[8] Evidence suggests that high mortality may be associated with deficiencies in the quality of hospital care provided. The IMIs are part of a suite of measures called Inpatient Quality Indicators (IQIs), developed by the Federal Agency for Healthcare Research and Quality (AHRQ), that provide a perspective on hospital quality of care. IMIs are calculated using patient data reported to OSHPD by all California-licensed hospitals. All IMIs include risk-adjustment, a process that takes into account patients' pre-existing health problems to "level the playing field" and allow fair comparisons among hospitals. AHD's mortality rates in 2009 for acute myocardial infraction were four percent compared to seven percent statewide, three percent for congestive heart failure which is the same rate as statewide, 12 percent for acute stroke compared to 10 percent statewide, four percent for gastro-intestinal hemorrhage compared to two percent statewide, two percent for hip fracture compared to two percent statewide, and two percent for pneumonia compared to 4.6 percent statewide. AHD is considered not significantly different from the statewide average for all Inpatient Mortality Indicators.

The hospital closed its emergency room to incoming patients for a total of 125 hours (one percent of the time) during 2011. During that time, ambulances were diverted to other hospitals to accommodate patients. In 2010, ambulances were diverted to other hospitals for a total of 165 hours (nearly two percent of the time). By comparison, providers statewide were required to divert ambulances a median of zero hours in 2011. Emergency room closures, typically caused by rising cost of emergency care, lead to long waits, diverted ambulances and, in the most extreme cases, patient deaths. The closures also mean that patients in need of emergency care may need to travel farther, delaying access to treatment.

[8] OSHPD did not report mortality rates for other conditions (for ecophageal resection, pancreatic resection, abdominal aortic aneurism repair, craniotomy, percutaneous transluminal coronary angioplasty, carotid endaterectomy, acute myocardial infraction, and hip fracture) for the District because fewer than three procedures were performed or conditions were treated.

AHD's hospital had an occupancy rate of 51 percent in 2010, compared to a statewide average of 71 percent.[9] This occupancy rate suggests that there are sufficient hospital beds in the area to serve patients as needed. The hospital's relatively low occupancy rate compared to the statewide rate may indicate a flaw in service adequacy, but it may also indicate an excess supply of hospital beds in the area. Detailed analysis of Alameda residents' use of other hospitals would be needed to distinguish between relatively low service demand in this area, due to demographics and an uncompetitive service level.

The adequacy of hospital facilities and services in meeting the needs of Alameda residents can be gauged by the extent to which residents travel outside their region to receive hospital services. The rates were calculated based on patient discharge data from OSHPD. Residential location was approximated by zip code. Of district constituents who used hospital services in 2011, 49 percent chose the AHD hospital.

[9] OSHPD, *Annual Financial Disclosure Report*, June 30, 2010, 1. CDC, Table 116. *Occupancy rates in community hospitals and average annual percent change, by state: United States, selected years 1960–2008*. Latest figure found for State of California was 2008.

3. MSR DETERMINATIONS

Growth and Population Projections

- As of 2010, the population within City of Alameda Healthcare District (AHD) was 73,847.
- Based on ABAG growth projections the population of AHD is anticipated to be 84,185 by 2035.
- There are five planned or proposed projects within the City of Alameda that would consist of just over 400 residential units and some mixed uses within AHD's boundaries and sphere of influence. These developments if completed would have a minimal impact on demand for AHD services.

Location and Characteristics of Any Disadvantaged Unincorporated Communities Within or Contiguous to the Sphere of Influence

- Based on Census Designated Places, Alameda LAFCo determines that there are no disadvantaged unincorporated communities that meet the basic state-mandated criteria. Alameda LAFCo recognizes, however, that there are communities in the County that experience disparities related to socio-economic, health, and crime issues, but the subject of this review is municipal services such as water, sewer, and fire protection services to which these communities, for the most part, have access.

Present and Planned Capacity of Public Facilities and Adequacy of Public Services, Including Infrastructure Needs and Deficiencies

- With a 51 percent occupancy rate, AHD appears to have sufficient capacity to provide inpatient healthcare services to existing and future demand.
- Diversion of ambulances to other facilities can decrease survival chances or increase the severity of injury. There is a need to develop strategies to reduce the number and type of emergency room closures through education, a decrease in unnecessary visits, and increase in emergency room capacity, or by other means.
- Two out of the seven Alameda Hospital buildings do not meet the 2013 seismic requirements and are in need of retrofitting.
- By comparison with other national healthcare providers, the AHD hospital facility is aging and in need of updates.

- There are three key projects that need to be completed by the end of FY 12-13 that relate to seismic compliance for the SB 90 Seismic Extension, CMS regulations and Bay Area Air Quality Management District regulations—bulk oxygen tank replacement, anchoring of emergency lighting, emergency communication and nitrous oxide canister anchoring; installation of sprinkler system within the Sub-acute Unit, and the boiler burner replacement project.

- Based on patient outcomes, including heart attack mortality rates, ER closure rates, occupancy rates, and the number of district residents using AHD hospital, it appears that AHD services are adequate. While the hospital's relatively low occupancy rate compared to the statewide rate may indicate a service adequacy issue, it may also indicate an excess supply of hospital beds in the area

Financial Ability of Agency to Provide Services

- AHD reported that its financing levels were adequate to deliver services; however, multiple challenges to financing were identified, including a reduction in Medicare and MediCal reimbursements, impacts of the recent recession and the loss of the Kaiser contract.

- In FY 10-11, AHD's expenses exceeded revenues by about $3 million dollars.

- AHD has two long-term debts and a line of credit. The two notes payable are scheduled to be repaid in 2013 and 2014.

- At the end of FY 10-11, AHD had a cash balance of $2 million.

Status and Opportunities for Shared Facilities

- AHD participates in one joint financing arrangement.

- No future opportunities for regional cooperation or shared facilities were identified.

Accountability for Community Services, Including Governmental Structure and Operational Efficiencies

- AHD is governed by a five-member Board of Directors. The Board updates constituents, broadcasts its meetings, solicits constituent input, discloses its finances, and some of its public documents on its website.

- No alternative governance structure options with regard to AHD were identified.

- AHD demonstrated accountability in its cooperation with the LAFCo information requests.

4. SPHERE OF INFLUENCE UPDATE

Existing Sphere of Influence Boundary

AHD's existing SOI is coterminous with its boundary and includes the entire territory of the City of Alameda.

SOI Options

One option was identified with respect to AHD's SOI.

Option #1 – Maintain coterminous SOI

Should the Commission wish to continue to reflect the existing service boundary, then a coterminous SOI would be appropriate.

Recommended Sphere of Influence Boundary

AHD's SOI was established in 2003 as coterminous with its bounds. There have been no annexations to or detachments from AHD since its formation. There have also been no changes to its sphere of influence. During the 2004 SOI updates, the Commission reaffirmed the coterminous SOI given that no reorganizations or changes in service area were proposed by AHD.

This continues to hold true during this SOI update. Given the fact that no change in service area is proposed, it is recommended that the Commission maintain a coterminous SOI for AHD.

Proposed Sphere of Influence Determinations

Nature, location, extent, functions, and classes of services provided

- The City of Alameda Healthcare District provides emergency room, general acute care, surgery, physical therapy, long term care services, and cardiac rehabilitation within the district boundaries, which encompass the City of Alameda.
- AHD provides services to both district residents and non-residents.

Present and planned land uses, including agricultural and open-space lands

- AHD encompasses all land uses designated by the City of Alameda, including open space land. There are no agricultural or Williamson Act lands within the City.
- AHD's SOI does not conflict with planned land uses; the District has no authority over land use, and the City of Alameda is an urban area needing AHD's services.
- Services are presently being provided. Hospital and healthcare services are needed in all areas, and do not, by themselves induce or encourage growth on agricultural or open space lands.

Present and probable need for public facilities and services

- As indicated by demand for AHD's services, there is a present and anticipated continued need for healthcare services offered by AHD.

Present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide

- With a 51 percent occupancy rate, AHD appears to have sufficient capacity to provide inpatient healthcare services to existing and future demand. However, the hospital facility is aging and in need of updates to remain competitive with other providers.
- Based on accreditation and accolades, AHD appears to provide adequate services. AHD is fully accredited for hospital services and has received several service awards. The hospital's emergency room care consistently ranks in the top ten for patient satisfaction in the State.
- The MSR report indicates that acceptable service levels are being achieved, and the hospital has the resources to continue to provide services. Continuance of the existing service structure ensures acceptable levels of emergency, acute care and other medical services for residents, commuters, and visitors.

Existence of any social or economic communities of interest

- AHD was primarily formed to serve the residents of the City of Alameda. Most of the patients served by Alameda Hospital live in the City. City residents voted to tax themselves to pay for district services, and have an economic interest in receiving those services. Residents of the cities of Oakland and San Leandro also use district services and have an interest in cost and adequacy of such services.

ALAMEDA LOCAL AGENCY FORMATION COMMISSION
RESOLUTION NO. 2013-04

Adopting Municipal Service Review Determinations, Sphere of Influence Determinations, and Updating the Sphere of Influence for the City of Alameda Healthcare District

WHEREAS, Government Code Section 56425 et seq. requires the Local Agency Formation Commission (LAFCo) to develop and determine the sphere of influence (SOI) of each local governmental agency under LAFCo jurisdiction within the County; and

WHEREAS, Government Code Section 56425(g) requires that LAFCo review and update adopted SOI boundaries, as necessary, not less than once every five years; and

WHEREAS, Government Code Section 56430 requires that a municipal services review (MSR) be conducted prior to or in conjunction with a SOI update; and

WHEREAS, LAFCo conducted a municipal services review of the services provided by the City of Alameda Healthcare District; and

WHEREAS, the City of Alameda Healthcare District has a SOI that is coterminous to the District's jurisdictional boundary; and

WHEREAS, no change in regulation, land use or development will occur as a result of updating the CSA's coterminous SOI; and

WHEREAS, in the form and manner prescribed by law, the Executive Officer has given notice of a public hearing by this Commission regarding the SOI update action; and

WHEREAS, the MSR determinations, the SOI determinations and the SOI update were duly considered at a public hearing held on January 10, 2013; and

WHEREAS, the Alameda LAFCo heard and received all oral and written protests, objections and evidence that were made, presented or filed, and all persons present were given an opportunity to appear and be heard with respect to any matter pertaining to said action.

NOW, THEREFORE, BE IT RESOLVED, DETERMINED AND ORDERED that the Alameda LAFCo hereby:

1. Adopt the following MSR determinations:
   a. *Growth and Population Projections*
      i. As of 2010, the population within City of Alameda Healthcare District (AHD) was 73,847.
      ii. Based on Association of Bay Area Governments (ABAG) growth projections the population of AHD is anticipated to be 84,185 by 2035.
      iii. There are five planned or proposed projects within the City of Alameda that would consist of just over 400 residential units and some mixed uses within AHD's boundaries and SOI. These developments if completed would have minimal impact on demand for AHD services.
   b. *Location and Characteristics of Any Disadvantaged Unincorporated Communities Within or Contiguous to the Sphere of Influence*
      i. Using Census Designated Places, Alameda LAFCo determines that there are no disadvantaged unincorporated communities that meet the basic state-mandated criteria within the County. Alameda LAFCo recognizes, however, that there are communities in the County that

experience disparities related to socio-economic, health, and crime issues, but the subject of this review is municipal services such as water, sewer, and fire protection services to which these communities, for the most part, have access.

c. *Present and Planned Capacity of Public Facilities and Adequacy of Public Services, Including Infrastructure Needs and Deficiencies*
   i. With a 51 percent occupancy rate, AHD appears to have sufficient capacity to provide inpatient healthcare services to existing and future demand.
   ii. Alameda Hospital closed its emergency room (ER) to incoming patients for a total of 125 hours (1% of the time) during 2011. During that time, ambulances were diverted to other hospitals to accommodate patients. Diversion of ambulances to other facilities can decrease survival chances or increase the severity of injury. There is a need to develop strategies to reduce the number and type of ER closures through education, a decrease in unnecessary ER visits, and increase in ER capacity, or by other means.
   iii. Two out of the seven Alameda Hospital buildings do not meet the 2013 seismic requirements and are in need of retrofitting.
   iv. By comparison with other national healthcare providers, the AHD hospital facility is aging and in need of updating.
   v. There are three key projects that need to be completed by the end of FY 12-13 that relate to seismic compliance for the SB 90 Seismic Extension, CMS regulations and Bay Area Air Quality Management District regulations—bulk oxygen tank replacement, anchoring of emergency lighting, emergency communication and nitrous oxide canister anchoring; installation of sprinkler system within the sub-acute unit, and the boiler burner replacement project.
   vi. Based on patient outcomes, including heart attack mortality rates, ER closure rates, occupancy rates, and the number of district residents using AHD hospital, it appears that AHD services are adequate. While the hospital's relatively low occupancy rate compared to the statewide rate may indicate a service adequacy issue, it may also indicate an excess supply of hospital beds in the area.

d. *Financial Ability of Agency to Provide Services*
   i. AHD reported that its financing levels were adequate to deliver services; however, multiple challenges to financing were identified, including a reduction in Medicare and MediCal reimbursements, impacts of the recent recession and the loss of the Kaiser contract.
   ii. In FY 10-11, AHD's expenses exceeded revenues by about $3 million dollars.
   iii. AHD has two long-term debts and a line of credit. The two notes payable are scheduled to be repaid in 2013 and 2014.
   iv. At the end of FY 10-11, AHD had a cash balance of $2 million.

e. *Status and Opportunities for Shared Facilities*
   i. AHD participates in one joint financing arrangement.
   ii. No future opportunities for regional cooperation or shared facilities were identified.

f. *Accountability for Community Services, Including Governmental Structure and Operational Efficiencies*
   i. AHD is governed by a five-member Board of Directors. The Board updates constituents, broadcasts its meetings, solicits constituent input, discloses its finances, and some of its public documents on its website.
   ii. No alternative governance structure options with regard to AHD were identified.
   iii. AHD demonstrated accountability in its cooperation with the LAFCo information requests.

2. Retain the coterminous SOI for the City of Alameda Healthcare District as generally depicted in Exhibit A attached hereto.

3. Consider the criteria set forth in Government Code Section 56425(e) and determine as follows:

a. *The present and planned land uses in the area, including agricultural and open-space lands* – AHD encompasses all land uses designated by the City of Alameda, including open space land. There are no agricultural or Williamson Act lands within the City. AHD's SOI does not conflict with planned land uses; the District has no authority over land use, and the City of Alameda is an urban area needing AHD's services. Services are presently being provided. Hospital and healthcare services are needed in all areas, and do not, by themselves induce or encourage growth on agricultural or open space lands.

b. *The present and probable need for public facilities and services in the area* –As indicated by demand for AHD's services, there is a present and anticipated continued need for healthcare services offered by AHD.

c. *The present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide* –With a 51 percent occupancy rate, AHD appears to have sufficient capacity to provide inpatient healthcare services to existing and future demand. However, the hospital facility is aging and in need of updates to remain competitive with other providers. Based on accreditation and accolades, AHD appears to provide adequate services. AHD is fully accredited for hospital services and has received several service awards. The hospital's ER care consistently ranks in the top ten for patient satisfaction in the State. The MSR report indicates that acceptable service levels are being achieved, and the hospital has the resources to continue to provide services. Continuance of the existing service structure ensures acceptable levels of emergency, acute care and other medical services for residents, commuters, and visitors.

d. *The existence of any social or economic communities of interest in the area* – AHD was primarily formed to serve the residents of the City of Alameda. Most of the patients served by AHD live in the City. City residents voted to tax themselves to pay for district services, and have an economic interest in receiving those services. Residents of the cities of Oakland and San Leandro also use district services and have an interest in cost and adequacy of such services.

e. *Nature, location, extent, functions & classes of services to be provided* –AHD provides emergency room, general acute care, surgery, physical therapy, long term care services, and cardiac rehabilitation within the district boundaries, which encompass the City of Alameda. AHD provides services to both district residents and non-residents.

4. Determine, as lead agency for the purposes of the California Environmental Quality Act (CEQA), that update of the agency's SOI and the related MSR are categorically exempt under Sections 15061(b)(3) and 15306, Class 6 of the CEQA Guidelines.

5. Direct staff to file a Notice of Exemption as lead agency under Section 15062 of the CEQA Guidelines.

* * * * * * * *

This Resolution was approved and adopted by the Alameda Local Agency Formation Commission at the public hearing held on January 10, 2013, at 7051 Dublin Blvd., Dublin, California on the motion made by Commissioner Haggerty, seconded by Commissioner Sbranti, and duly carried.

Ayes: 7 (Commissioners Haggerty, Miley, Sblendorio, Wieskamp, Johnson, Sbranti, and Marchand)
Noes:
Excused:

1

/Nate Miley/

Nate Miley, Chair, Alameda LAFCo

Approved as to Form:

By:

Andrew Massey, LAFCo Legal Counsel

CERTIFICATION: I hereby certify that the foregoing is a correct copy of a resolution adopted by the Alameda Local Agency Formation Commission, Oakland, California.

Attest:

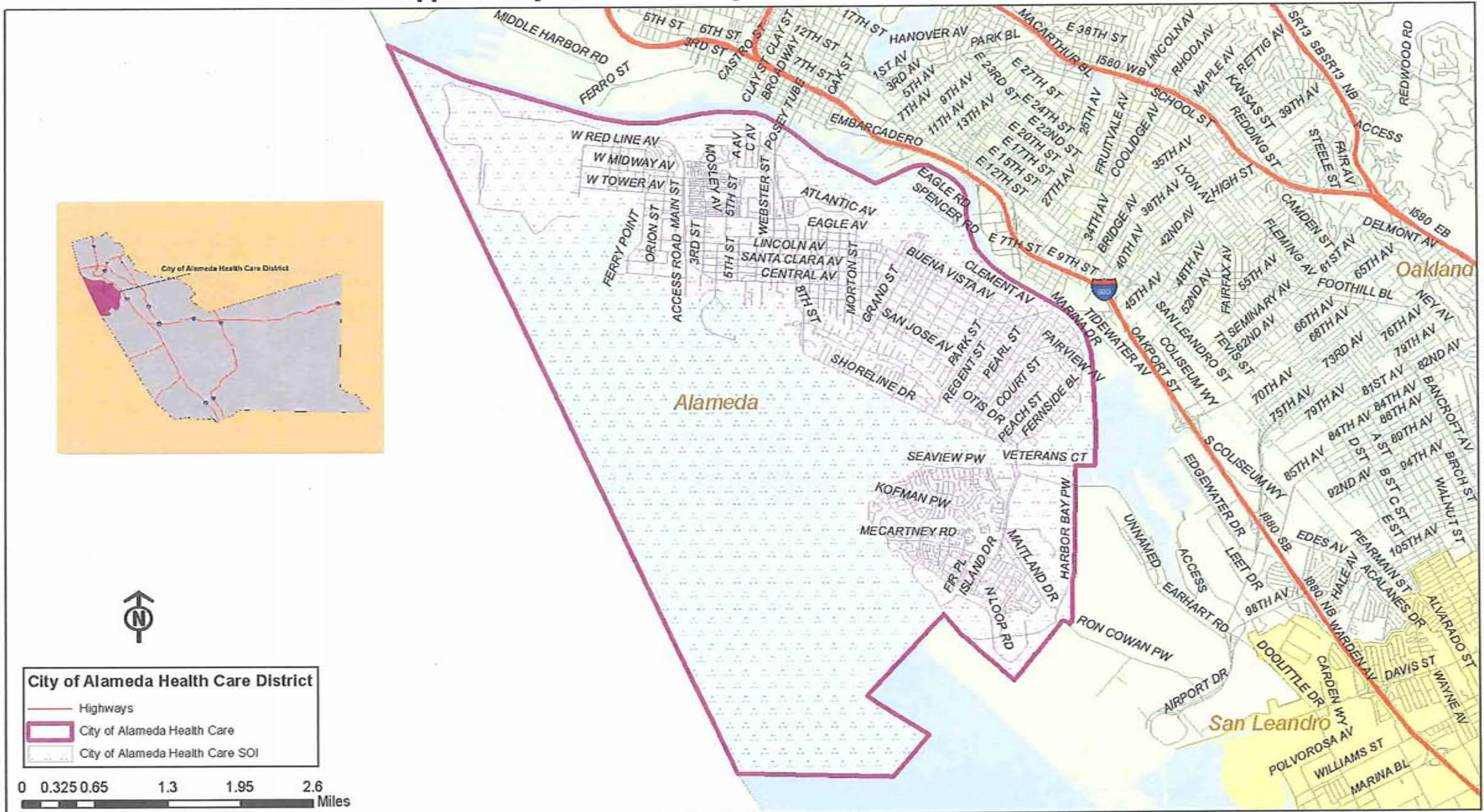
Mona Palacios, LAFCo Executive Officer

Date: 2/22/2013

1

EXHIBIT A

City of Alameda Health Care District Boundary and SOI*
Approved by Alameda County LAFCo, January 10, 2013



*Agency sphere equals the service area boundary

Created for Alameda LAFCo by the Alameda County Community Development Agency