BOARD OF TRUSTEES MEETING

WEDNESDAY, JULY 9, 2025
5:00pm to 9:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:

Open Session, In Person: HCP Conference Center, see above address

ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLgY4GWf4PQBwp3w0Puy2.1&omn=83616918838
Meeting ID: 936 145 7125
Meeting Password: 20200513

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MEMBERS

Alan E. Fox — Greg Garrett
Lilavati Indulkar, MD — Donna Linton
Nicholas Moss, MD — Nely Obligacion
Rachel Richman — David Sayen
Sblend A. Sblendorio

BOARD OF TRUSTEES REGULAR MEETING AGENDA

SPECIAL NOTE: Per Brown Act requirements, Trustees of the Alameda Health System will attend board and committee meetings in person at the location(s) noticed on this agenda. Staff and members of the public may attend either in person at the location noticed on this agenda, or remotely via Zoom, using the link included on this agenda.

[1] Log into the meeting at www.zoom.com. You will be directed to download the meeting app (free) if you have not used ZOOM previously. ZOOM meetings may be accessed on computers and portable devices.

Public Comment Instructions
If you attend the meeting in person and wish to address the Board or Committee regarding an item on the agenda or in their purview, please see the Clerk of the Board to sign up.

If you attend the meeting remotely and wish to address the Board of Trustees or Committee regarding an item on the agenda or in their purview, send an email to cob@alamedahealthsystem.org prior to the start of the meeting, or via Zoom chat during the meeting. Your comment will be heard at the appropriate time.

Each speaker, whether in person or remote, will be allotted between one and three minutes to speak, depending on the number of speakers present.

OPEN SESSION / ROLL CALL

PUBLIC COMMENT

A. CEO REPORT
James E.T. Jackson, Chief Executive Officer

B. MEDICAL STAFF REPORTS
AHS Medical: Berenice Perez, MD, Chief of Medical Staff
AH Medical: Catherine Pyun, DO, Chief of Medical Staff

C. COMMITTEE AND TRUSTEE REPORTS

C1. Audit and Compliance Committee: June 18, 2025
Sblend Sblendorio, Chair

C2. Quality Professional Services Committee: June 26, 2025
Lilavati Indulkar, MD, Chair

C3. Finance Committee: July 2, 2025
Alan Fox, Committee Chair

D. CONSENT AGENDA: ACTION

D1. Approval of the May 14 and June 11 Board of Trustees Meeting Minutes.

D2. Recommendation to the Board of Trustees for approval of the System Wide Policies and Standardized Procedures listed below:

- Medication Drug Recall
- Outpatient Pharmacy Dispensing

D3. Recommendation to the Board of Trustees for approval of the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

- Identifying and Credentialing HIV/AIDS Specialists

AHS Medical Staff:

- Medical Staff Department Structure and Division Leadership
- Introduction of a New Privilege or New Privilege for a Specific Department or Specialty

D4. Contracts

D4a. Renewal agreement with Alliance HealthCare Services, Inc. dba Alliance HealthCare Radiology for provision of mobile imaging services. The term of this renewal agreement is effective April 23, 2025 through April 22, 2028. The estimated impact of this renewal is $3,333,044.
Mark Fratzke, Chief Operating Officer

D4b. Renewal agreement with CareFusion Solutions, LLC for provision of infusion pumps and supplies. The term of this renewal agreement is effective August 19, 2025 through August 18, 2030. The estimated impact of this renewal agreement is $7,206,000.
Romoanetia Lofton, Chief Nursing Executive

D4c. Renewal agreement with East Oakland Community Project for provision of respite care services. The term of this renewal agreement is effective August 1, 2025 through July 31, 2028. The estimated impact of this agreement is $1,593,600.
Romoanetia Lofton, Chief Nursing Executive

D4d. Renewal agreement with The Regents of the University of California on behalf of the University of California, San Franciso, Department of Neurological Surgery for provision of professional neurosurgery services. The term of this renewal agreement is August 1, 2025 through July 31, 2027. The estimated impact of this renewal agreement is $7,594,371.
Elizabeth Mahler MD, Chief Medical Officer

E. ACTION/DISCUSSION

E1. ACTION / DISCUSSION: Resolution Accepting Grant Funds From the California Health Facilities Financing Authority and Authorize the Chief Executive Officer to Execute the Grant Agreement and Related Documents
Mark Fratzke, Chief Operating Officer

E2. ACTION / DISCUSSION: Resolution Approving 401(h) Account, Pursuant to Section 31592
Arleen Gomez, Interim Chief Human Resources Officer
Ahmad Azizi, General Counsel

E3. **DISCUSSION: Operating Plan**
Mark Fratzke, Chief Operating Officer
Christy Roberg, Vice President, Business Planning

F. DISCUSSION: Board Calendar and Tracking

G. STAFF REPORTS (Written)

G1. **Chief Financial Officer Report**, April Financial Report
Kimberly Miranda, Chief Financial Officer

G2. **Public Affairs and Community Engagement Report**
Alice Kinner, Administrative Director

CLOSED SESSION

1. CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION
(Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
Case name unspecified: Disclosure would jeopardize settlement negotiations
Ahmad Azizi, General Counsel

1. Conference with Labor Negotiators
[Government Code Section 54957.6]
AHS Designated Representatives: Ulysses Madison, Director of People Operations
Employee Organization: UAPD

2. Public Employee Performance Evaluation
[Pursuant to Government Code Sections 54957(b)(1)]
Title: Chief Executive Officer

3. Public Employee Performance Evaluation; Conference with Labor Negotiator Pursuant to Government
Code Sections 54957(b)(1) and 54957.6
Title: Chief Executive Officer
Agency Designated
Representative: David Sayen, President Board of Trustees

4. Regulatory Affairs, Risk Management, Patient Safety
[Health and Safety Code 101850(ai)(1)]

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

OPEN SESSION

H. Discussion and Possible Action to Amend the Employment Agreement with the Chief Executive Officer

TRUSTEE COMMENTS

ADJOURNMENT

Our Mission
Caring, Healing, Teaching, Serving All

Strategic Vision
AHS will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimizes the health of our diverse communities.

Values
Compassion, Commitment, Teamwork, Excellence, Integrity, and Respect.

Meeting Procedures
All items appearing on the agenda are subject to action by the Board of Trustees. Staff recommendations are subject to action and change by the Board of Trustees.

The Board of Trustees is the Policy Body of the Alameda Health System. The Board has several standing Committees where Board matters are the subject of discussion at which members of the public are urged to testify. Board procedures do not permit: 1) persons in the audience at a Committee meeting to vocally express support or opposition to statements by Board Members or by other persons testifying; 2) ringing and use of cell phones, pagers, and similar sound-producing electronic devices; 3) signs to be brought into the meeting or displayed in the room; 4) standing in the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the Clerk of the Board or to its members, 1411 East 31st Street Oakland, CA 94602.

Members of the public are advised that all Board and Committee proceedings are recorded (audio), including comments and statements by the public in the course of the meetings. Copies of the audio recordings will be made available to the public. Copies of the agendas and supporting documents can be found here: http://www.alamedahealthsystem.org/meeting-agendas-and-minutes/**. By attending and participating in Board/Committee meetings, members of the public consent to audio recording of any statements they may make during the proceedings.**

Disability Access
To request accommodation or assistance to participate in the meeting please contact the Clerk of the Board. Requests made at least 48 hours in advance of the meeting will help to ensure availability.

In order to accommodate persons with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to perfumes and various other chemical-based scented products. Please help us to accommodate these individuals.

The AHS Board of Trustees is committed to protecting the private health information (PHI) of our patients. We ask that speakers refrain from disclosing or discussing the PHI of others. Please also know that, should you decide to disclose your PHI, the Trustees will

still likely refer your matter, to the extent it involves PHI, to the executive staff for a confidential review of the facts and for confidential handling. If you would like more information regarding the confidentiality of PHI as it relates to the Health Insurance Privacy and Accountability Act, please refer to 45CFR Section 164.101, et.seq.

A. CEO REPORT

No Written Materials

Agenda Item A CEO Report

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.

B. MEDICAL STAFF REPORTS

No Written Materials

Agenda Item B Medical Staff Reports

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.

C. COMMITTEE AND TRUSTEE REPORTS

No Written Materials

Agenda Item C Committee Reports

No written materials were submitted for this agenda item. If materials become available, the item will be updated in Boardvantage and on the internet. A verbal discussion of the item may take place at the meeting.

D1. Approval of the May 14 and June 11 Board of Trustees Meeting Minutes.

BOARD OF TRUSTEES MEETING

WEDNESDAY, MAY 14, 2025
5:00pm to 9:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:
Open Session, In Person: HCP Conference Center, see above address

MEMBERS

Alan E. Fox	Greg Garrett
Lilavati Indulkar, MD	Donna Linton
Nicholas Moss, MD	Nely Obligacion
David Sayen	Sblend A. Sblendorio

THE MEETING WAS CALLED TO ORDER AT 5:03 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Nely Obligacion, David Sayen, and Sblend Sblendorio

ABSENT: Greg Garrett, excused

PUBLIC COMMENT: None

A. CEO REPORT
James E.T. Jackson, Chief Executive Officer

Trustee Linton spoke of the news regarding anticipated cuts to immigrant health programs at the State level. She asked if, as AHS developed the budget for the upcoming year, there were any thoughts on the impact these cuts may have on the care of the undocumented patients. Mr. Jackson said the impact was not likely to take effect until January though AHS fully intends to honor the mission of serving all, regardless of ability to pay. They had a working group tasked with trying to understand the changes coming down from both the State and the Federal governments and how it will impact what we do. But it is too early in the process to articulate what the changes may be.

B. MEDICAL STAFF REPORTS

AHS Medical:	Berenice Perez, MD, Chief of Medical Staff
AH Medical:	Catherine Pyun, DO, Chief of Medical Staff

C. COMMITTEE AND TRUSTEE REPORTS

C1. Human Resources Committee: April 16, 2025
David Sayen, Committee Chair

C2. Quality Professional Services Committee: April 23, 2025

C3. Finance Committee (no quorum): May 7, 2025
Alan Fox, Committee Chair

Trustee Linton asked if improvements in labor have been factored into the overall budget as it had the potential to exacerbate the labor concerns and impact the number of staff on payroll. Mr. Fratzke said the COLAs were incorporated into the budget. It was important for AHS to keep up with market rate salaries. They would look elsewhere to balance the budget.

Trustee Linton asked if the County was going to pay the cost of JGPH because that could have a very significant impact not just on the current year's budget but in terms of what needs to be budgeted for the upcoming year. The budget presentation on June 11 did not give Trustees a lot of opportunity to understand some of the policy implications. Mr. Fratzke asked if she wanted Kim to go into more detail in June. Trustee Linton said she would appreciate that. Mr. Jackson said there was a $30M delta between what they knew the County would pay and what they thought the County should pay. They had been having productive conversations with the County and they believed the delta would be closed. They did not know if it would be entirely closed or only some portion of it.

Trustee Linton asked if there was a policy approach on how the organization would prioritize the purchase of equipment. Mr. Fratzke said they were getting better at it every year. They used criteria around safety, efficiency, connecting to strategy, etc. When the capital was submitted, they pointed to all of those elements. Mr. Jackson said they had their budget planning meeting the day prior and this was a topic. They were at about 52% of the budget spend for the year, which was concerning. If staff needed something and it was budgeted for, they should buy it. They were actively having conversations about how they were going to be better at identifying and then purchasing things that will benefit the system. Mr. Fratzke added that they had the strategic planning cycle, the capital equipment purchase cycle, and the budgeting cycle. Those cycles should run parallel.

D. CONSENT AGENDA: ACTION

Trustee Sayen asked if there was any public comment on the consent agenda. Ms. Jojola Gonsalves said there was not.

D1. Approval of the Minutes from the April 9, 2025 Board of Trustees Meetings

D2. Approval of the System Wide Policies and Standardized Procedures listed below:

- HR SECTION 2.00 - POLICY 2.20 HOLIDAYS
- HR SECTION 1.00 - POLICY 1.81 EMPLOYEE PREFERRED NAME

- HR SECTION 3.00 POLICY 3.25 Compliance Non-Retaliation and Non-Retribution

D3. Recommendation from the Quality Professional Services Committee to approve the policies listed below:

- Surgical and Procedural Area Attire Policy
- Patient Complaints and Grievances Policy
- Healthcare Industry Representative Relations Policy and Procedure
- Teaching Physician Billing Policy
- Medications: Hazardous Drugs Preparation and Handling in Pharmacy
- Use of Echocardiography Contrast Imaging Agents
- Patients own Medications Storage, Security, Handling and Administration
- Medication Therapeutic Interchange Policy
- Pharmaceutical Company Representative Policy
- System Medication Samples Policy
- Medications: Inpatient Medication Dispensing Policy
- Critical Value Policy – Nursing
- Standards of Nursing Practice

D4. Recommendation from the Quality Professional Services Committee to approve the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

- Medical Staff Access to Medical Staff Records
- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Ongoing Monitoring and Evaluation of actions Related to Providers

Moved by Trustee Linton and seconded by Trustee Obligacion to approve the consent agenda.

ACTION: A motion was made and seconded to approve the consent agenda. A roll call was taken, and the motion passed.
AYES: Trustees Fox, Indulkar, Linton, Moss, Obligacion, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

E. ACTION / DICUSSION: Contracts

Trustee Sayen asked if there was any public comment on the consent agenda. Ms. Jojola Gonsalves said there was not.

E1. Amendment with Virtual Radiologic Professionals of California, P.A. to renew terms of our remote imaging services agreement. The term of this amendment is July 1, 2025 through July 1, 2026 auto-renewing each year after unless prior written notice is provided no less than 120 days prior to the end of the initial term. The estimated impact of this amendment is $3,197,097.
Elizabeth Mahler, Chief Medical Officer

Trustee Fox asked why the annual increase so high at 15%. Dr. Mahler said it was to accommodate the vendor's costs.

Trustee Fox said they would be realizing about $1.5M in incremental professional fees to offset that increase and asked if that would be in the budget. Mr. Holley said he wasn't sure how it was budgeted. The costs were included. He would work with Finance to get the answer and circle back after the meeting. Trustee Fox said he was curious because what they would pay year over year would be $421K, but they'll be getting $1.5M in incremental professional fees, that would put them a million dollars ahead. If that was the case it should be in the budget.

E2. Amendment with East Bay Foundation for Graduate Medical Education to renew our surgical residency program. The term of this amendment is July 1, 2025 through June 30, 2026. The estimated impact of this amendment is $4,325,956.
Elizbeth Mahler, Chief Medical Officer

Trustee Fox asked why the personnel and payroll fees increased so much in the next year. Dr. Mahler said the COLA increase for the residents was decided by the Board and the other adjustments were to go along with the colas. Mr. Holley said he asked EBFG the same question. They said they had some staffing changes, and they changed some vendors that provide certain things. They did not want to provide details on all the changes. Additionally, they had to find a new insurance carrier, which was more expensive.

E3. New agreement with Strata Decision Technology, LLC for provision of financial and budgeting software services. The term of this agreement is June 1, 2025 through May 31, 2030. The estimated impact of this agreement is $2,491,181.
Kimberly Miranda, Chief Financial Officer

Trustee Sayen asked for clarification on if the costs were for a new project and how much more the new project was than the last one. Ms. Miranda said it was quite a bit more. The current software was outdated.

Moved by Trustee Sblendorio, seconded by Trustee Linton to approve the contracts.

ACTION: A motion was made and seconded to approve the contracts. A roll call was taken, and the motion passed.
AYES: Trustees Fox, Indulkar, Linton, Moss, Obligacion, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

F. ACTION/DISCUSSION

F1. DISCUSSION/ACTION: Bylaws Update
Ahmad Azizi, General Counsel

Trustee Sblendorio said the last time this was brought to the Board there were a lot of items that members who are no longer on the Board wanted. The process got sidetracked. For

example, there was talk about expanding the Board. They could have that conversation, but they should do so separate from this update.

Moved by Trustee Fox, seconded by Trustee Moss to recommend approval to the BOS.

ACTION: A motion was made and seconded to recommend approval to the BOS. A roll call was taken, and the motion passed.
AYES: Trustees Fox, Indulkar, Linton, Moss, Obligacion, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

F2. DISCUSSION: Highland Labor and Delivery Update
LanNa Lee, MD, Chair Obstetrics, Midwifery, and Gynecology

Trustee Fox, speaking about the 58% percent of the patients who were assigned to AHS but not seen, asked if they were not seen due to capacity issues or because they did seek care. Dr. Lee said they could do some more outreach, they had been looking at different ways to manage the screening, but at this point, they did not have the capacity. Trustee Fox asked what they could do about that. Dr. Mahler said part of the reason for the approval of the FTEs was to improve inpatient time and coverage of the hospitalist model. The number of assigned unseen patients was not unique to Labor and Delivery. Trustee Fox asked if the primary care doctors followed up with patients regarding whether they have been screened. Dr. Lee said they have worked hard to make the care gap in cervical cancer screenings available to all primary care physicians.

Trustee Indulkar asked if the 2.8 FTE they said was for a nocturnist hospitalist would help cover what would be needed to bring physicians back to the ambulatory space. Dr. Lee said currently it would not. Since last year they had two providers leave the organization and one that was converted to per diem and one that would potentially convert to per diem. They needed three more providers to truly fulfill their inventory requirements.

Trustee Linton asked how many of the patients who came to AHS for delivery did not have any prenatal care, how many received prenatal care at the community clinics, and how many of the ambulatory patients got prenatal care and delivered here. Dr. Lee said about 30% of the patients who deliver here were from our outside partners, so most patients who deliver here received prenatal care here. It was difficult to track, in the ambulatory setting, what percentage of patients got prenatal care because a lot of them shift to CHCN for a little while or fall out of care.

Trustee Fox asked what level nursery they had at Highland. Dr. Lee said it was a level two nursery. Mothers who were at risk to deliver their baby younger than 32 weeks or required more advanced care were transferred to Alta Bates for delivery.

Trustee Indulkar said if they had to decrease their clinic access, patients who would normally have been referred for elective surgeries would have also decreased creating a whole population of patients who should get surgeries but were no longer able to and likely ending up in the ER. She asked if the recommended staffing model was able to close that gap. Dr. Lee said they needed more FTEs. The hospitalist model worked because they

would have a group of people dedicated to the inpatient side. It made scheduling easier and the financial analysis around their productivity was easier as well.

Trustee Linton asked if the expansion plans included St. Rose. Dr. Lee said at this time, it did not.

Trustee Sblendorio asked what was left on the table by not having the staffing. Dr. Lee said they had a large unseen population in Alameda County, who wanted care but were unable to get it. Outpatient gynecological care clinicians could medically stabilize that patient, so they could be an elective surgery candidate when they were healthier, rather than when they ended up in the ER. Strengthening ambulatory care in general led to a healthier patient population. They could also see more patients in one hour in an ambulatory setting than in an acute setting, increasing revenue.

Trustee Sblendorio asked if the increased revenue from an ambulatory setting versus an acute setting has been somehow analyzed or documented. Dr. Mahler said they had a workgroup that was evaluating FTEs by service line presenting pro forma from emergency medicine and gynecology as well as a couple of other specialties to measure how improved ambulatory would be with three FTEs.

Trustee Sblendorio said if what they were saying has not led to more hiring, perhaps leadership wasn't hearing them and if he were the head of the Finance Committee he'd ask for the numbers, he would want to see what they were missing. Dr. Lee said they were working with Dr. Mahler and others to look at physician productivity and staffing models to bring that work to the committee.

Trustee Obligacion said it seemed like there were issues with retention. This creates burn out. She asked about the mechanism to prevent burn out and retain the FTEs so they don't end up with the same problem. Dr. Mahler said it takes time. She did not know what the pace to switch to the new model would be.

Trustee Indulkar asked once they got all the physicians hired, would they expect an increase in how ORs were utilized and how cases were brought in as elective surgeries and if they would be able to meet that need. Dr. Mahler said with this model they would have better access, they would see patients more frequently and be able to see patients for elective surgeries.

G. DISCUSSION: Board Calendar and Tracking

H. STAFF REPORTS (Written)

H1. Chief Financial Officer Report, February Financial Report
Kimberly Miranda, Chief Financial Officer

H2. Public Affairs and Community Engagement Report
Alice Kinner, Administrative Director

Truste Obligacion recused herself from agenda item 2, as an employee of SEIU. She requested they hear agenda item 2 last.

Mr. Azizi said the Board would meet in closed session to discuss the items set forth on the agenda.

CLOSED SESSION

1. **CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION**
   (Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
   Case name unspecified: Disclosure would jeopardize settlement negotiations
   Ahmad Azizi, General Counsel

2. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Ulysses Madison, Director of People Operations
   Employee Organization: CNA/ILWU Local 6/SEIU 1021/ACMEA

3. **Regulatory Affairs, Risk Management, Patient Safety**
   [Health and Safety Code 101850(ai)(1)]

(Reconvene to Open Session)

Mr. Azizi said the Board met in closed session and there was no reportable action.

ADJOURNMENT: pm

This is to certify that the foregoing is a true and correct copy of the minutes of the meeting of May 14, 2025 as approved by the Board of Trustees on June 11, 2025.

_____
Ronna Jojola Gonsalves
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _____
Ahmad Azizi
General Counsel

BOARD OF TRUSTEES MEETING

WEDNESDAY, JUNE 11, 2025
5:00pm to 9:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:

Open Session, In Person: HCP Conference Center, see above address

MEMBERS

Alan E. Fox	Greg Garrett
Lilavati Indulkar, MD	Donna Linton
Nicholas Moss, MD	Nely Obligacion
Rachel Richman	David Sayen
Sblend A. Sblendorio	

THE MEETING WAS CALLED TO ORDER AT 5:06 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Greg Garrett, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Nely Obligacion, Rachel Richman, and David Sayen

ABSENT: Alan Fox and Sblend Sblendorio, excused

PUBLIC COMMENT:

John Young spoke regarding his pending layoff. He served the organization for over seven years and spoke of the accomplishments achieved during his tenure. That this was about a reduction in staff, and that the job could be handled by nurses was not true. He had the support of his staff and hoped the Board would consider this as an appeal.

A. CEO REPORT

James E.T. Jackson, Chief Executive Officer

Trustee Garrett asked if they had specific timing on the hiring of the Chief Medical Officer and the Chief Human Resources Officer. Mr. Jackson said the bylaws required him to bring the CMO candidate to the Board and the CHRO was hired at his discretion, though he intended to bring both candidates to the Board for review. He hoped to do that at the next full meeting of the Board.

B. MEDICAL STAFF REPORTS

AHS Medical: Berenice Perez, MD, Chief of Medical Staff
AH Medical: Catherine Pyun, DO, Chief of Medical Staff

Trustee Linton asked if the imaging equipment needs discussed were being funded in the proposed budget. Dr. Mahler said the MRI wasn't owned, it was a contracted service. The CT scanner was old and there were times when the unit was down because it needed servicing. The ultrasound was a staffing issue that they were taking a multi-pronged approach to fix. They were working on fixing all of the issues, but the needs were diverse.

Trustee Sayen said the construction on the Posey and Webster Street Tubes into Alameda would clog up traffic and slow down medical transport for several years. Mr. Fratzke said they would need to chat with EMS about this.

Trustee Garrett said they saw the same report in QPSC as they did at the full Board meeting. Some things that are operational affect the budget. He considered that at the committee level they should get more specific details on projects then at the full Board meetings they should get a broader view.

Trustee Indulkar agreed and added that it was a balancing act between operations and clinical work. The business side of medicine was important as it kept operations going. They had to understand how to create that bridge between operations and clinical so that the budget decisions the Board made had some connection to what was being experienced on the clinical frontline side of the business.

Trustee Linton asked for an agenda item at an upcoming QPSC meeting to discuss how to coordinate the reports. It could be that they get a deeper dive at QPSC and they could pull out the more salient issues that the full Board needed to be aware of. Mr. Azizi said the purpose of the Committees was to do the legwork then bring the high level of what took place at the Committee meetings to the Board.

Trustee Sayen said there was value in hearing those items and the Joint Commission required that the Board spend a certain amount of time on quality items. It was a tricky balance. It wasn't for the full Board to take apart the committee's decisions, but they needed to understand them. He didn't want to hear less here at the Board meetings, but streamlined reports would be helpful.

Trustee Linton said they did have a deeper discussion about equipment challenges at the QPSC meeting. But it wasn't clear how they were resolving the problems that were brought to the Committee's attention. Some might be operational needs, and some might be equipment needs. Bringing those to the Board when they are issues that the Board may be able to solve is useful.

Trustee Indulkar said being clear about what the asks were would be helpful as well. That way the Board could be more focused on solutions.

Trustee Obligacion said it was important to understand the priorities so they could understand where they really needed to prioritize the spending now.

C. COMMITTEE AND TRUSTEE REPORTS

C1. Quality Professional Services Committee: May 28, 2025
Lilavati Indulkar, MD, Chair

C2. Finance Committee: June 4, 2025
Alan Fox, Committee Chair

Trustee Garrett asked about the offset on the NNB chart. Ms. Miranda said they wanted to set aside the one time funding for the skilled nursing pass through. They showed that they had to use it, or they would exceed the NNB.

Truste Garrett asked about the loss of personnel. Ms. Miranda said it was $9.6M and 10.9% to date. It's been jumping every month. Trustee Garrett said he wanted to highlight that as they had asked the leadership team to manage labor better, which resulted in some very difficult decisions.

Trustee Moss asked what the skilled nursing passthrough was. Ms. Miranda said it was a supplemental program. The skilled nursing benefits for Medi-Cal patients got moved under managed Medi-Cal. They were now paid by the Alliance. As a result, the State actually put up the local share for us. The pool itself grew as well. It was a one time pick up.

D. CONSENT AGENDA: ACTION

Trustee Sayen asked if there was any public comment on the consent agenda. Ms. Jojola Gonsalves said there was not.

D1. Recommendation from the Quality Professional Services Committee to approve the policies listed below:

- Antibiotic Desensitization Policy, Procedure and Protocol
- Oral Amoxicillin Challenge Policy and Procedure
- Medication Adverse Drug Reaction (ADR) Reporting
- Medication Heparin Continuous Infusion Policy
- MARIJUANA_RECREATIONAL AND_MEDICATION_USE Policy
- SYSTEM MEDICATIONS LOOK ALIKE SOUND ALIKE Policy
- Social Networking and other Web Based Communications Policy
- Internal Communications Policy
- AHS Bed Bug, Lice, Scabies Management Prevention Plan
- CARBAPENEM-RESISTANT ORGANISM (CRO) INFECTION PREVENTION AND CONTROL PLAN
- Blood Product Administration
- Critical Results and Critical Results Communication
- Patient Identification Policy
- HR SECTION 3.00 POLICY 3.24 Compliance Enforcement and Discipline
- Alameda Health System MRSA Policy

D2. Recommendation from the Quality Professional Services Committee to approve the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:
- Medical Staff Ongoing Professional Practice Evaluation (OPPE) Policy and Procedure
- Telemedicine Credentialing By Proxy

AHS Medical Staff:
- Medical Staff Committees
- Medical Staff Department Structure and Division Leadership

AH Medical Staff:
- Medical Staff Committees

Moved by Trustee Indulkar and seconded by Trustee Linton to approve the consent agenda.

ACTION: A motion was made and seconded to approve the consent agenda. A roll call was taken, and the motion passed.
AYES: Trustees Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen
NAYS: None
ABSTENTION: None

E. ACTION/DISCUSSION: Contracts

Trustee Sayen asked if there was any public comment on agenda item E. Ms. Jojola Gonsalves said there was not.

E1. Renewal agreement with Carefusion Solutions, LLC for provision of medication storage and dispensing cabinets. The term of this renewal agreement is effective date last signed for a term of 5 years. The estimated impact of this renewal agreement and additional funding for current services is $6,874,800.
Mark Fratzke, Chief Operating Officer

E2. Renewal agreement with Alameda County Sherrif's Office for provision of supplemental law enforcement services at Wilma Chan Highland Hospital. The term of this renewal agreement is July 1, 2025 through June 30, 2028. The estimated impact of this renewal agreement is $15,050,054.
Mark Fratzke, Chief Operating Officer

Moved by Trustee Linton Garrett and seconded by Trustee to approve agenda items E1 and E2.

ACTION: A motion was made and seconded to approve agenda items E1 and E2. A roll call was taken, and the motion passed.
AYES: Trustees Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen
NAYS: None
ABSTENTION: None

F. ACTION/DISCUSSION

F1. ACTION / DISCUSSION: Approval of the FY 26 Capital and Operating Budget

Kimberly Miranda, Chief Financial Officer

Trustee Sayen asked if there was any public comment on agenda item F1. Ms. Jojola Gonsalves said there was not.

Trustee Linton asked for a definition of EBIDA and an explanation of why it was important. Ms. Miranda said it was Earnings Before Interest, Depreciation, and Amortization. It typically was an indicator of cash flow. They have historically used that as their measure.

Trustee Garrett asked if the items on the Proposed Budget slide were non-cash items. Ms. Miranda confirmed that the items that took them from net income to EBIDA were non-cash items.

Trustee Linton asked if the information regarding the planning for St. Rose has been shared with the County. Ms. Miranda said they will typically share it at the County Health Committee meeting after the budget is passed by the Trustees. Trustee Linton said that it may be helpful for the Supervisors, as they contemplate adopting their own budget, to see that there was an issue with St. Rose as they looked at all the other needs in the County. Ms. Miranda said they had regular meetings with the County leaders to update them on these items. This would not be a surprise to them. Mr. Jackson said he also had regular meetings with the County leadership and will be happy to reaffirm this information with them.

Trustee Indulkar asked if the work committee was currently working on the physician FTE. Ms. Miranda said the work committee was approving FTE in real time. If a department needed an FTE that was not in the budget, it wasn't that they couldn't get it, there just needed to be a way to pay for it.

Trustee Indulkar asked if the revenue that was associated with the FTE that was hired was reflected in the budget. Ms. Miranda said there was usually a ramp up time, so the volumes may not cover their costs, particularly in the first year.

Trustee Garrett asked for clarification around the idea that they were justifying new physicians because there was volume and also saying that they needed volume to get the billing up. Dr. Mahler said some specialties were different. Hospital medicine and emergency medicine had enough volume that they needed more people to meet it. Other specialties needed to have volume built up or perhaps had a back log to fill.

Trsutee Garrett noted that registry was more expensive during the pandemic and now it was less expensive, even as they've been working so hard to reduce the use of registry. He still supported the initiative to have more staff who were invested in the agency versus registry staff.

Trustee Indulkar agreed that reducing registry was a great decision. The level of commitment by the staff on the floors who accept AHS as their home qas much better.

Trustee Linton agreed but added that the implications were such that there was a gap between the budgeted FTEs and the ones they had on board. They were not fully covering the number of positions they had and what was onboard. It was the right decision but there are consequences to the decision. Mr. Jackson said that there was an intangible here for the people who were committed to making this place their home. This is where they want to spend their career they were committed to AHS and the community and that was hard to quantify. If we are committed to providing the best care possible this was what we need.

Trustee Moss asked if there was a target number for registry FTEs needed to keep the baseline level for flexibility purposes or was the goal zero. Mr. Fratzke said the goal was zero, but it was nearly impossible. He wasn't aware of any hospital system that did not use travelers. He said he would chat with Ro Lofton and see if they could come up with a reasonable expectation.

Trustee Garrett noted that the Skilled Nursing Facilities at AHS had achieved that goal of zero registry workers.

Trustee Linton said the County had been pushing for AHS to take over the Santa Rita Jail health services contract. She was certain that should that happen, AHS would look for full cost recovery. That was one reason why the John George contract was important. The County could not assume that AHS was ready to cover these costs. Mr. Jackson said there had been conversations to that effect. AHS has not committed one way or the other. It was a fair point to ensure they would not subsidize the care. The County was a wonderful and fair partner. He expected that partnership would continue, should the Santa Rita contract come to pass.

Trustee Sayen said they had less people in 2019 than currently and more visits. Ms. Miranda said that was correct.

Trustee Garrett said staff was growing at a higher rate proportionately than visits were. Ms. Miranda said they did the benchmarking. They have had this conversation in the Finance Committee. Dr. Mahler said correct physician staffing could generate revenue. Being able to look at the service lines and where people were deployed and what they were doing was important.

Trustee Moss asked if adjusted patient days generally moved the same way as revenue. Ms. Miranda said they did not. If length-of-stay goes up, we have more adjusted days, but we don't get paid.

Trustee Linton asked if she heard staff say that our labor costs were higher than other safety nets. Ms. Miranda said it was a mixed bag. They could give an update on that at a future meeting.

Trustee Moss asked if the benchmark survey with FTI had been presented to the Board. Ms. Miranda said they gave us benchmarks, but they didn't provide a report on what AHS should do. Mr. Jackson said they could share that with the Trustees, but they did not want to make it a public document. Mr. Azizi said he'd have to determine if they could hear that item in closed session.

Trustee Linton asked if the NNB included St. Rose. Ms. Miranda said they did not include St. Rose in the budget. Because AHS gave them $12.2M it was in the final numbers, but the

projection did not include anything. Trustee Linton said if they had that $12M back in the budget they would be pretty close to the $90M. Ms. Miranda agreed. Trustee Linton asked if the cost of St. Rose would eventually be contemplated in the NNB. Ms. Miranda said AHS lived on a line of credit, so anything they bought or donated went against the NNB.

Trustee Garrett asked for a recap off the agreement to provide NNB funds to the benefit of St. Rose. Ms. Miranda said there was a line of credit, up to $15M. They did not borrow the whole $15M. They were paying AHS back the $11M that they borrowed, with interest, on Friday. The IGT has gone through. The projections showed they would not need to borrow more money this fiscal year.

Trustee Linton said there would be more discussions with the County about the line of credit. AHS was being asked to pay back issues that took place years ago. It was hard to do that when this administration and Board did not create the overages at the point in time that the payback began.

Trustee Linton asked what has held up the actual acquisition of the carried forward CAPEX items. Mr. Fratzke said the chart was somewhat deceiving. Most equipment was being purchased. There as a fair amount of very expensive year over year carryover projects. There was, for better or worse, a rigorous process for purchasing new equipment. Mr. Jackson said they were looking at ways to make that process more efficient by perhaps running the tasks in parallel rather than sequentially.

Trustee Linton asked why the Alameda Parcel Tax varied so much. It was $4.7M in FY24, was currently projected at $2.5M in FY25 and then back up to $4.1M. Ms. Miranda said the District Board had to pay their bills first. In FY25 they had to pay fees to get ready for the seismic updates.

Moved by Trustee Garrett and seconded by Trustee Obligacion to approve agenda item F1.

ACTION: A motion was made and seconded to approve agenda item F1. A roll call was taken, and the motion passed.
AYES: Trustees Garrett, Indulkar, Linton, Moss, Obligacion, Richman, Sayen
NAYS: None
ABSTENTION: None

F2. DISCUSSION: Behavioral Health Continuum Infrastructure Program (BHCIP)
Mark Fratzke, Chief Operating Officer
Christy Roberg, Vice President, Business Planning

Trustee Garrett asked what the estimate was for the amount of funds that would be needed to cover specific invoices until disbursements begin. Ms. Roberg said the architect has this broken down by month, and they could provide that to the Board. Trustee Garrett asked if there was any concern about using these funds. Mr. Fratzke said they were not worried as it was short term.

Trustee Sayen said they still needed to figure out the seismic concerns. Mr. Jackson said it would be ideal to weave the seismic needs into this funding. Ms. Roberg said they were planning on addressing the seismic needs of these two units with the funding.

Trustee Indulkar asked if they needed a geriatrician for a geriatric psych unit. Mr. Fratzke said it was not required. But it would be ideal to have one. Every single patient was served by a psychiatrist and followed up on by a doctor, it would be ideal to have a geriatrician.

Trustee Linton asked if AHS owned St. Rose. Mr. Azizi said AHS governs and controls St. Rose through their Board, but we do not own St. Rose. They are a non-profit owned by the St. Rose Board, which AHS has tremendous control over.

G. DISCUSSION: Board Calendar and Tracking

H. STAFF REPORTS (Written)

H1. Chief Financial Officer Report, April Financial Report
Kimberly Miranda, Chief Financial Officer

H2. Public Affairs and Community Engagement Report
Alice Kinner, Administrative Director

Mr. Azizi said the Board would meet in closed session to discuss the items set forth on the agenda.

CLOSED SESSION

1. CONFERENCE WITH LEGAL COUNSEL - EXISTING LITIGATION
(Paragraph (1) of subdivision (d) of Gov. Code § 54956.9)
Case name unspecified: Disclosure would jeopardize settlement negotiations
Ahmad Azizi, General Counsel

2. Public Employee Performance Evaluation
[Pursuant to Government Code Sections 54957(b)(1)]
Title: Chief Executive Officer

3. Regulatory Affairs, Risk Management, Patient Safety
[Health and Safety Code 101850(ai)(1)]

(Reconvene to Open Session)

Mr. Azizi said the Board met in closed session and there was no reportable action.

ADJOURNMENT: 8:34 pm

This is to certify that the foregoing is a true and correct copy of the minutes of the meeting of June 11, 2025 as approved by the Board of Trustees on July 9, 2025.

Ronna Jojola Gonsalves
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _____
Ahmad Azizi
General Counsel

D2. Recommendation to the Board of Trustees for approval of the System Wide Policies and Standardized Procedures listed below:

Alameda Health System			CPC Executive Summary to AHS and AH Medical Executive Committee(s) – June 2025			
Policies and Procedures				Chars: Dr. Bullard & Wacheera Davis		
TOPIC or TITLE OF POLICY	**Document Owners**	**Summary of Changes**	**Last Approved Date**	**Next review date after BOT approval**	**Purpose**	**History of Review Committee**
AHS System Wide Policies & Procedures						
Medication Drug Recall	Priya Patel, PharmD	• Change process of reporting drug recall from Midas to • System P&T approved 5/2025 • Consent Item – PolicyTech		06/2028		• System P&T 5/2025 • CPC 6/05/2025 • MEC 6/18/2025
Outpatient Pharmacy Dispensing	Nataliya Miller, PharmD	• TJC Triennial review • System P&T approved 5/2025 • Consent Item – PolicyTech		06/2028		• System P&T 5/2025 • CPC 6/05/2025 • MEC 6/18/2025

ALAMEDA HEALTH SYSTEM

MEDICATION: DRUG RECALL

Site	Alameda Health System	***Previous Revision Dates***	7/2017, 3/2020
Effective Date	6/2025	***Date Revised***	5/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	5/2028
Approvals	BOT, QPSC		

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POLICY

Pharmacy department promotes patient safety by immediate removal of unstable, improperly labeled, or otherwise unsuitable drugs for patient administration. The pharmacy department shall be responsible for the initiation and coordination of removing all medications identified for recall.

DEFINITIONS: Recalls are actions taken by a firm to remove a product from the market. Recalls may be conducted on a firm's own initiative, by FDA request, or by FDA order under statutory authority. Recall may be undertaken voluntarily and at any time by manufacturers and distributors, or at the request of the Food and Drug Administration. A request by the Food and Drug Administration that a firm recall a product is reserved for urgent situations and is to be directed to the firm that has primary responsibility for the manufacture and marketing of the product that is to be recalled.

1. **Class I recall:** a situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death.
2. **Class II recall:** a situation in which use of or exposure to a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.
3. **Class III recall:** a situation in which use of or exposure to a violative product is not likely to cause adverse health consequences.
4. **Market withdrawal:** occurs when a product has a minor violation that would not be subject to FDA legal action. The firm removes the product from the market or corrects the violation. For example, a product removed from the market due to tampering, without evidence of manufacturing or distribution problems, would be a market withdrawal.
5. **Voluntary Recalls:** Based on 21CFR7 Recall is a voluntary action that takes place because manufacturers and distributors carry out their responsibility to protect the public health and well-being from products that present a risk of injury or gross deception or are otherwise defective.

PROCEDURE

1. Upon receipt of "Drug Recall Bulletins" the pharmacy buyer, designated pharmacy technician(s) or pharmacist(s) under direction of pharmacist on duty or management will, within 72 hours. The designee (s) will check pharmacy stock, each nursing station/patient care area and for Class I and Class II agents, the sterile compounding log to identify any current patients who have received the product and take appropriate action as signified by the "Recall Notice" itself
2. Purchase histories are obtained to identify affected product in stock.
3. The buyer, pharmacist on duty or pharmacy staff designee will document "total number in stock" or "none in stock", whichever is applicable on the bulletin or manufacturer's return slip.
    a. For departments that have an automated dispensing machine, the pharmacy technician will remove/return all recalled medications for the pharmacist to sign off.
    b. Upon removal from storage areas, recalled medications will be quarantined in a designated area in the pharmacy until disposition. Documentation will be given to the pharmacy buyer and the Pharmacist-in-Charge (PIC) for verification.
    c. The following documentation will be completed for each recalled items:
        a. Date notified
        b. Date action taken
        c. Action taken: areas inspected, quantities removed, notification of shipment to wholesaler/manufacturer, notifications to prescribers and staff (if necessary),other actions required by the recall notice, law or regulation, and organizational policy
4. The documentation will be completed by the buyer, the Pharmacist-in-Charge (PIC), pharmacist on duty or a pharmacist designee.
5. The buyer, pharmacist on duty or pharmacy technician designee will process all paperwork, and notify the Pharmacist-in-Charge (PIC) or Pharmacy Director in case of any pertinent recalls.
    1. Pertinent recalls will be defined based on FDA classification Class I – III.
6. The pharmacy buyer or pharmacy technician designee is responsible for the proper handling and/or shipping of all recalled items.
7. If deemed appropriate, the medical staff will be informed through the AHS email system orat System P&T meeting,
8. Patients who may have received Class I or II recalled medications will be notified of the recall.
9. After all of the proceeding steps have been taken, pharmacy buyer or pharmacist-in-charge will complete recall documentation into the AHS ECRI Product Recall system in order to track all recalls and notify other potentially affected departments of the recall items.
10. If pharmacy has been advised that a patient has been harmed by using a non-sterile and/or sterile compounded product, pharmacy will report the event to MedWatch within 72 hours, and to AHS specific Midas event reporting immediately.
11. Pharmacy to contact the Board of Pharmacy within 12 hours of the recall notice if the use of or exposure to the recalled drug preparations has caused serious adverse health consequences or death.

REFERENCES

TJC MM05.01.17

21 CFR 7.40-59 Title 21 Chapter 7 SubPart C https://www.ecfr.gov/current/title-21/chapter-I/subchapter-A/part-7?toc=1

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	**Date:**	4/2025		
Pharmacy and Therapeutics (P&T)	**Date:**	5/2025		
Clinical Practice Council (CPC)	**Date:**	11/2022 6/2025		
Medical Executive Committee	**Date:**	6/2025		
Board of Trustees	**Date:**	7/2025		

ALAMEDA HEALTH SYSTEM

OUTPATIENT PHARMACY DISPENSING

Site	Highland/FMT/JGPH/ALH/SLH	***Previous Revision Dates***	3/2017,01/2022
Effective Date	8/05	***Date Revised***	4/2025
Document Owner	MGR SYS MED SAFETY-CLIN PHARM	***Next Scheduled Review***	4/2028

Printed copies are for reference only. Please refer to electronic copy for the latest version.

Purpose

To establish the process for the accurate, safe and compliant processing and filling of outpatient prescriptions at pharmacy locations where take-home medications are prepared.

Policy

1. Only prescriptions from Alameda Health System (AHS) patients, prescribed by AHS providers, as deemed eligible for 340B (when processed at 340B-sites), will be processed, filled and dispensed.
    a. Prescriptions sent with a corresponding referral documentation may be processed.
    b. For 340B eligible sites, refer to requirements and procedures set forth in the 340B Policy.
2. Proper use of robotic filling devices or automatic delivery device systems (ADDS) and pharmacy software systems, such as Epic-Willow and Willow Ambulatory software equipment and respective bar-coding using National Drug Codes (NDC's) will be used to lessen the risk of dispensing errors.
    a. Examples of automatic delivery devices and storage devices include: ScriptPro, Parata, Pyxis, RxSafe.

Procedure

1. The pharmacy will ensure the patient is registered within the Epic system.
2. For 340B sites, the pharmacy will ensure the patient is eligible under340B eligible, before proceeding.
3. All prescriptions will be checked for accuracy, drug-drug interactions, allergy, drug-disease interactions, and completeness at clinical review, point of take-in, or order entry.
    a. If clarifications are needed or concerning red flags arise, provider and/or patient will be contacted to facilitate resolution.
4. All pharmacy regulations must be followed, including but not limited to Board of Pharmacy requirements, DEA requirements, HRSA 340B requirements.
5. Receipt of controlled substance prescriptions should be in electronic format via DEA compliant systems, such as Epic software system.

6. Pharmacy may continue to dispense medications from legally valid written, oral, or faxed prescriptions pursuant to Board of Pharmacy- Business and Professions Code Subdivision 688(i).
    a. In the case where a directly printed prescription order is received, only Schedule II-V medications must be on a compliant prescription form with a serialized barcode.
        i. Telephone prescriptions may be accepted for non-control or schedule III-V medications if there is an IT barrier with sending an electronic prescription, or other applicable parameters as listed within Business and Professions Code 688.
            1. Faxed prescriptions are only accepted if sent from a secure number, for non-control or schedule III-V.

7. Medications will be pulled and filled in in a manner that ensures accuracy, package integrity, quality, storage and safe handling.

8. Prescriptions may interface with an automatic delivery device system (ADDS), if the medication is loaded into the device.
    a. Highland Outpatient Pharmacy Only: prescriptions filled via ADDS will be done with ScriptPro.
        i. Routine maintenance of the ScriptPro machine will be performed according to manufacturer's guidelines to ensure the cells are calibrated appropriately and cleaned to reduce dust particles.
        ii. Random audits will be conducted to ensure correct dispensation of medications.
        iii. Pharmacists or Epic-Willow analysts are responsible for updating the NDC that is loaded into the ScriptPro and linking it in Epic.
        iv. Pharmacy personnel are responsible for refilling the ScriptPro cells with the correct medication and updating the expiration date and lot numbers on the cells.
    b.

9. The pharmacist will verify prescriptions at the verification step to ensure proper the medication was accurately filled, ensure proper labeling and printing of medication guides and monographs.

10. All prescription labels will be completed with expiration date and initials of reviewing pharmacist and if applicable, filling technician..

Lot or batch number will be included for compounded medications. -.

11. The Epic-Willow trainer is responsible for systems training; the Epic security team is responsible for assigning user access.

12. If applicable, co-pays or share of cost are collected at the point of dispensation (refer to Cash Control Policy and Medication Discharge Policy).

13. All pharmacy personnel will dispense medications to the patient, nurse, provider, clinic team member, or patient's agent using two patient identifiers (name, social security number and/or date of birth, MRN, address, phone number).
    a. Proof of identification is required when patients are picking up CII-V medications.

14. All of the patient's prescription information will appear within Epic point of sale. The technician or pharmacist will verify the number of prescriptions and medications with the patient or patient's agent.

15. The patient or patient's agent will sign for or notate receipt of the medication.
16. Consultation will be provided for the following:
    a. For new medications
    b. For medications dispensed in a different dosage form, strength, or with new directions
    c. Upon request from the patient or provider
    d. Whenever pharmacist deems it is warranted

    Consultation declinations may only be provided to a pharmacist or intern-pharmacist (under direct pharmacist supervision).
17. If consultation is requested, only a registered pharmacist or intern under the direct supervision of the pharmacist is authorized. The pharmacist will provide the following at a minimum (patient information sheets may also be provided):
    a. Name of medications
    b. Indications if known
    c. Directions for use
    d. Potential Drug-food or drug-drug interactions
    e. Potential side effects
    f. Essential storage information
    g. Any other pertinent information

18. For medications that are delivered to the patient by a healthcare provider or team member, nurse, or through the courier delivery process, patient will be provided a consultation notice with instructions to contact the pharmacy to review their medications.
    a. For medications that are delivered through the meds-to beds- process, to the nurse or nursing unit or emergency room, the provider or nurse will provide the patient teaching and consultation.
19. Prescriptions will be profiled or returned to stock in the following situations:
    a. Prescriptions are received and are too soon based on last filled date, or are not yet due for the patient
    b. Prescriptions that are not picked up or fail courier delivery
    c. Upon request of patient, patient's agent, or provider
20. For Highland Outpatient Pharmacy only: Patients may request refills by doing any of the following:
    a. Coming to the pharmacy during business hours
    b. Accessing MyChart

c. Calling the pharmacy and placing a request with pharmacy personnel
d. Calling the pharmacy and requesting refill automatically via IVR

Approvals

Departmental	**Date: 1/2022, 4/2025**
System Pharmacy and Therapeutics Committee	**Date: 2/2022, 5/2025**
Clinical Practice Committee	**Date: 3/2022, 6/2025**
Medical Executive Committee	**Date: 3/2022, 6/2025**
Board of Trustees	**Date: 4/2022, 6/2025**

D3. Recommendation to the Board of Trustees for approval of the AHS Medical Staff Policies and Procedures listed below:

ALAMEDA HEALTH SYSTEM

June 25, 2025

TO: Quality Professional Services Committee

FROM: Berenice Perez, M.D., Alameda Health System Chief of Staff
Catherine Pyun, D.O., Alameda Hospital Chief of Staff

SUBJECT: **Agenda Item:** A3

Meeting Date: June 25, 2025

Item Description: Medical Staff Policies and Procedures

COMMITTEE ACTION: **Recommend Approval of Medical Staff Policies and Procedures**

Background:
The Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff align policies and procedures to provide continuity across the two Medical Staffs.

The Medical Staff policies provide alignment of credentialing and privileging processes by offering a systematic approach to assessment across our facilities.

Analysis:
The Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff policies align with the Bylaws and are key to the operational functions and compliance with regulatory requirements.

Board Action Requested: Approval

AHS and AH Medical Staff:
- Identifying and Credentialing HIV/AIDS Specialists

AHS Medical Staff:
- Medical Staff Department Structure and Division Leadership
- Introduction of a New Privilege or New Privilege for a Specific Department or Specialty

Alameda Health System

IDENTIFYING AND CREDENTIALING HIV/AIDS SPECIALISTS

Department	Medical Staff	***Effective Date***	3/2018
Campus	AHS, AH	***Date Revised***	3/2022; 2/2023; 5/2023; 6/2025
Unit	Medical Staff	***Next Scheduled Review***	6/2029
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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Purpose

This policy as an extension of the Medical Staff Bylaws, Rules and Regulations and Policies of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs, establishes the verification steps for designation of HIV/AIDS physician specialists.

Policy Statement

This policy of the Medical Staff at Alameda Health System (AHS) and Alameda Hospital (AH) is to ensure that HIV/AIDS specialists wishing to be designated as such are identified and meet the qualifying criteria as defined by the California State Regulations.

Procedure

1. Annually, the Medical Staff Department verifies the HIV/AIDS credentials of any physician requesting to be so designated based upon the criteria of an HIV/AIDS Specialist according to California State regulations prior to being listed as an HIV/AIDS Specialist.

2. The physician will be required to complete the form which includes attestation of the required qualifications of an HIV / AIDS specialist (Attachment A). This form will be maintained in the physician's credentials file and made available, electronically, to the respective department(s) requiring notification.

3. The Medical Staff Department's Provider Enrollment Services provides a list of identified qualifying physicians to the payors.

4. In accordance with the Alameda Health System Confidentiality Policy and all applicable state and federal laws, any and all information that is required to be kept confidential, shall be kept confidential.

5. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:

a. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
b. The nurse practitioner or physician assistant meets the qualifications specified in subsection (e)(4); and
c. The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient.

Definitions / Acronyms

A. AIDS means Acquired Immunodeficiency Syndrome
B. HIV means Human Immunodeficiency Virus
C. Category 1 continuing medical education means continuing medical education courses recognized as qualifying for category 1 credit by the Medical Board of California
D. HIV/AIDS Specialist means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:
   1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or
   2. Is board certified in HIV Medicine, or has earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties; or
   3. Is board certified in the field of Infection Diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
      a. In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
      b. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuous medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year; or
   4. In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and has completed any of the following:
      a. In the immediately preceding 12 months has obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; or
      b. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
      c. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV

Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Resources

- Alameda Health System and Alameda Hospital, Medical Staff Bylaw, Rules & Regulations, Policies and Procedures.
- Cal. Code Regs. Tit. 28, § 1300.74.16
- H&SC, Division 2, Chapter 2.2, § Article 5 1374.16

Approvals:

		AHS Core	AH
Credentials Committee	**Date:**	**6/12/25**	
Medical Executive Committee	**Date:**	**6/18/25**	**6/20/25**
QPSC	**Date:**	**6/25/25**	

ALAMEDA HEALTH SYSTEM

Letter to Practitioner
Screening for Identification of Qualified HIV/AIDS Practitioners

[Date]

[Insert practitioner's name]
[Insert address]
[Insert City, State Zip]

Dear Doctor [name],

California Health & Safety Code (CA H&SC) 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative, or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

California code 28 CCR1300.74.16 (e) establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

In order to comply with this regulation, we need to routinely identify appropriately qualified specialists within the payer networks who meet the definition of an HIV/AIDS specialist. Please complete the attached form indicating:

• Your preference to be listed as a qualifying HIV/AIDS specialist for the purpose of receiving standing referrals for members whose condition requires ongoing treatment by a practitioner with the specified expertise in treating their condition.

• If you state you wish to be listed for purposes of standing referrals, then please indicate the criterion or criteria, as defined by state regulation, under which you qualify. You must meet at least one of these criteria as written in order to qualify.

We will provide your information to the payers for internal referral procedures.
As always, please notify us promptly if information about your clinical practice changes.

Thank you for your cooperation. We appreciate your continued dedication to our patients.
Sincerely,

Alameda Health System Medical Staff Services

ALAMEDA HEALTH SYSTEM

Medical Staff HIV/AIDS Specialist Designation Form

□ No, I do not wish to be designated as an HIV/AIDS specialist.

□ Yes, I do wish to be designated as an HIV/AIDS specialist based on one of the criteria below:

□ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine ***OR***
□ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. ***OR***
□ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
2. In the Immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV Infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year ***OR***

□ Meet the following qualifications:
In the Immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND** Completed any of the following:

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; ***OR***
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category I continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; ***OR***
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category I continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Physician's Name (print): _____ Date:_____
Physician's Signature: _____ License#: _____
Physician's NPI: _____Telephone #: _____

Alameda Health System

MEDICAL STAFF DEPARTMENT STRUCTURE AND DIVISION LEADERSHIP

Department	Medical Staff	***Effective Date***	9/2023
Campus	AHS	***Date Revised***	1/24/24, 1/29/25, 5/21/25, 6/18/25
Unit	All	***Next Scheduled Review***	6/2028
Manual	Medical Staff	***Author***	Vice Chief of Staff
Replaces the following Policies:		***Responsible Person***	Chief of Staff

Printed copies are for reference only. Please refer to electronic copy for the latest version.

Purpose

To outline the organization of Clinical Departments and their Divisions within the Alameda Health System Medical Staff and define the process for their Leadership.

Policy

The Alameda Health System Medical Staff (AHS) divides the governance of the Medical Staff into Clinical Departments and their Divisions.

The Medical Executive Committee will periodically review the designation of the Departments and what action is desirable in creating, eliminating, or combining them for better organizational efficiency and improved patient care. Subsequent action shall be solely effective upon approval by the Medical Executive Committee.

Procedure

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chair selected and entrusted with the authority, duties, and responsibilities specified in the Medical Staff Bylaws.

A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which they function, and a Division Chief shall be selected and entrusted with the authority, duties and responsibilities specified. When appropriate, the affected Department Chair(s) may recommend to the Medical Executive Committee the creation, elimination, modification, or combination of divisions.

Clinical Departments

Clinical departments and Divisions shall be approved by the Medical Executive Committee and be under the supervision of the Chief of Staff. Their scope of services shall include leadership roles to assure their adequacy for quality of care, patient safety, and clinical efficiency of services.

The Medical Executive Committee will periodically review the designation of the Departments in creating, eliminating, or combining Departments for better

organizational efficiency and improved patient care. Action shall be solely effective upon approval by the Medical Executive Committee.

There shall be the following Departments and Divisions under the supervision of the Chief of Staff:

a. Ambulatory Care and Preventive Medicine
    i. Urgent Care
b. Anesthesiology, Perioperative and Pain Medicine
    i. Pain Medicine
c. Emergency Medicine
    i. Addiction Medicine
    ii. Community Emergency Medicine
d. Medicine
    i. HIV Services
    ii. Cardiology
    iii. Pulmonary and Critical Care Medicine
    iv. Dermatology
    v. Endocrinology
    vi. Gastroenterology
    vii. Geriatrics
    viii. Hematology and Oncology
    ix. John George and Fairmont Internal Medicine
    x. Infectious Disease
    xi. Hospital Medicine
    xii. Nephrology
    xiii. Neurology
    xiv. Palliative Care
    xv. Primary Care Medicine
    xvi. Rheumatology
e. Obstetrics, Midwifery and Gynecology
    i. Family Planning
    ii. Gynecology
    iii. GYN Oncology
    iv. Maternal Fetal Medicine
    v. Obstetrics
    vi. Urogynecology
f. Orthopaedic Surgery
    i. Podiatry
    ii. Physical Medicine and Rehabilitation (PM&R)
g. Pathology & Laboratory Medicine
    i. Anatomical Pathology
    ii. Laboratory Medicine (Clinical Pathology)
h. Pediatrics

    i. Ambulatory Pediatrics
    ii. Newborn Services
i. Psychiatry
    i. Inpatient Psychiatry
    ii. Psychiatry Emergency Services
j. Radiology/Imaging
    i. Breast Imaging
    ii. Interventional Radiology
k. Surgery
    i. Dentistry
    ii. General Surgery
    iii. Neurological Surgery
    iv. Ophthalmology
    v. Optometry
    vi. Oral Maxillofacial Surgery
    vii. Otolaryngology
    viii. Plastic Surgery
    ix. Surgical Critical Care
    x. Trauma Surgery
    xi. Urology

Creation of Divisions

Departments may propose a new division to the Medical Executive Committee. The designation of a Division Chief is designed to effectively assist the Department Chair in leading credentialing and privileging, clinical care, operations and education within the specialty.

Consideration and the criteria for a new division shall be determined by the Department Chair in consultation with the Chief of Staff (COS) for quality and peer review considerations, and the Chief Medical Officer (CMO) for allocation of administrative time and support. This shall be summarized in a written request to the COS. The MEC shall review the request, may request a presentation and further details, and vote to approve the new division by majority vote (as defined in the Medical Staff Bylaws). The COS will report on the creation of a division to the BOT.

Elimination of Divisions

Consideration for eliminating a division shall be presented to MEC. MEC may request further details and/or a presentation and vote to approve the elimination by majority vote (as defined in the Medical Staff Bylaws).

Assignment to Departments and Divisions
Each member shall be assigned primary membership in at least one department, and to a division, if any, within such department. They may also be granted clinical privileges in other departments or divisions consistent with practice privileges granted.

Functions of Divisions
Subject to the approval of the Medical Executive Committee, each Division Chief shall perform the functions assigned to it by the Chair of Department. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review, privilege delineation, and continuing education programs. The Division Chief shall transmit regular reports to the Chair of the Department on the performance of their assigned functions.

Division Chief Qualifications
Each Division Chief must be an Active Staff member or a Provisional Staff member and a member of the division. The Division Chief must be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Department/Division.

All Division Chiefs appointed after May 1, 2003, shall be:

a. board certified by an appropriate specialty board approved by the American Board of Medical Specialties or American Osteopathic Association, **or** have successfully completed an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved residency training program and achieve board certification within three (3) years of board eligibility; or

b. be board certified by the American Board of Podiatric Surgery **or** have completed a podiatric residency program approved by the Council on Podiatric Medical Education and achieve board certification within three (3) years of board eligibility; or

c. be board certified by the American Board of Oral and Maxillofacial Surgery as recognized by the American Dental Association **or** have successfully completed a residency program in an accredited oral and maxillofacial surgery program recognized by the American Dental Association and achieve board certification within three (3) years of board eligibility.

Division Chief Appointment and Removal
A Division Chief shall be appointed by the Chair of the Department after careful review of the candidate's qualifications. Such appointments shall be made in consultation with the CMO and the COS, and with approval of the Medical Executive Committee.

The Division Chief's performance shall be periodically reviewed by the Chair of the Department and the appointment shall continue if performance is satisfactory.

A Division Chief will immediately cease being the Division Chief upon any of the following:

a. They resign.

b. They are no longer an Active or Provisional Staff member.

c. They are removed by the Chair of the Department with the concurrence of the Chief of Staff and reported to the Medical Executive Committee.

- Such removal shall have no effect on the individual's clinical privileges or Medical Staff membership and is not subject to hearing procedures described in Article 9 of the Bylaws.

d. Their Division is eliminated.

Division Chief Duties

a. act as presiding officer at Division meetings;

b. assist in the development and implementation, in cooperation with the Chair of the Department, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the Division;

c. evaluate the clinical work performed in the Division;

d. conduct inquiries and investigations and submit reports and recommendations to the Chair of the Department;

e. recommend to the Chair of the Department, specific clinical privileges for providers requesting clinical privileges in the department/division; and

f. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chair of the Department, the Chief of Staff or the Medical Executive Committee.

Site Director Qualifications

Each Site Director must be an Active Staff member or a Provisional Staff member and a member of the department. The Site Director must be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Department.

Site Director Appointment and Removal

A Site Director shall be appointed by the Chair of the Department after careful review of the candidate's qualifications. Such appointments shall be made in consultation with the CMO and the COS, and with approval of the Medical Executive Committee.

The Site Director's performance shall be periodically reviewed by the Chair of the Department and the appointment shall continue if performance is satisfactory.

A Site Director will immediately cease being the Site Director upon any of the following:

a. They resign.

b. They are no longer an Active or Provisional Staff member.

c. They are removed by the Chair of the Department with the concurrence of the Chief of Staff and reported to the Medical Executive Committee.

- Such removal shall have no effect on the individual's clinical privileges or Medical Staff membership and is not subject to hearing procedures described in Article 9 of the Bylaws.

d. Their Site Director role is eliminated.

Site Director Duties

a. assist in the development and implementation, in cooperation with the Chair of the Department, of programs to carry out the quality review, and evaluation and monitoring functions;

b. evaluate the clinical work performed at the site;

c. conduct inquiries and investigations and submit reports and recommendations to the Chair of the Department;

d. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chair of the Department, the Chief of Staff or the Medical Executive Committee.

Approvals

		AHS
Medical Executive Committee	**Date:**	**6/18/2025**
Quality Professional Services Committee of the Board	**Date:**	

Alameda Health System

INTRODUCTION OF A NEW PRIVILEGE OR A NEW PRIVILEGE FOR A SPECIFIC DEPARTMENT OR SPECIALTY

Department	Medical Staff	***Effective Date***	4/2003
Campus	AHS, AH	***Date Revised***	2/2008, 10/2011, 6/2014, 6/2017, 6/2019, 6/2022, 6/2025
Unit	Medical Staff	***Next Scheduled Review***	6/2028
Manual	Medical Staff	***Author***	Vice President, Physician Services
Replaces the following Policies:		***Responsible Person***	Chief Medical Officer

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Purpose

As medical technology changes, the types of services provided by the Medical Staff also change. As medical technology changes the groups of practitioners within the Medical Staff providing a specific clinical service or procedure may also change. The purpose of this policy is to define the procedure for introducing a new privilege into the Medical Staff or introducing a new privilege into a specific department or specialty.

Policy

All practitioners who provide clinical services at Alameda Health System (AHS) and Alameda Hospital (AH) must be competent to perform the services they provide. When members of different departments or specialties exercise the same privilege, there must be an equivalent comparable standard for the granting of the same clinical privilege in each department or specialty.

Procedure

Introducing a new procedure to AHS and AH

1. If a practitioner or group of practitioners (collectively referred to as "Medical Staff Members") wish to exercise a new privilege at AHS and AH , the Medical Staff Members shall submit the request for the new privilege in writing to the Division Chief (if applicable), Site Director, Department Chair, or Chief of Staff.

2. The Medical Staff Members' request for a new privilege should include the following information:
    a. A detailed description of the privilege.
    b. Copies of scientific articles related to the privilege.
    c. Recommendations for specific training and education necessary to be granted the new privilege.
    d. Recommendations for specific experience and current competence necessary to be granted the new privilege.
    e. Recommendations for proctoring requirements to the new privilege.

   f. Recommendations for the number of times the privilege must be exercised or performed during a two- (2) year reappointment cycle in order to maintain current competence.
   g. Other information that is relevant and required in Attachment A

3. If the new privilege is an update or replacement of an existing privilege and no new additional credentialing criteria are required, this information shall also be submitted to the Division Chief/ Site Director.

4. The Division Chief/Site Director shall review the information submitted and make a recommendation to the Department Chair regarding the addition of the new privilege, and if addition of the privilege is recommended, a recommendation also shall be made regarding criteria for the new privilege. The Division Chief's/Site Director's recommendation shall address items A2 (c-f) described above and include a copy of all relevant supporting documents.

5. The recommendation of the Division Chief/Site Director shall also include submission of Attachment A —"Criteria for New Privilege Delineation."

6. The Department Chair shall review the information submitted and make a recommendation to the Credentials Committee regarding the addition of the new privilege, and if addition of the privilege is recommended, a recommendation also shall be made regarding criteria for the new privilege. The Department Chair's recommendation shall address items A2 (c-f) described above and include a copy of all relevant supporting documents.

7. The recommendation of the Department Chair shall also include submission of Attachment A.

8. The Credentials Committee shall review the recommendation of the Department Chair and shall:
   a. Meet with a representative of the Medical Staff Members requesting the new privilege.
   b. Submit a recommendation to the Medical Executive Committee regarding whether the new privilege should be introduced at AHS and, if so, the specific credentialing criteria to be utilized.

9. The Medical Executive Committee shall review the recommendation of the Credentials Committee and may request an interview with a representative of the Medical Staff Members requesting the new privilege. The recommendation of the Medical Executive Committee regarding the new privilege, including the criteria for granting the new privilege, will be forwarded to the Quality Professional Service Committee (QPSC) of the Board of Trustees for action.

10. Once a new privilege has been approved by favorable recommendation of the Medical Executive Committee, practitioners who meet all applicable criteria may begin to apply for the new privilege. No new privileges will be granted, however,

until the new privilege and associated criteria have been reviewed and approved by the QPSC and appropriate organizational and nursing policies and procedures have been developed and implemented as may be necessary to support the safe and effective performance of the new privilege.

Introducing a new privilege in one department which is currently being granted by another department or specialty

1. The Department Chair, upon recommendation by the Division Chief/Site Director, shall recommend to the Medical Executive Committee the addition of the new privilege to the department privilege delineation form.

2. If the Medical Staff is not currently utilizing appropriate criteria for the privilege, the procedure described in Section A shall be followed to develop appropriate criteria. All departments or specialties that will be granting the privilege will be involved in the criteria development process. The recommendations of this interdepartmental group shall be submitted to the Medical Executive Committee for action.

3. If appropriate criteria for the privilege have already been developed, a meeting will be scheduled to include the Division Chief/Site Director, the Department Chair, and specialty representatives from each department in which the privilege is currently granted and those departments who wish to grant the clinical privilege in the future. The interdepartmental group will meet to assure either development of single criteria that are applicable to all departments and specialties **or** development of multiple equivalent comparable criteria sets.

4. If multiple equivalent comparable criteria sets are designed, the interdepartmental group must assure that a single level of care is maintained relevant to granting of the privilege.

5. The interdepartmental group shall submit a recommendation to the Medical Executive Committee for action.

6. If the interdepartmental group is unable to arrive at consensus related to privilege criteria, the issue will be referred to the Medical Executive Committee for evaluation and action.

7. The Medical Executive Committee may recommend privileging criteria to the QPSC with or without the recommendation of the interdepartmental group.

Medical Executive Committee's Considerations

1. In making a recommendation regarding the granting of a new privilege or extending an existing privilege to a new department or specialty, the Medical Executive Committee shall consider the following:

a. Whether the new privilege may be performed safely using the health system's available resources including facilities, equipment, support personnel, and support services.
b. Whether the current composition of the Medical Staff permits its members to appropriately monitor and review the competence of those who perform the new privilege or whether it is feasible to arrange to have other qualified physicians proctor performance of the new privilege.
c. Whether qualified physicians are available to provide continuous care in the event physicians performing the new privileges are unavailable or ill.
d. Whether sufficient research has been conducted to determine the new privilege is safe and clinically efficacious.
e. Whether the performance of the new privilege poses any bioethical concerns.
f. Whether the benefits of the new privilege outweigh the consequences of not exercising the new privilege.

2. The Medical Executive Committee shall also consider information available from other organizations currently performing the new procedure and/or other organizations that have extended the new privilege to additional departments or specialties.

Quality Monitoring

1. When the Medical Staff has added a new privilege, or a new privilege has been added to a particular department or specialty, the VP/Director of Quality Management (or designee) shall be notified.

2. The VP/Director of Quality Management (or designee shall work with appropriate Medical Staff representatives to determine if and how the new privilege shall be included in the organization's performance improvement program.

3. The Medical Executive Committee, prior to granting the privilege to any Medical Staff Member, shall review issues regarding quality management monitoring related to the privilege.

Approvals

		AHS	Alameda
Medical Executive Committee	**Date:**	**6/18/2025**	**6/20/2025**
QPSC	**Date:**		

ATTACHMENT A

Introduction of a New Privilege or a New Privilege for a Specific Department or Specialty

CRITERIA FOR NEW PRIVILEGE DELINEATION

SPECIFIC PROCEDURE:

DEPARTMENT/DIVISION:

DESCRIPTION:

Training & Education

Experience & Current Competence

Proctoring Requirements

Reappointment Requirements

Recommend ☐ As submitted ☐ With the following modifications

Approval:
Department Chair : _____ Date : _____

Division Chief :_____ Date : _____

D4. Contracts

Contract Approvals
July 2025

1. Renewal agreement with Alliance HealthCare Services, Inc. dba Alliance HealthCare Radiology for provision of mobile imaging services. The term of this renewal agreement is effective April 23, 2025 through April 22, 2028. The estimated impact of this renewal is $3,333,044.
Mark Fratzke, Chief Operating Officer

2. Renewal agreement with CareFusion Solutions, LLC for provision of infusion pumps and supplies. The term of this renewal agreement is effective August 19, 2025 through August 18, 2030. The estimated impact of this renewal agreement is $7,206,000.
Romoanetia Lofton, Chief Nursing Executive

3. Renewal agreement with East Oakland Community Project for provision of respite care services. The term of this renewal agreement is effective August 1, 2025 through July 31, 2028. The estimated impact of this agreement is $1,593,600.
Romoanetia Lofton, Chief Nursing Executive

Contract Approvals
July 2025

4. Renewal agreement with The Regents of the University of California on behalf of the University of California, San Franciso, Department of Neurological Surgery for provision of professional neurosurgery services. The term of this renewal agreement is August 1, 2025 through July 31, 2027. The estimated impact of this renewal agreement is $7,594,371.

Elizabeth Mahler MD, Chief Medical Officer

Recommendation: Motion to Recommend Approval for the above contracts to the Board of Trustees

<table>
<tr><td>Contractor/
Vendor Name:</td><td>Alliance HealthCare Services, Inc. dba Alliance HealthCare Radiology (“Alliance”)</td></tr>
<tr><td>Description:</td><td>Alliance HealthCare Services, Inc. is a provider of imaging services. Alliance is part of Akumin, Inc., which acquired Alliance in 2017. Per terms of the current arrangement between Alameda Health System (“AHS”) and Alliance, vendor places a mobile magnetic resonance imaging (“MRI”) trailer at Alameda Hospital (“AH”) staffed by Alliance personnel, including 1 technician to operate the MRI and 1 patient coordinator to assist the technician, to support imaging services to the local community. The placement of the trailer allows for rapid patient MRI services keeping patients within the system and revenue in-house. The trailer is available for MRI procedures seven days a week for eight hours each day for both inpatient and outpatient imagery. Outpatient imagery includes Emergency Department services.

Alliance is a California-based provider of mobile imaging services. Mobile imaging affords AHS flexible access to advanced imagining services without the onerous capital and space commitments associated with direct ownership. This in addition to the ability to respond to changes in imaging demand at the facilities served make utilization of the Mobile MRI the preferred solution to our community hospital MRI needs and Alliance the preferred provider of those Services.

In light of the importance of maintaining cost-effective access to MRI services for our AH patients, AHS leadership recommends Board approval for continuing mobile MRI services from Alliance (“Renewal”) on the terms described above and below.

The cost of 36-month renewal is estimated as follows:

<table>
<tr><th>Year 1</th><th>Year 2</th><th>Year 3</th><th>Total</th></tr>
<tr><td>$
995,331.50</td><td>$
1,076,451.02</td><td>$
1,164,181.78</td><td>$
3,235,964.30</td></tr>
</table>

Pricing is per procedure. The volume of MRI procedures performed using the AH trailer has been increasing at the rate of 5% annually. Pricing terms remain unchanged from Current Agreement.</td></tr>
<tr><td>Contract Type and Term:</td><td>Renewal
Contract Term: April 23, 2025 through April 22, 2028</td></tr>
<tr><td>Termination Clause:</td><td>Client may terminate this Agreement if Alliance does not provide service which is in material accordance with industry standards provided that Client has provided Alliance with written notice of such deficiency within thirty (30) days of such notice. Client and Alliance shall act in good faith to resolve any disputes as to the quality of service provided. If Alliance has not corrected such deficiency, this Agreement can terminate sixty (60) days following the end of the correction period.</td></tr>
</table>

<table>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>36-Month Renewal Period 4/23/2025- 4/22/2028</td><td></td><td>$3,235,965</td></tr>
<tr><td>Contingency of 3%</td><td></td><td>$97,079</td></tr>
<tr><td>Total Estimated Spend:</td><td>Approval Requested</td><td>$3,333,044</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>Annual pricing increases are tied to the Consumer Price Index and limited to the anniversary of the commencement date.</td></tr>
<tr><td>Fiscal Implications:</td><td>This agreement has been included in the budget for FY26.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>Alliance is the recognized leader in provision of Mobile MRI services nation-wide and has a proven record of providing reliable, affordable and high-quality Services at AHS. In light of that record and our ongoing need for these Services, AHS leadership recommends approving the extension addendum on the terms discussed above.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td></td><td></td><td></td><td></td><td>X</td><td></td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>This agreement was reviewed by the Chair of Radiology.</td></tr>
<tr><td>Administrative Review:</td><td>Primary: Chief Operating Officer
Secondary: System Director of Imaging Services</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>In October 2019, the Board approved a contract with Alliance for mobile MRI services.</td></tr>
<tr><td>Executive Sponsor:</td><td>Chief Operating Officer</td></tr>
</table>

Contractor/Vendor Name:	CareFusion Solutions, LLC ("CareFusion")
Description:	CareFusion is a medical technology company specializing in providing medical devices, equipment, and related services to public health agencies such as Alameda Health System (AHS). AHS currently obtains a fleet ("Fleet") of rental infusion pumps under agreement ("Current Agreement") with a different vendor ("Incumbent"). Infusion pumps are used widely across the spectrum of care to administer large-volume intravenous medications in both inpatient and outpatient settings. The current Fleet is approaching end-of-life with FDA designation for discontinuation effective June 30, 2026. In order to comply with FDA requirements and ensure uninterrupted delivery of infusion services to our patients, AHS leadership has negotiated a more cost-effective arrangement ("New Arrangement") with CareFusion under which AHS will purchase a new Fleet of smart infusion pumps. CareFusion will also provide support and maintenance for the new Fleet (equipment and software) as well as supply AHS with the disposable components ("Disposables") required to operate the infusion pumps. As part of the Fleet replacement effort, AHS will be upgrading to "smart" infusion pumps. These pumps will interface with Epic allowing more precise monitoring and documentation of infusion therapy encounters. Roll-out of the new pumps and integration with Epic will take place over the next 9-12 months with full go-live anticipated prior to the June 30, 2026 FDA deadline. AHS leadership negotiated significant discounts on the New Arrangement terms, as described below: 1. New Infusion Pumps & Software – 37% reduction over initial quote resulting in $2,561,000 cost over the proposed 5-year term. 2. Disposables – 9% reduction over initial quote resulting in $4,645,000 cost over the proposed 5-year term.
Contract Term:	Contract August 19, 2025 – August 18, 2030
Termination Clause:	Termination for Cause. Either party may terminate for cause the then-remaining performance of any Customer Agreement upon written notice if the other party: (i) fails to comply with any material term or condition of any agreement between the parties; and fails to cure such non-compliance within thirty (30) days after receipt of written notice providing full details of such non-compliance; (ii) terminates or suspends substantially all of its business activities; or (iii) becomes subject to any bankruptcy or insolvency proceeding. Upon any such termination, CareFusion may repossess Equipment subject to any outstanding payment obligations. Notwithstanding the foregoing, Customer's obligation to pay for any Products that it has accepted will not be affected by any termination under this Section.

Total Spend with Vendor:

Description	Board Approval	Total
Infusion Pump Purchase and Maintenance		**$2,561,000.00**
Disposables Accessories for Infusion Pumps (5 Years)		**$4,645,000.00**
Total Estimated Spend:	**Approval Requested**	**$7,206,000.00**

Estimated Cost Savings:

There are a number of cost savings associated with this New Arrangement, including negotiated reductions over list price agreed to by CareFusion, rental costs avoided, as well as increased revenues. Details below:

1) $1,489,000 discount on infusion pump purchase and maintenance;
2) $425,000 discount on Disposables;
3) $3,500,000 infusion pump rental costs (on current Fleet) foregone;
4) $750,000 estimated additional revenues due to enhanced billing accuracy enabled by smart-pump Epic billing function

In addition to the above cost savings, infusion pump inclusion in the Epic network improves accuracy of administration during infusion sessions resulting in improved clinical efficacy with commensurate reduction in risk of medication errors.

Fiscal Implications:

The current agreement is within budget for FY26 and will be accounted for in future budget requests.

Reasons for Recommendation:

In preparation for the anticipated end-of-life transition from the current Fleet of infusion pumps, AHS began evaluating FDA-approved infusion pump vendors in the U.S. market starting in April 2024. Based on nursing feedback and clinical experience, the evaluation was narrowed to three vendors. A comprehensive infusion pump fair was held across the Wilma Chan Highland, San Leandro, and Alameda Hospital campuses, engaging over 100 nurses. Feedback from the fair indicated support for the CareFusion solution as the preferred option due to its ease of use, functionality, Epic EHR interoperability, and familiarity among staff.

Key stakeholders – including representatives from Pharmacy, Information Services (IS), Bio-Med, Supply Chain, and Purchasing – actively participated in the selection process and reached a consensus identifying CareFusion as the vendor of choice. The decision was driven by the platform's strong integration with Epic, streamlined maintenance requirements, robust safety features, and the benefit of a single, unified drug library.

Impacted Facilities:

JGPH	Highland	Fairmont	San Leandro	Alameda	Clinic(s)
	x		X	X	

Coordination with Medical Staff:

This Agreement was reviewed in association with Department of Pulmonary and Critical Care Medicine.

Administrative Review:	Primary: System Director of Pharmacy Secondary: Chief Nurse Executive
Prior BOT Review/Action:	N/A
Executive Sponsor	Chief Nurse Executive

Contractor/Vendor Name:	East Oakland Community Project
Description:	East Oakland Community Project ("EOCP") is a locally-based organization that provides residential, veteran, and other community-based services. EOCP has been providing respite care services to Oakland residents for thirty (30) years under which short-term residential housing ("Respite Care") is provided for individuals experiencing homelessness after discharge from a period of stay in hospital. This allows the individuals to continue post-acute care recovery in a safe and supportive environment. AHS has contracted with EOCP since 2013 to secure access for AHS patients who require Respite Care services upon discharge from AHS care. Per terms of this arrangement, EOPC provides the following services: 1. Beds. Provision of 15 respite care beds for clients of AHS for four to six weeks, with the possibility of extending their stay on a case-by-case basis and as approved by AHS Complex Care designee. 2. Client Supervision. EOCP will provide clients with on-going supervision and supportive services through a nursing coordinator who will be responsible for monitoring and providing support. Nurses will be available from 8AM-7PM. Supervision includes addiction Services in the form of harm reduction-oriented individual and group support services to be provided for clients living with addictions. These services will include daily wellness checks. 3. Transportation. EOCP provides transportation for follow-up medical appointments. 4. Coordinate other Supportive Services. To ensure smooth transition of clients to living independently, EOCP will assist clients with other supportive services including but not limited to: a. Referral to EOCP's Bay Area Community Resource Case Management services for orientation and access to the following: 1. Long-term housing placement services, 2. Employment services, and 3. Other benefits (i.e., food distribution programs, substance abuse counseling services, etc.). To ensure uninterrupted provision of the above services, AHS leadership is requesting Board approval to enter a 3-year renewal with EOCP.
Contract Type and Term:	Contract Extension 8/1/2025 through 7/31/2028
Termination Clause:	Either Party may terminate the Agreement without cause and without further liability by providing 30 days' notice, in writing, to the other Party.
Total Spend with Vendor:	**Description** | **Board Approval** | **Total**

<table>
<tr><td></td><td>
<table>
<tr><td>Renewal (8/1/2025 thru 7/31/28)</td><td>Approval Requested</td><td>$1,593,600</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>For the next three years, the rate with EOCP will remain the same and will not increase, resulting in cost savings for the organization. This price stability supports predictable budgeting and reduces the market rate fluctuations.

Cost Off-Set: Patients discharged to respite care typically stay for six weeks, allowing each bed to serve 8 to 9 individuals annually—approximately 130 patients across all beds.
With an average inpatient night costing approximately $5,000, and each patient avoiding about five nights by being discharged to respite care, the estimated cost avoidance is $25,000 per patient. This results in total annual savings of $3.25 million, with net savings of $2.72 million after contract costs per year.
This partnership improves discharge efficiency, reduces avoidable hospital stays, and ensures vulnerable patients receive care in more appropriate settings.</td></tr>
<tr><td>Fiscal Implications:</td><td>Cost has been included in FY 26 budget.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>To ensure compliance with SB 1152 (Homeless Patient Discharge Planning Policy and Process), AHS entered into this agreement with EOCP. In addition, AHS and EOCP have maintained a positive and collaborative working relationship over the years and wish to continue their partnership moving forward.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td><td></td></tr>
</table>
</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>Vice President, Patient Care Administrative Services</td></tr>
<tr><td>Administrative Review:</td><td>Chief Nurse Executive</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>N/A</td></tr>
<tr><td>Executive Sponsor</td><td>Chief Nurse Executive</td></tr>
</table>

Contractor/Vendor Name:	The Regents of the University of California on behalf of the University of California, San Francisco, Department of Neurological Surgery ("UCSF")
Description:	Alameda Health System ("AHS") has a long-established and well-regarded relationship with the UCSF East Bay Faculty Surgeons ("EBFS") under which EBFS have successfully provided comprehensive surgical services including general, thoracic, vascular, breast, trauma, and minor surgery as well as staffing for administrative and education positions since July 1, 2001. Due to this long-term and positive relationship with UCSF, in 2017 AHS and East Bay Medical Group, subsequently known as Alameda Health Medical Group ("AHMG"), leadership recommended and the Board approved expanding our contractual relationship with UCSF to include UCSF's provision of neurosurgery services ("Services") at Wilma Chan Highland Hospital ("WCHGH") under agreement ("Current Agreement"). UCSF's provision of neurosurgery services over the past 8 years has resulted in a significant improvement in our delivery of neurosurgery services to the community as reflected below: • Positive patient outcomes resulting from timely care delivery of neuro-trauma services. • Increased clinic time coupled with "level-loaded" access (based on the principle of standardizing workflows to reduce waste and enhance productivity) has resulted in an improvement in patient satisfaction. In recognition of the above and to ensure uninterrupted delivery of these critical life-saving Services going forward, AHS leadership is requesting Board approval to enter a renewal agreement ("Renewal Agreement") with UCSF, including provision of the following services: <u>WCHGH Neurosurgery services</u> • 24/7 365-day continuous coverage of the service, including "on-call" status (1st and 2nd call). • 9 hours daily inpatient and critical care unit rounding. • 6 half-day neurosurgery clinics per week, 52 weeks per year. • 2 full-day operating room blocks, 52 weeks per year. • Chief of the Division of Neurosurgery, 40 hours per month. UCSF will adjust clinical staffing levels to reduce call and administrative burden levels. Addition of a 1.0 FTE neurosurgeon will bring the department roster to 4.0 FTEs enabling more sustainable coverage of two-deep call and a very full clinic and elective surgical schedule. UCSF will also provide a 0.6 FTE admin position to reduce the current (and significant) non-clinical burden on the Chief of Neurosurgery. These staffing adjustments will allow enhanced deployment of scarce clinical resources with a focus on addressing patient care needs while improving quality of work for our clinical partners.
Contract Type and Term:	Renewal Agreement Term: 8/1/2025 – 7/31/2027 (24 months)
Termination Clause:	Without Cause: Either party may terminate with one-hundred eighty (180) days' prior written notice.

<table>
<tr><td>Total Spend with Vendor:</td><td>
<table>
<tr><th>Description</th><th>Board Approval</th><th>Total</th></tr>
<tr><td>Renewal Agreement (08/01/2025–07/31/2027)</td><td>Approval Requested</td><td>$7,594,371</td></tr>
</table>
</td></tr>
<tr><td>Estimated Cost Savings:</td><td>There are no cost savings associated with this agreement.</td></tr>
<tr><td>Fiscal Implications:</td><td>Total costs are increasing by 32% reflecting: 1) the additional 1.0 Neurosurgeon FTE, 2) a 10% increase in compensation rates only (no change to call rates), and the addition of a 0.6 FTE administrative position. Compensation rates last increased in 2023 and are locked over the 2-year Renewal term. The Renewal has been included in the FY 26 budget based on Current Agreement run rate in keeping with AHS budgeting protocol. Unbudgeted costs associated with the rate increase and additional staffing levels will result in an estimated $661,082 variance to FY 26 budget. Year 2 of the agreement will be fully in budget (FY27), as there is no escalator.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>UCSF has a proven track-record of providing high quality and reliable physicians that enhance AHS’ ability to provide vital services to the community.</td></tr>
<tr><td>Impacted Facilities:</td><td>
<table>
<tr><th>AHS</th><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr>
<tr><td></td><td></td><td>X</td><td></td><td></td><td></td><td>X</td></tr>
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</td></tr>
<tr><td>Coordination with Medical Staff:</td><td>The proposed renewal agreement was jointly reviewed by the Chief Medical Officer. In addition, the Chair of Surgery was consulted on the clinical component of this contract.</td></tr>
<tr><td>Administrative Review:</td><td>Primary: Chair of Surgery
Secondary: Chief Medical Officer</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>In July 2023, the Board approved the fourth extension to the Current Agreement with UCSF.</td></tr>
<tr><td>Executive Sponsor:</td><td>Chief Medical Officer</td></tr>
</table>

MONTHLY REPORT
LIFETIME VENDOR SPEND - JULY 2025

Vendor Name	Revised Contract Term	Proposed Contract Spend	Total Lifetime Vendor Spend (including proposed contract)	Proposed Contract Description	Status
GE Healthcare	06/01/2025-12/31/2025	$18,591	$7,175,520	This is a 1-time SOW to upgrade our GE Muse application to the latestet version (NX)	Executed
GE Healthcare	06/01/2025-12/31/2025	$8,278.80	$7,165,207.80	This is a 1-time SOW to modify our GE Muse database medical record number length to match our EHR system.	Executed
GE Healthcare	06/01/2025-12/31/2025	$36,486.64	$7,193,415.64	This is a 1-time SOW to integrate GE Muse with our Clinical Document Repository, Hyland	Executed
United Systems Fire and Security	05/01/2025-04/30/2026	$67,136.67	$1,751,400.79	Annual Testing: testing of all devices currently reporting to the fire alarm system per the device counts below (required once per year) Semi-Annual Testing: water flows, valve tamper switches, and batteries (required every six months) (This agreement includes testing only devices that are currently associated with the existing fire alarm control panel.)	Executed
Johnson & Johnson Health Care Systems	06/02/2025-06/01/2026	$250,000.00	$19,760,483.13	Subject to the terms and conditions of this agreement, Biosense Webster, Inc. (the "Company") shall offer the Electrophysiology product(s) set forth on Schedule A (each a "Product") to the Customer at the pricing indicated on the schedule. These are the only time of sale discounts available on the Products and they supersede all other time of sale discount arrangements	Executed
Stryker ENT	05/27/2025-05/26/2030	$223,609.92	$5,797,871.01	This scope of service aims to establish a comprehensive service contract for the Stryker ENT Navigation System at SLH Hospital, addressing both immediate and future needs. Currently, there is no established service protocol for ENT navigation systems within our hospital system, and this contract will fill that void, ensuring optimal performance and maintenance.	Executed

ALAMEDA HEALTH SYSTEM

BOT Previously Approved Contracts - FY25 (July 1, 2024 - June 30, 2025)

#	Vendor	Amount Requiring BOT Approval	Start Date	Ending Date	BOT approved Date	Agenda Summary	Expectation	Executive Sponsor
1	Cardea Health	$2,075,025	8/1/2024	7/31/2025	FC - 7-3-24 BOT Approved 7-10-24	Medically supported shelter for AHS-discharged homeless patients.		Chief Operating Officer
2	D'ville Construction, Inc.	$2,210,979	8/1/2024	7/31/2026	FC - 7-3-24 BOT Approved 7-10-24	Construction services for SPD expansion at SLH.		Chief Administrative Officer, Community Hospitals
3	Mesa Energy Systems, Inc. dba EMCOR Services	$2,811,758	7/15/2024	7/14/2026	FC - 7-3-24 BOT Approved 7-10-24	Chillers replacement at SLH.		Chief Operating Officer
4	Onward Health Inc.	$7,052,370	8/1/2024	7/31/2028	FC - 7-3-24 BOT Approved 7-10-24	Non-medical patient transport services.		Chief Operating Officer
5	Royal Ambulance, Inc.	$23,408,147	8/1/2024	7/31/2028	FC - 7-3-24 BOT Approved 7-10-24	Medical transport services.		Chief Operating Officer
6	Mint Medical, LLC dba Mint Medical Services	$4,242,697	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Vascular ultrasound services.		Chief Medical Officer
7	Vascular Surgery Group Inc.	$1,783,527	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Vascular surgery call coverage services at SLH and AH.		Chief Medical Officer
8	The Regents of the University of California on behal of the University of California, San Francisco, School of Medicine, Department of Obstetrics, Gynecology, and Reproductive Sciences	$2,071,685	10/1/2024	9/30/2026	FC - 9-4-24 BOT Approved 9-18-24	Maternal-fetal medicine coverage services at HGH.		Chief Medical Officer
9	Optum360 Solutions, LLC	$2,100,000	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Utilization management transactional services.		Chief Medical Officer
10	Lescure Company, Inc.	$2,066,300	10/1/2024	9/30/2025	FC - 9-4-24 BOT Approved 9-18-24	Construction services for above-ground fuel storage tanks at SLH.		Chief Operating Officer
11	Compass Group USA, Inc. by and through its subsidiary Morrison Management Specialists, Inc.	$23,227,049	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Food and nutrition management services.		Chief Operating Officer
12	Inter-Con Security Systems, Inc.	$40,872,148	10/1/2024	9/30/2027	FC - 9-4-24 BOT Approved 9-18-24	Security services.		Chief Operating Officer

13	Medline Industries, Inc.	$50,000,000	10/20/2024	10/20/2026	FC - 10-2-24 BOT Approved 10/9/24	Surgical supplies.		Chief Operating Officer
14	Agiliti Health, Inc.	$18,341,250	12/1/2024	11/30/2029	FC - 11-6-24 BOT Approved 11-13-24	Imaging equipment maintenance and repair services		Chief Information Officer
15	EverWatt Lights, LLC	$1,591,053	12/1/2024	6/30/2025	FC - 11-6-24 BOT Approved 11-13-24	Installation of energy efficiency upgrades at HGH		Chief Operating Officer
16	Diablo Infectious Disease Consultative Medical Group, Inc.	$2,414,031	1/1/2025	12/31/2027	FC - 11-6-24 BOT Approved 11-13-24	Infectious disease professional services		Chief Medical Officer
17	Traditions Behavioral Health	$10,605,018	1/1/2025	12/31/2027	FC - 11-6-24 BOT Approved 11-13-24	Behavioral health professional services		Chief Medical Officer
18	Agiliti Healthcare, Inc.	$1,554,222	5/1/2024	12/31/2025	FC - 1-8-25 BOT Approved 1-15-25	Extension of biomedical maintenance and repair report services		Chief Technology Officer
19	Agiliti Healthcare, Inc.	$13,987,994	2/1/2025	1/31/1930	FC - 1-8-25 BOT Approved 1-15-25	Renewal of biomedical maintenance and repair report services		Chief Technology Officer
20	Inter-Con Security Systems, Inc.	$1,600,000	10/1/2024	9/30/2027	FC - 1-8-25 BOT Approved 1-15-25	Funding increase for provision of unplanned additional security services.		Chief Operating Officer
21	Inter-Con Security Systems, Inc.	$2,000,000	2/1/2025	9/30/2027	FC - 1-8-25 BOT Approved 1-15-25	Provision of patient watch services in San Leandro Hospital		Chief Operating Officer
22	Lescure Company, Inc.	$1,429,300	2/1/2025	4/30/2026	FC - 1-8-25 BOT Approved 1-15-25	Provision of temporary HVAC services at Alameda Hospital.		Chief Operating Officer
23	Lescure Company, Inc.	$80,993	2/1/2025	4/30/2026	FC - 1-8-25 BOT Approved 1-15-25	Provision of Phase 1 repair and upgrade services for legacy HVAC system at Alameda Hospital.		Chief Operating Officer
24	EverWatt Lights, LLC	$3,915,013	3/1/2025	3/31/2026	FC - 2-5-25 BOT Approved 2-12-25	Installation of energy efficiency upgrades at SLH.		Chief Operating Officer
25	Hayward Sisters Hospial dba St. Rose Hospital and Saint Rose Medical Building, Inc.	$49,420,328	11/1/2024	10/31/2029	FC - 2-5-25 BOT Approved 2-12-25	Management services agreement.		Chief Executive Officer
26	Metropolis California, LLC	$2,258,508	11/1/2024	12/31/2025	FC - 3-5-25 BOT Approved 3-12-25	Parking services agreement		Chief Operating Officer
27	East Bay Foundation for Graduate Medical Education	$4,325,956	7/1/2025	6/30/2026	FC - 5-7-25 BOT Approved 5-14-25	Surgical residency agreement		Chief Medical Officer

28	Virtual Radiologic Professionals of California, P.A.	$3,197,097	7/1/2025	6/30/2026	FC - 5-7-25 BOT Approved 5-14-25	Remote radiology services agreement		Chief Medical Officer
29	Strata Decision Technology, LLC	$2,491,181	6/1/2025	5/31/1930	FC - 5-7-25 BOT Approved 5-14-25	Financial planning software subscription agreement		Chief Financial Officer
30	CareFusion Solutions, LLC	$6,874,800	7/1/2025	6/30/1930	FC - 6-4-25 BOT Approved 6-11-25	Medication storage and dispensing cabinets agreement		Chief Operating Officer
31	Alameda County Sheriff's Office	$15,050,054	7/1/2025	6/30/2028	FC - 6-4-25 BOT Approved 6-11-25	Supplemental law enforcement services agreement		Chief Operating Officer
	Total Amount for FY 24 year to date	$305,058,483						

E1. ACTION _ DISCUSSION_ Resolution Accepting Grant Funds From the California Health Facilities Financing Authority and Authorize the Chief Executive Officer to Execute the Grant Agreement and Related Documents

BOARD OF TRUSTEES
RESOLUTION NO: 2025-003

RESOLUTION TO ACCEPT GRANT FUNDS FROM THE CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY AND AUTHORIZE THE CHIEF EXECUTIVE OFFICER TO EXECUTE THE GRANT AGREEMENT AND RELATED DOCUMENTS

WHEREAS, the California Health Facilities Financing Authority ("CHFFA") has awarded Alameda Health System ("AHS") a grant in the amount of Four Million Three Hundred Fifty Thousand Dollars ($4,350,000) under the Specialty Dental Clinic Grant Program;

WHEREAS, the Specialty Dental Clinic Grant Program is intended to expand access to dental services for the Special Health Care Needs Population, including children and adults with disabilities that prevent them from receiving routine or specialty dental care due to physical, developmental, or cognitive conditions;

WHEREAS, the grant requires AHS to develop or expand infrastructure to include a minimum of four (4) new dental operatories and three (3) exam/consultation rooms to deliver these critical services;

WHEREAS, accepting this grant aligns with AHS's mission to improve health equity and access to comprehensive care for vulnerable and underserved communities;

NOW, THEREFORE, BE IT RESOLVED, that the Board of Trustees of Alameda Health System hereby accepts the $4,350,000 grant from the California Health Facilities Financing Authority under the Specialty Dental Clinic Grant Program;

BE IT FURTHER RESOLVED, that the Board of Trustees authorizes the Chief Executive Officer of Alameda Health System, or designee, to execute the grant agreement and any documents necessary to implement and administer the terms of the grant.

THE FOREGOING Resolution was presented this the 9th day of July 2025, to wit:

I hereby certify under penalty of perjury that the President of the Board of Trustees was duly authorized to execute this document on behalf of the Alameda Health System by majority of vote of the Board on July 9, 2025 and that a copy has been delivered to the President.

ATTEST:

_____
Ronna Jojola Gonsalves
Clerk of the Board of Trustees
Alameda Health System

Date:_____

APPROVED AS TO FORM:

_____ _____
Ahmad Azizi, General Counsel Date

THE FOREGOING Resolution was **PASSED** and **ADOPTED** by the Alameda Health System Board of Trustees on this 9th day of July 2025, to wit:

_____
David Sayen
President, Board of Trustees
Alameda Health System

E2. ACTION / DISCUSSION: Resolution Approving 401(h) Account, Pursuant to Section 31592

ALAMEDA HEALTH SYSTEM

1411 East 31 st Street
Oakland, CA 94602

MEMORANDUM

TO: Board of Trustees

FROM: Arleen Gomez, Interim Chief Human Resources Officer
Ahmad Azizi, General Counsel

DATE: July 9, 2025

SUBJECT: **Agenda Item:**
Meeting Date: July 9, 2025
Item Description: Approval of a Resolution Approving 401(h) Account Pursuant to Section 31592

BOARD ACTION: Approve Resolution.

Background: Alameda Health System (AHS) provides non-vested Retiree Health Benefits (RHB) to eligible retirees on a non-taxable basis. An account has been established under Internal Revenue Code Section 401(h) from which RHBs are paid. The account is funded by contributions from AHS to ACERA specifically for RHBs. Annually, upon determination of the amount needed to fund RHBs for the next year, ACERA requests authorization from the governing boards of its member employers permitting the transfer of contributions to the 401(h) account.

Purpose/Analysis: Attached to this memorandum is a draft resolution that would authorize ACERA to take this action. It is accompanied by a letter from the ACERA Fiscal Services Officer, to the CEO, dated May 22, 2025, explaining the transfer process and the required contributions. This letter is supported by a report from ACERA's actuary detailing the calculation of the 401(h) contribution. Contributions used for RHBs are held by ACERA in a Supplemental Retiree Benefit Reserve (SRBR) pending authorization for transfer to the 401(h) account. The transfer of assets from the SRBR is governed by section 5.5 of the County Employee Retirement Law of 1937. The effect of the resolution is simply to continue to allow our retired employees to receive their medical, dental and vision insurance on a tax-free basis. Failure of AHS to approve the resolution would immediately cause our retired employees' health and welfare benefits to be taxed on the ACERA contribution amounts. This transfer is balanced each year and AHS' financial liability is not increased in any manner.

Prior Review/Action: AHS Board of Trustees review and approval of similar resolutions in the past is an annual exchange between ACERA and AHS, along with every other employer participating in the ACERA retirement plan.

Board Action Requested: Staff recommends the Board adopt the attached resolution authorizing transfer of assets from ACERA Account (Supplemental Retiree Benefits Reserve (SRBR) to IRC (h) Sub Account**.**

Fiscal Impact: There is no new/added fiscal impact. The contribution for RHB is a reallocation or prior contribution to ACERA that have been included in the operating budget.

Budgeted/Authorization: This cost is included in the Budget for FY 2024/25

Estimated Cost Savings: None, directly to AHS, however, AHS Retirees will be entitled to receive favorable tax treatment for earned health care benefits.

Strategic Plan Pillar: Workforce

ALAMEDA HEALTH SYSTEM

BOARD OF TRUSTEES
RESOLUTION NO: 2025-002

RESOLUTION APPROVING 401(h) ACCOUNT PURSUANT TO SECTION 31592

WHEREAS, in 1996, the Alameda County Employees' Retirement Association ("ACERA") Board of Retirement informed the Board of Supervisors that by adoption of Resolution No. 96-111, the Board of Retirement had established a health benefits account intended to satisfy the requirements of Internal Revenue Code ("IRC") Section 401(h) and the regulations thereunder ("401(h) Account") in order to provide non-vested, tax-free health benefits to eligible County and Participating Employer retirees (collectively, the "Retirees"); and

WHEREAS, in 1996, this Board of Supervisors adopted Resolution No. R-96-634, which provided that ACERA could off such non-taxable benefits if the County designated a portion of its contribution to ACERA for a fiscal year as a contribution to the 401(h) Account, and

WHEREAS, under Section 31592.4 and Article 5.5 of the County Employees Retirement Law of 1937 ("CERL"), assets in the Supplemental Retiree Benefit Reserve ("SRBR") at the end of a fiscal year of ACERA may, in the immediately succeeding fiscal year, be transferred to the Employer Advance Reserve account of the Participating Employers, and treated as a contribution to ACERA by the County and as applicable by other Participating Employers to the extent that in the immediately succeeding fiscal year the County and other Participating Employers make contributions to ACERA's 401(h) Account in order to pay for retiree health benefits; and

WHEREAS, Section 31592.4 and Article 5.5 of the CERL thus permit the Participating Employers to contribute to a 401(h) Account and pay for retiree health benefits for a fiscal year without increasing the Alameda Health System's total contributions to ACERA for that fiscal year; and

WHEREAS, commencing with the 1996-1997 fiscal year, and for each fiscal year thereafter, the County has directed that a specified portion of its fiscal year contribution to ACERA for that year be contributed to the 401(h) Account; and

WHEREAS, in 2007 Alameda County Medical Center ("ACMC"), now known as Alameda Health System ("AHS"), authorized ACERA to establish and manage a 401(h) sub-account on its behalf to provide tax free health benefits for its retirees.

NOW THEREFORE, IT IS RESOLVED AS FOLLOWS:

1. In fiscal year July 1, 2025 - June 30, 2026, AHS shall contribute to ACERA $7,808,777.00 to be used only for the payment of retiree health benefits. This contribution shall be made on the terms and conditions set forth in the Agreement between ACMC (now known as AHS) and ACERA concerning such contributions, executed on October 15, 2007.

2. This contribution shall be designated, in writing, as being only for AHS's IRC § 401(h) Account and such designation shall be made at the time of the contribution.

3. Such contribution is contingent on the Board of Retirement immediately transferring, in accordance with Government Code §31592.4, an amount equal to such contribution from ACERA's SRBR account to AHS's Advance Reserve account. Such amount shall be treated as a contribution for pension and therefore shall be applied to reduce the pension contribution otherwise required by AHS for the fiscal year beginning July 1, 2025.

4. No party including any existing or future AHS employee, retiree, spouse or dependent, shall have any vested rights, contractual rights or other rights in or to any retiree health benefits or payment or subsidy for any such benefits nor shall any such person or ACERA have any such rights to have AHS contribute towards paying or subsidizing the cost of any retiree health benefits provided by ACERA under the 401(h) Account or otherwise. AHS may modify or terminate, at any time and without any limitation, its decision to contribute to AHS's 401(h) Account. This modification or termination may occur even if it may affect any employee first hired prior to the date of such modification, any person who retired prior to such date, and/or any person who became a spouse or dependent of an employee or retiree prior to such date.

5. All contributions by AHS to its 401(h) sub-account shall be governed by requirements of the IRC and all administrative and other applicable rules established by ACERA governing such sub-account and ACERA's 401(h) Account.

THE FOREGOING Resolution was presented this the 9th day of July 2025, to wit:

I hereby certify under penalty of perjury that the President of the Board of Trustees was duly authorized to execute this document on behalf of the Alameda Health System by majority of vote of the Board on July 9, 2025 and that a copy has been delivered to the President.

ATTEST:

_____
Ronna Jojola Gonsalves
Clerk of the Board of Trustees
Alameda Health System

Date:_____

APPROVED AS TO FORM:

_____ _____
Ahmad Azizi, General Counsel Date

THE FOREGOING Resolution was **PASSED** and **ADOPTED** by the Alameda Health System Board of Trustees on this 9th day of July 2025, to wit:

_____
David Sayen
President, Board of Trustees
Alameda Health System

ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

475 14th Street, Suite 1000, Oakland, CA 94612 800/838-1932 510/628-3000 fax: 510/268-9574 www.acera.org

May 22, 2025

James Jackson
Chief Executive Director
Alameda Health System
1411 East 31st Street
Oakland, CA 94602

Re: Authorization for 2025-2026 IRC § 401(h) Sub-Account

Dear Mr. Jackson:

In fiscal year 2007-2008, the Alameda County Medical Center (ACMC), now known as Alameda Health System (AHS), authorized the creation of an Internal Revenue Code (IRC) Section 401(h) sub-account under the Alameda County Employees' Retirement Association's (ACERA) overall 401(h) Account in order to provide non-vested Retiree Health Benefits (RHBs) to eligible retirees on a non-taxable basis. If AHS intends to continue with this practice in the upcoming fiscal year, it is time to initiate the process to authorize the contributions to AHS's IRC § 401(h) sub-account.

The 401(h) sub-account is based on the following criteria:

1. The account is funded by the contributions made directly by AHS to ACERA for the sole purpose of providing RHBs to retirees,
2. AHS specifies that these contributions are for the sole purpose of providing RHBs to retirees,
3. The contributions are separately accounted for by ACERA, and
4. The contributions are used by ACERA solely for RHBs.

In accordance with the County Employees Retirement Law of 1937 (CERL), ACERA holds assets in an account called the Supplemental Retiree Benefit Reserve (SRBR), which may be used only to provide benefits to retirees and their beneficiaries as determined by the Board of Retirement. In accordance with § 31592.4 of the CERL, ACERA may transfer amounts from the SRBR to the Employer Advance Reserve account and treat these transfers as if they were contributions made by AHS to fund health benefits, as long as AHS makes equal contributions directly to ACERA's 401(h) Account. AHS does not have an obligation to pay for health benefits for retirees since they are non-vested. Refer to the 401(h) Agreement signed in October 2007.

Included with this letter are the following documents that will assist you with the authorization process, if so desired.

1. A letter from ACERA's actuary setting forth the required contributions for the 401(h) Account for fiscal year 2025-2026 (Exhibit A).
2. A schedule showing the summary of the 401(h) contributions by Participating Employer for fiscal year 2025-2026 (Exhibit B).
3. A proposed resolution for your governing body to authorize contributions to a 401(h) Account (Exhibit C).

Exhibit A is a letter from ACERA's Actuary, Segal Consulting, which estimates the fiscal year 2025-2026 funding requirements of the 401(h) Account from all employers is $63,824,000.00. This estimate includes projected health premium subsidy increases of 3.50% for medical, 4.50% for Medicare Part B, and 4.00% for dental and vision plans. An additional 10% subsidy is included to provide a margin for unexpected retirements (e.g., if the employer grants Golden Handshake benefits or other increased benefits). Effective July 1, 2011 administrative expenses for health benefits are also included.[1]

Exhibit B is the schedule of the 401(h) Contributions Summary by Participating Employer for the Fiscal Year 2025-2026. This schedule shows that AHS's net 401(h) contribution amount is $7,808,777.00. This result was obtained by multiplying the percentage of AHS retirees eligible for retirement benefits, 14.22%, by the total required contribution amount of $63,824,000.00 and adjusting it by the estimated balance of $1,266,995.74 that is remaining in AHS's 401(h) sub-account as of June 30,2025.

Beginning with pay period 25-14, AHS should allocate $300,338.00 of your total contribution amount per pay period toward your 401(h) contributions if your intent is to provide non-vested tax-free health benefits to retirees. There is no net financial impact to AHS because ACERA contributes an equal amount from the SRBR to the Employer Advance Reserve account.

In order to ensure uniform tax compliance in the resolutions passed by the various Participating Employers, we have enclosed a proposed resolution which appears as Exhibit C. This resolution authorizes AHS to contribute $7,808,777.00 to your 401(h) sub-account for fiscal year 2025-2026. ACERA appreciates that AHS may require additional language in the resolution, but we request that you include the language provided that relates to the authorization and funding of the 401(h) sub-account. If you wish to change the resolution in any way, including adding to it, ACERA must review the changes before they are adopted to ensure that they comply with federal law that governs the 401(h) Account and your sub-account. We believe that this language addresses and ensures compliance with the CERL statutory issues, the agreed upon funding mechanism and IRC § 401(h) tax code requirements. Once the resolution has been passed, please send me a copy for our files.

Authorization to fund AHS's 401(h) sub-account must be completed by June 30, 2025. If this date poses a problem, or if you have any questions about any of the material contained in this packet, please contact ACERA for further clarification.

Sincerely,

Assistant Chief Executive Officer

Attachment:
Memo from Segal
401(h) Contributions needed for County and Special Districts FY 2025-2026
Proposed Resolution

[1] This is required to comply with tax qualification requirements per ACERA's Tax Counsel.

cc: David Nelsen, Chief Executive Officer, ACERA
Carlos Barrios, Assistant Chief Executive Officer, ACERA
Jeffrey Rieger, Chief Counsel, ACERA
Cynthia Enriquez, Senior Retirement Plan Administrator, Alameda Health System
Catherine Kozul, Director, Total Rewards, Alameda Health System
Marylou Lestro-Mayo, Payroll Manager, Alameda Health System

Segal

180 Howard Street
Suite 1100
San Francisco, CA 94105-6147
T 415.263.8200
F 415.376.1167
segalco.com

April 11, 2025

Lisa Johnson
Assistant Chief Executive Officer
Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, CA 94612-1916

Re: 401(h) Contributions for the 2025–2026 Fiscal Year

Dear Lisa:

Pursuant to the Association's request, we have estimated the 401(h) contributions for the 2025–2026 fiscal year.

Results and analysis

We project that, for the 2025–2026 fiscal year, the Association will need $63,824,000 to provide medical benefit subsidies from the 401(h) account. The process used to determine the actual biweekly contribution amounts is discussed on page 2. Please note that as previously directed by ACERA, in developing the estimated 401(h) contribution amount, we have included the expenses related to the administration of health benefits for retirees.

The 401(h) funding requirement is developed as follows:

	Component	Amount
1.	Total monthly premium subsidy paid by ACERA to all health benefit plan providers during the month of February 2025, projected to June 2025 by the Association (for comparison purposes only).	$4,381,000*
2.	Annualized premium subsidy as of February 2025, projected to June 2025 (for comparison purposes only).	$52,572,000

* Last year, the total monthly premium subsidy paid by ACERA to all health benefit plan providers for February 2024 and projected to June 2024 by the Association was $4,274,000, or $51,288,000 annualized. There is an increase in the projected monthly premium subsidy amount from last year to this year primarily as a result of an increase in the medical subsidies from 2024 to 2025.

	Component	Amount
3.	Best estimate of annualized premium subsidy required for 2025–2026 (based on actual payouts from July 2024 through February 2025 and estimated payouts from March 2025 through June 2025 provided by ACERA). Following the Association's current practice, we have assumed that the Retirement Board will increase the Monthly Medical Allowance at the rate equal to one-half of the lowest medical trend assumption for the non-Medicare and Medicare Advantage plans. We have assumed that the Medicare Part B, dental and vision subsidies will increase at the full rate of the trend assumption for those plans for calendar year 2025 (as assumed in the December 31, 2023 SRBR valuation). The assumed increases in the subsidy calculation are 3.50%[1] for medical, 4.50% for Medicare Part B, 4.00% for dental and vision plans.	$56,007,000
4.	Increase of 10% in Item 3 to provide a margin for unexpected retirements rounded to nearest $1,000.	$5,601,000
5.	Administrative expenses for health benefits, rounded to nearest $1,000.	$2,216,000[2]
6.	**Sum of Items 3, 4, and 5.**	**$63,824,000**

Important assumptions regarding anticipated change in health premium subsidy

Except for the projected health premium subsidy increases described above, we have not assumed any other changes in the level of subsidy from 2024–2025 to 2025–2026. Our estimate will have to be revised if the Retirement Board later decides to amend the level of benefits.

401(h) contributions

The actual required contributions for the 2025–2026 fiscal year should be determined by subtracting the June 30, 2025 balance in the 401(h) account from the $63,824,000. We understand that this net amount will be contributed to the 401(h) account on a biweekly basis by the employers and the Association will transfer a like amount from the Supplemental Retirees Benefit Reserve to the Employer Advance Reserve.

As instructed by the Association, we have provided a breakdown of the 401(h) expense by employer in the following table. We understand that the breakdown has been compiled by the Association as of February 2025, based on the number of retirees eligible for retirement benefits.

[1] This is based on 50% of the 7.00% trend assumption used to project the increase for Medicare Advantage plans from calendar year 2025 to calendar year 2026, as described in the assumptions section of the December 31, 2023 SRBR sufficiency valuation. The medical trend assumptions in our letter dated March 21, 2025, recommended for the December 31, 2024 sufficiency valuation, will be applied in the 401(h) contribution estimate for the 2026–2027 fiscal year.

[2] As part of the determination of the 401(h) contributions for the 2024–2025 fiscal year, we followed the directions from the Association (as provided in the past) to use the actual 2023 calendar year expense as a proxy for the 2024–2025 fiscal year expense. We have maintained this procedure and have used the actual 2024 calendar year expense as a proxy for the 2025–2026 fiscal year expense.

Employer	Percentage of 401(h) Contributions
Alameda County[1]	78.55%
Health System	14.22%
Superior Court	5.62%
Livermore Area Recreation and Park District	0.74%
Housing Authority	0.66%
First 5	0.21%
Total	**100.00%**

Under IRC Section 401(h), medical benefits must be "incidental" to the retirement benefits under a plan. Section 401(h) indicates that medical benefits will be considered "incidental" if the contributions for medical benefits are less than 25% of the total contributions under the plan (excluding unfunded actuarial accrued liability (UAAL) payments). We believe that the transfer from the Supplemental Retirees Benefit Reserve should be treated as an offset to the UAAL contribution requirement (to the extent that the net UAAL payment after the offset is still positive), which means that in a given year the medical contributions can be up to 25% of the total Normal Cost contributions.

In the following table, we demonstrate that the value of the medical benefits is in compliance with the above requirement. Please note that as the Retirement Board has not yet adopted the contribution rates for the December 31, 2024 pension funding valuation, we have continued to apply the average employer and employee contribution rates calculated in the last valuation, that is, as of December 31, 2023, to the payroll calculated in that valuation, increased by 3.00% to reflect one year of projected payroll growth.

Source of Contributions	Estimated Amount ($ millions)
Employee Normal Cost (based on an aggregate member rate of 9.87% calculated in the December 31, 2023 valuation and an estimated payroll of $1,359 million)	$134.1
Employer Normal Cost (based on aggregate employer normal cost rate of 10.79% calculated in the December 31, 2023 valuation and an estimated payroll of $1,359 million)	$146.6
Recommended 401(h) Medical Contributions	$63.8
Total Normal Cost and Recommended 401(h) Medical Contributions	$344.5
Ratio of 401(h) Contributions to the Total Normal Cost Contributions and Recommended 401(h) Medical Contributions	18.5%[2]

[1] As in years past, retirees from the Office of Education and the Alameda County Fire Department are included in the County's percentage by ACERA.

[2] This ratio was 18.7% as provided in our 401(h) contributions letter for the 2024–2025 fiscal year.

These calculations were prepared under our supervision. Except as noted above, the calculations are based on the December 31, 2023 actuarial pension funding valuation results including the membership data and the non-health care cost trend actuarial assumptions on which that valuation was based, and the health care cost trend assumptions in the December 31, 2023 SRBR sufficiency valuation.

This document has been prepared for the exclusive use and benefit of the client, based upon information provided by you and your other service providers or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. This document should only be copied, reproduced, or shared with other parties in its entirety as necessary for the proper administration of ACERA. This document does not constitute legal, tax or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

We are members of the American Academy of Actuaries and we meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein. Please let us know if you have any questions.

Sincerely,

Andy Yeung, ASA, MAAA, FCA, EA
Vice President and Actuary

Mehdi Riazi, FSA, MAAA, FCA, EA
Vice President and Actuary

Eva Yum, FSA, MAAA, EA
Vice President and Actuary

/elf

cc: Eva Hardy
Katherine Martinez

Exhibit B

401(h) Contributions needed for County and Special Districts - For the Fiscal Year 2025-26

Employer	Percentage of 401(h) Contribution	Paid Interval	Actuarial 401(h) Account Balance Required for FY 2025-26	Est. 401(h) Balance as of 6/30/2025	FY 2025-26 Required 401(h) Contribution Amount	FY 2025-26 Per Pay Period 401(h) Payment	Monthly Payment 2 PP	Aug.'25 & Jan'26 3 PP	Required Adm. Allocation 2025-26 Total	Monthly Adm.Allocation
									$ 2,216,000.00	
Alameda County	78.55%	Bi-Weekly (26 PP)	$ 50,133,752.00	$ 7,275,361.75	$ 42,858,390.00	$ 1,648,399.62	$ 3,296,799.24	$ 4,945,198.86	$ 1,740,668.00	$ 145,056.00
AHS	14.22%	Bi-Weekly (26 PP)	9,075,772.80	1,266,995.74	$ 7,808,777.00	$ 300,338.00	$ 600,676.00	$ 901,014.00	$ 315,115.00	$ 26,260.00
Superior Court	5.62%	Bi-Weekly (26 PP)	3,586,908.80	514,831.77	$ 3,072,077.00	$ 118,157.00	$ 236,314.00	$ 354,471.00	$ 124,539.00	$ 10,378.00
Livermore Area Recreation & Park District	0.74%	Bi-Weekly (26 PP)	472,297.60	64,313.05	$ 407,985.00	$ 15,692.00	$ 31,384.00	$ 47,076.00	$ 16,398.00	$ 1,366.00
Housing Authority	0.66%	Bi-Weekly (26 PP)	421,238.40	58,613.34	$ 362,625.00	$ 13,947.00	$ 27,894.00	$ 41,841.00	$ 14,626.00	$ 1,219.00
First 5	0.21%	Bi-Weekly (26 PP)	134,030.40	17,342.04	$ 116,688.00	$ 4,488.00	$ 8,976.00	$ 13,464.00	$ 4,654.00	$ 388.00
Total	*100.00%*		*$ 63,824,000.00*	*$ 9,197,457.69*	*$ 54,626,542.00*	*$ 2,101,021.62*	*$ 4,202,043.24*	*$ 6,303,064.86*	*$ 2,216,000.00*	*$ 184,667.00*

Per SEGAL letter dated April 11, 2025 required amount $ 63,824,000.00

** Please see attached payment schedule.

Prepared by: Hema - 4/15/25

Reviewed by: Hermella - 4/16/25

90/219

EXHIBIT C

ALAMEDA HEALTH SYSTEM RESOLUTION APPROVING 401(H) ACCOUNT PURSUANT TO SECTION 31592

WHEREAS, in 1996, the Alameda County Employees' Retirement Association ("ACERA") Board of Retirement informed the Board of Supervisors that by adoption of Resolution No. 96-111, the Board of Retirement had established a health benefits account intended to satisfy the requirements of Internal Revenue Code ("IRC") Section 401(h) and the regulations thereunder ("401(h) Account") in order to provide non-vested, tax-free health benefits to eligible County and Participating employer retirees (collectively, the "Retirees"); and

WHEREAS, in 1996, this Board of Supervisors adopted Resolution No. R-96-634, which provided that ACERA could offer such non-taxable benefits if the County designated a portion of its contribution to ACERA for a fiscal year as a contribution to the 401(h) Account, and

WHEREAS, under Section 31592.4 and Article 5.5 of the County Employees' Retirement Law of 1937 ("CERL"), assets in the Supplemental Retiree Benefit Reserve ("SRBR") at the end of a fiscal year of ACERA may, in the immediately succeeding fiscal year, be transferred to the Employer Advance Reserve account of the Participating Employers, and treated as a contribution to ACERA by the County and as applicable by other Participating Employers to the extent that in the immediately succeeding fiscal year the County and other Participating Employers make contributions to ACERA's 401(h) Account in order to pay for retiree health benefits; and

WHEREAS, Section 31592.4 and Article 5.5 of the CERL thus permit the Participating Employers to contribute to a 401(h) Account and pay for retiree health benefits for a fiscal year without increasing the Alameda Health System's total contributions to ACERA for that fiscal year; and

WHEREAS, commencing with the 1996-1997 fiscal year, and for each fiscal year thereafter, the County has directed that a specified portion of its fiscal year contribution to ACERA for that year be contributed to the 401(h) Account; and

WHEREAS, in 2007 Alameda County Medical Center ("ACMC"), now known as Alameda Health System ("AHS"), authorized ACERA to establish and manage a 401(h) sub-account on its behalf to provide tax free health benefits for its retirees.

NOW THEREFORE, IT IS RESOLVED AS FOLLOWS:

1. In fiscal year July 1, 2025 – June 30, 2026, AHS shall contribute to ACERA $7,808,777.00 to be used only for the payment of retiree health benefits. This contribution shall be made on the terms and conditions set forth in the Agreement between ACMC (now knows as AHS) and ACERA concerning such contributions, executed on October 15, 2007.

2. This contribution shall be designated, in writing, as being only for AHS's IRC§ 401(h) Account and such designation shall be made at the time of the contribution.

3. Such contribution is contingent on the Board of Retirement immediately transferring, in accordance with Government Code § 31592.4, an amount equal to such contribution from ACERA's SRBR account to AHS's Advance Reserve account. Such amount shall be treated as a contribution for pension and therefore shall be applied to reduce the pension contribution otherwise required by AHS for the fiscal year beginning July 1, 2025.

4. No party, including any existing or future AHS employee, retiree, spouse or dependent, shall have any vested rights, contractual rights or other rights in or to any retiree health benefits or payment or subsidy for any such benefits nor shall any such person or ACERA have any such rights to have AHS contribute towards paying or subsidizing the cost of any retiree health benefits provided by ACERA under the 401(h) Account or otherwise. AHS may modify or terminate, at any time and without any limitation, its decision to contribute to AHS's 401(h) Account. This modification or termination may occur even if it may affect any employee first hired prior to the date of such modification, any person who retired prior to such date, and/or any person who became a spouse or dependent of an employee or retiree prior to such date.

5. All contributions by AHS to its 401(h) sub-account shall be governed by requirements of the IRC and all administrative and other applicable rules established by ACERA governing such sub-account and ACERA's 401(h) Account.

E3. DISCUSSION_ Operating Plan

STRENGTHENING THE CORE, EMBRACING THE FUTURE

July 2025

TABLE OF CONTENTS

INTRODUCTION

Planning efforts are essential to:

- **Understand Population Needs:** Identify the health needs, demographics, and preferences of the community to effectively design relevant services
- **Optimize Resource Allocation:** Assess demand for services, existing gaps, and competition to prioritize funding and infrastructure investments
- **Enhance Service Delivery:** Analyze trends, such as disease prevalence or emerging health issues, to tailor programs, improve accessibility, and ensure equitable care
- **Inform Policy and Planning:** Use data on market dynamics, like healthcare workforce availability or technology adoption, to shape evidence-based policies and long-term strategies
- **Engage Stakeholders:** Understand the roles of agencies, private sectors, or community groups to foster partnerships and avoid duplication of efforts
- **Ensure Financial Sustainability:** Evaluate cost structures, reimbursement models, and economic trends to maintain fiscal health while delivering quality care

[BACK]

MARKET DEFINITION

Defining AHS's service area(s) ensures the health system meets community-specific needs and maximizes its impact within a structured scope.

[BACK]

MARKET DEFINITION

AHS Service Area(s): How? And Why?

How Service Area is Defined

- Designated geography where majority of inpatient business originates from
- Primary Service Area: 70%-80% of inpatient discharges
- Secondary Service Area: an additional 10-15% of inpatient discharges
- Contiguous: includes entire cities, even if certain zip codes would otherwise be excluded
- Any inpatient discharges that originate outside of the service area are considered "in-migration"
- Any inpatient discharges that originate within the service area but seek care outside are considered leakage or "out-migration"

Why is a Service Area Necessary?

- A service area is critical for:
  - Studying demographic/socioeconomic trends to anticipate future healthcare needs for the population you serve
  - Service line planning
  - Predicting shrinkage or growth based on trends
  - Determining who? and how? for marketing/community outreach
  - Identifying areas of highest need
  - Measuring provider availability and need – FMV opinions, compensation reasonableness, etc.
  - Understanding competitive climate
  - Establishing payor contracting terms
- Reviewed annually based on prior year discharges and adjusted accordingly. It is unusual for a service area to dramatically shift year-to-year without large-scale market changes, e.g. new hospital entrants or program closures

MARKET DEFINITION

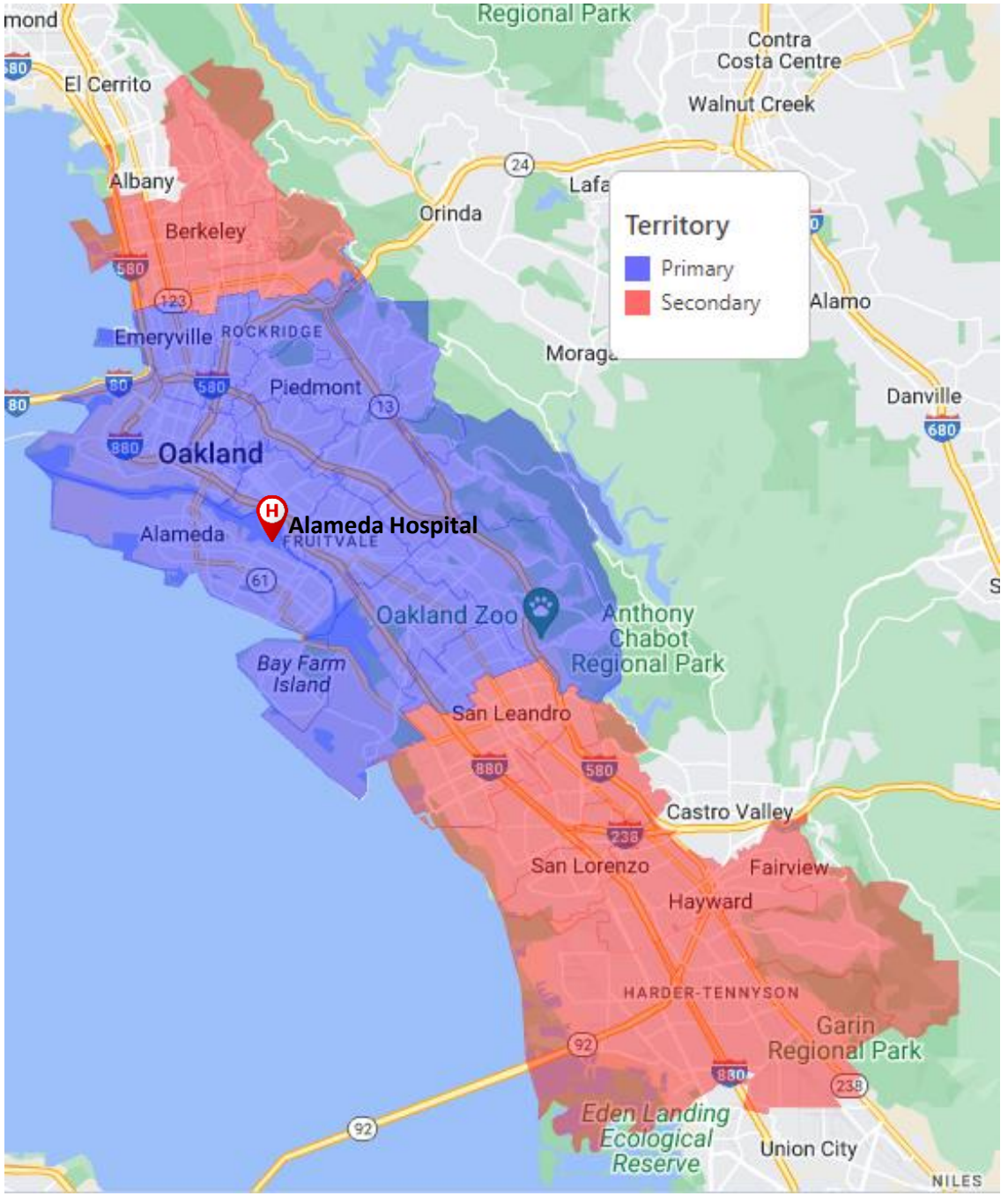
Service Area: Alameda Hospital

Primary Service Area

Zip	City	% of Discharges
94501	Alameda	38.01%
94502	Alameda	4.75%
94601	Oakland	7.96%
94621	Oakland	5.33%
94605	Oakland	4.03%
94603	Oakland	3.40%
94606	Oakland	3.02%
94602	Oakland	2.63%
94607	Oakland	1.87%
94619	Oakland	1.87%
94612	Oakland	1.66%
94609	Oakland	1.26%
94608	Oakland	0.79%
94610	Oakland	0.58%
94611	Oakland	0.58%
94618	Oakland	0.11%
Total		**77.85%**

Secondary Service Area

Zip	City	% of Discharges
94577	San Leandro	1.87%
94578	San Leandro	1.58%
94579	San Leandro	0.61%
94541	Hayward	4.06%
94544	Hayward	1.15%
94545	Hayward	0.40%
94542	Hayward	0.04%
94702	Berkeley	0.32%
94709	Berkeley	0.11%
94703	Berkeley	0.07%
94704	Berkeley	0.07%
94705	Berkeley	0.07%
94710	Berkeley	0.07%
94707	Berkeley	0.04%
94708	Berkeley	0.04%
94720	Berkeley	0.00%
94580	San Lorenzo	0.50%
Total		**10.50%**



Source: HCAI Non-public data set, CY 2022; Total discharges: 2,778; Homeless: 142

MARKET DEFINITION

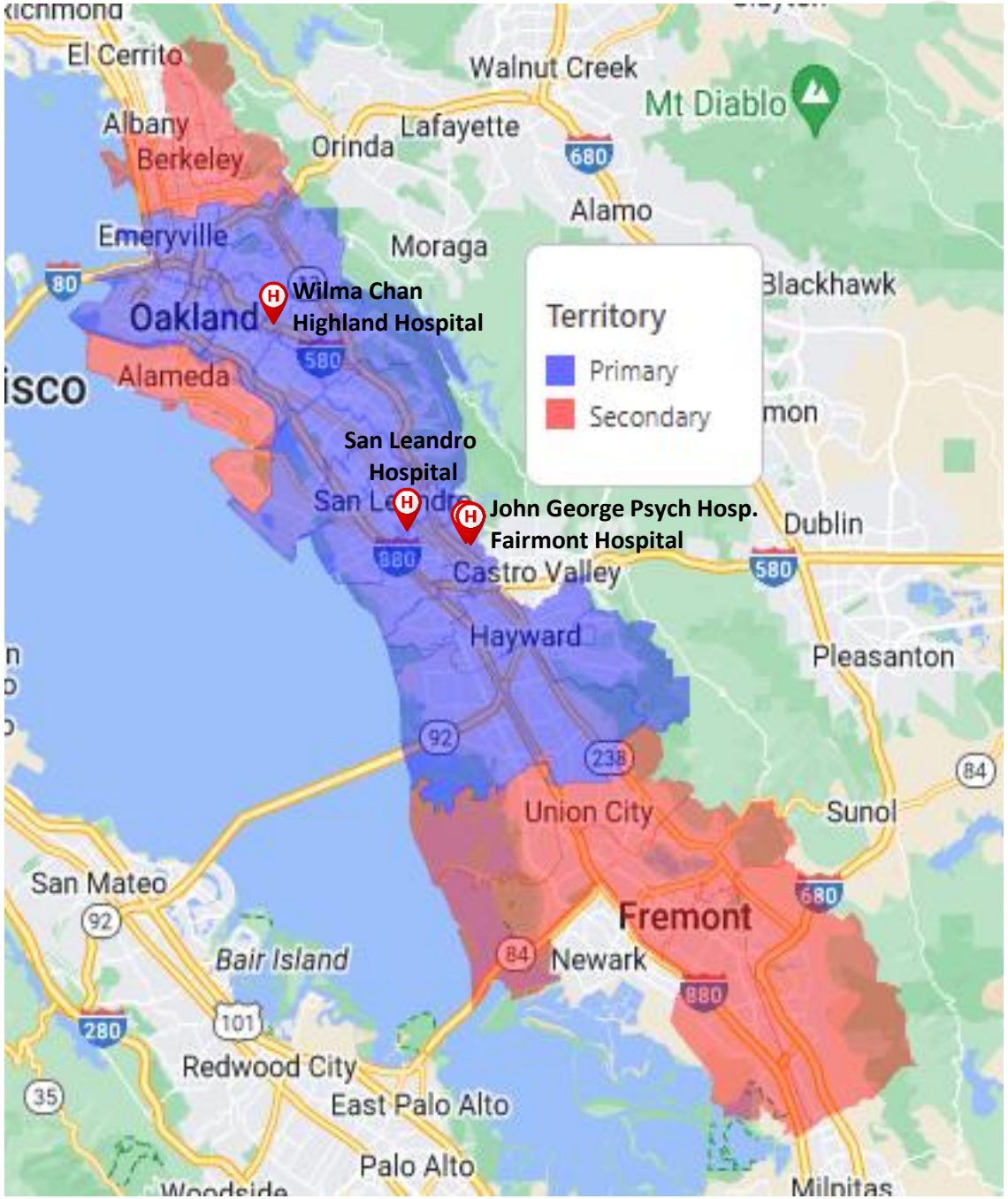
Service Area: Wilma Chan Highland Hospital, San Leandro Hospital
John George Psychiatric Hospital, and Fairmont Hospital

Primary Service Area

Zip	City	% of Discharges
94601	Oakland	10.11%
94621	Oakland	9.64%
94603	Oakland	8.27%
94605	Oakland	7.41%
94606	Oakland	5.32%
94602	Oakland	4.00%
94607	Oakland	2.55%
94612	Oakland	2.12%
94619	Oakland	2.10%
94608	Oakland	2.05%
94609	Oakland	1.49%
94610	Oakland	1.19%
94611	Oakland	0.96%
94618	Oakland	0.20%
94613	Oakland	0.01%
94578	San Leandro	5.11%
94577	San Leandro	5.04%
94579	San Leandro	1.19%
94541	Hayward	3.43%
94544	Hayward	3.37%
94545	Hayward	0.98%
94542	Hayward	0.41%
94580	San Lorenzo	1.45%
Total		**78.41%**

Secondary Service Area

Zip	City	% of Discharges
94501	Alameda	3.37%
94502	Alameda	0.44%
94703	Berkeley	0.54%
94702	Berkeley	0.47%
94710	Berkeley	0.28%
94705	Berkeley	0.27%
94704	Berkeley	0.24%
94707	Berkeley	0.20%
94708	Berkeley	0.14%
94709	Berkeley	0.11%
94720	Berkeley	0.01%
94703	Berkeley	0.54%
94702	Berkeley	0.48%
94710	Berkeley	0.29%
94705	Berkeley	0.27%
94704	Berkeley	0.24%
94707	Berkeley	0.20%
94708	Berkeley	0.14%
94709	Berkeley	0.12%
94720	Berkeley	0.01%
Total		**8.36%**



Source: HCAI Non-public data set, CY 2022; Total discharges: 17,210 excl. DRG 795 Normal Newborn; Homeless: 1,941

MARKET DEFINITION

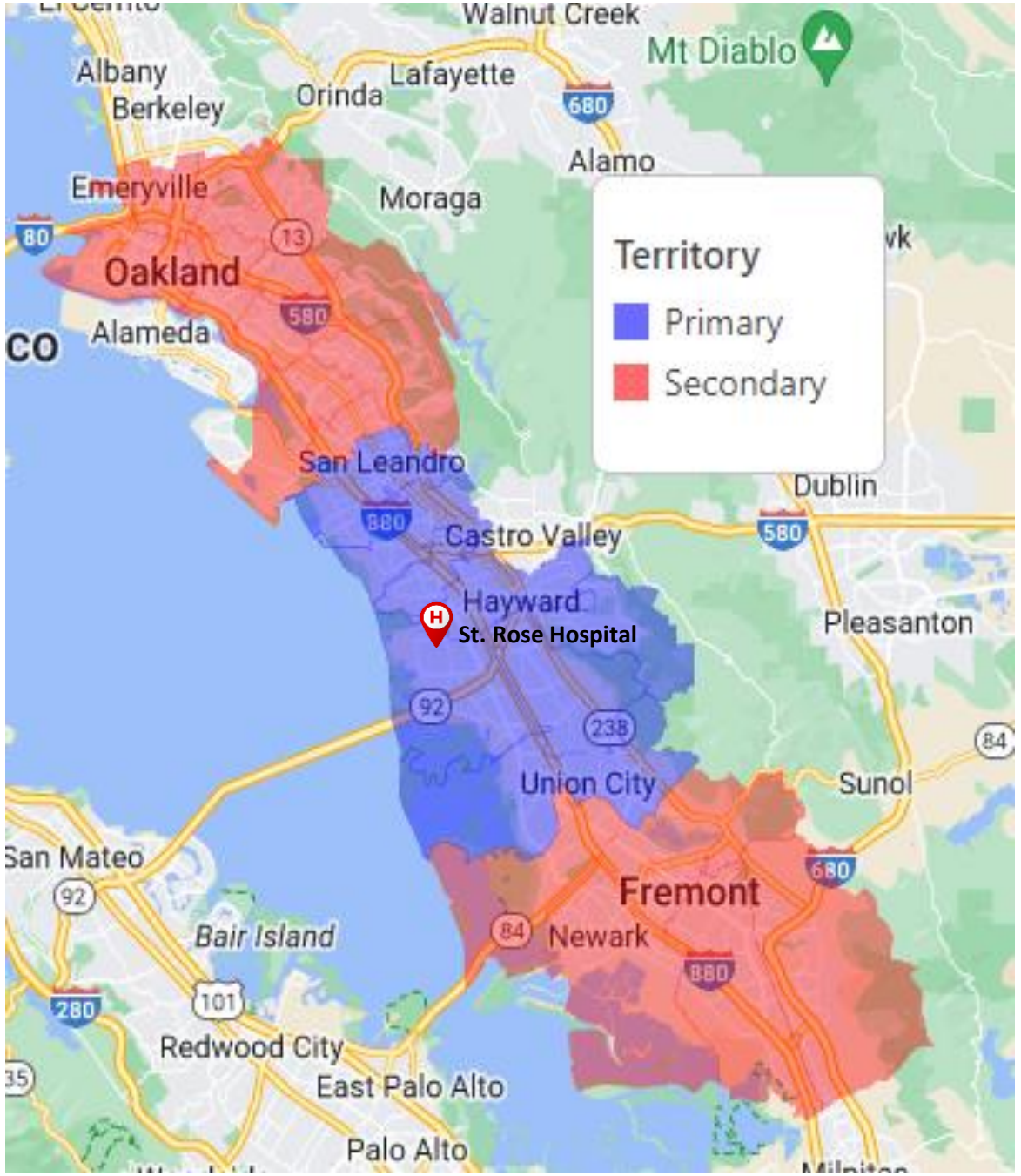
Service Area: St. Rose Hospital

Primary Service Area

Zip	City	% of Discharges
94544	Hayward	30.44%
94541	Hayward	16.72%
94545	Hayward	12.90%
94542	Hayward	1.47%
94587	Union City	6.27%
94580	San Lorenzo	2.79%
94577	San Leandro	3.22%
94578	San Leandro	2.86%
94579	San Leandro	1.68%
Total		**78.35%**

Secondary Service Area

Zip	City	% of Discharges
94538	Fremont	2.97%
94536	Fremont	2.24%
94555	Fremont	0.90%
94539	Fremont	0.49%
94621	Oakland	0.80%
94605	Oakland	0.85%
94603	Oakland	1.06%
94606	Oakland	0.26%
94602	Oakland	0.39%
94601	Oakland	0.52%
94607	Oakland	0.31%
94619	Oakland	0.18%
94612	Oakland	0.26%
94609	Oakland	0.10%
94608	Oakland	0.31%
94610	Oakland	0.10%
94611	Oakland	0.13%
94618	Oakland	0.05%
94613	Oakland	0.00%
94560	Newark	1.96%
Total		**13.88%**

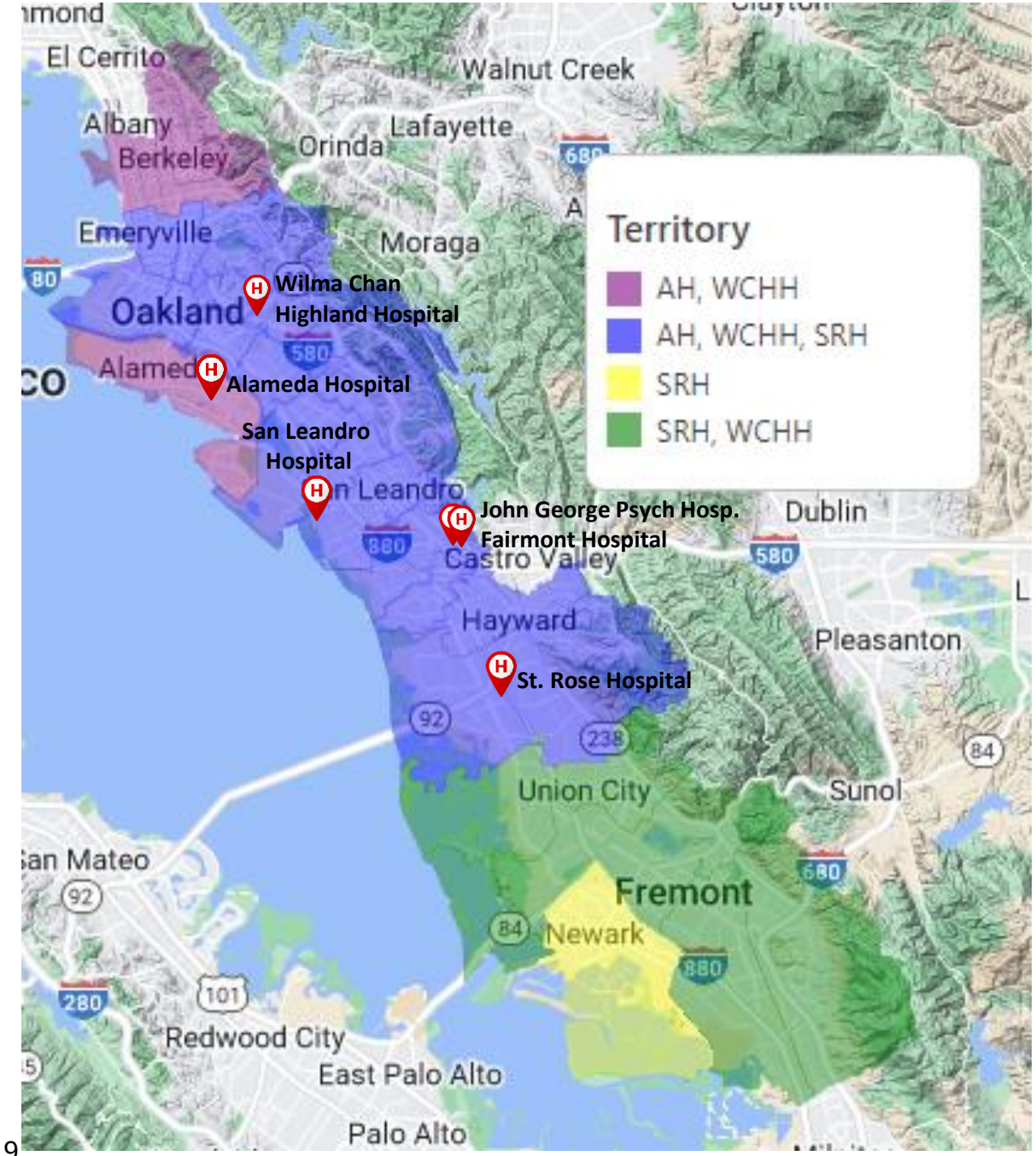


Source: HCAI Non-public data set, CY 2022; Total discharges: 3,876 excl. DRG 795 Normal Newborn; Homeless: 133

MARKET DEFINITION

Combined Service Areas: AHS and SRH

City	AHS Hospital
Oakland	All Hospitals
Hayward	
San Leandro	
San Lorenzo	
Alameda	Alameda Hospital Wilma Chan Highland Hospital
Berkeley	
Freemont	St. Rose Hospital Wilma Chan Highland Hospital
Union City	
Newark	St. Rose Hospital Only



DEMOGRAPHIC SNAPSHOT

AHS Total Area

	Area	USA
2024 Total Population	1,332,813	338,440,954
2029 Total Population	1,355,653	344,873,411
% Change 2024 - 2029	1.7%	1.9%
2024 Average Household Income	$171,443	$113,185
2029 Average Household Income	$197,456	$130,580
2024 Per Capita Household Income	$59,799	$43,830

	2024	2029	% Change
Total Male Population	664,519	671,796	1.1%
Total Female Population	668,294	683,857	2.3%
Female Child Bearing Age (15 - 44)	291,810	286,473	-1.8%
Male Average Age	37.6	38.6	2.6%
Female Average Age	38.8	39.9	2.6%

	Age Distribution					USA
Age Group	2024	% of Total	2029	% of Total	% Change	% Change
Age 0-4	68,982	5.18%	66,795	4.9%	-3.2%	0.3%
Age 5-9	72,121	5.41%	68,362	5.0%	-5.2%	-5.4%
Age 10-14	70,880	5.32%	73,691	5.4%	4.0%	-1.9%
Age 15-19	77,835	5.84%	78,106	5.8%	0.3%	-4.3%
Age 20-24	91,672	6.88%	88,871	6.6%	-3.1%	-2.3%
Age 25-29	93,773	7.04%	94,318	7.0%	0.6%	7.5%
Age 30-34	114,561	8.60%	98,296	7.3%	-14.2%	-4.8%
Age 35-39	111,685	8.38%	111,382	8.2%	-0.3%	4.6%
Age 40-44	105,206	7.89%	107,862	8.0%	2.5%	1.5%
Age 45-49	88,112	6.61%	101,359	7.5%	15.0%	10.5%
Age 50-54	85,583	6.42%	84,911	6.3%	-0.8%	-4.9%
Age 55-59	74,743	5.61%	79,319	5.9%	6.1%	-0.8%
Age 60-64	72,918	5.47%	69,321	5.1%	-4.9%	-8.4%
Age 65-69	64,894	4.87%	67,395	5.0%	3.9%	3.8%
Age 70-74	52,996	3.98%	59,336	4.4%	12.0%	12.9%
Age 75-79	39,772	2.98%	46,839	3.5%	17.8%	15.8%
Age 80-84	22,887	1.72%	31,842	2.3%	39.1%	33.6%
Age 85+	24,193	1.82%	27,648	2.0%	14.3%	17.4%
Total	1,332,813	100.00%	1,355,653	100.0%	1.7%	1.9%

	Race / Ethnicity Distribution				
Race / Ethnicity	2024	% of Total	2029	% of Total	% Change
American Indian/Alaska Nati	17,714	1.3%	17,867	1.3%	0.9%
Asian	456,804	34.3%	483,906	35.7%	5.9%
Black/African American	141,643	10.6%	139,355	10.3%	-1.6%
Other Race	206,878	15.5%	215,669	15.9%	4.2%
Pacific Islander	12,934	1.0%	13,234	1.0%	2.3%
Population of 2 or More Rac	153,077	11.5%	158,492	11.7%	3.5%
White	343,763	25.8%	327,130	24.1%	-4.8%
Total	1,332,813	100.0%	1,355,653	100.0%	1.7%
Hispanic	345,183	25.9%	358,589	26.5%	3.9%

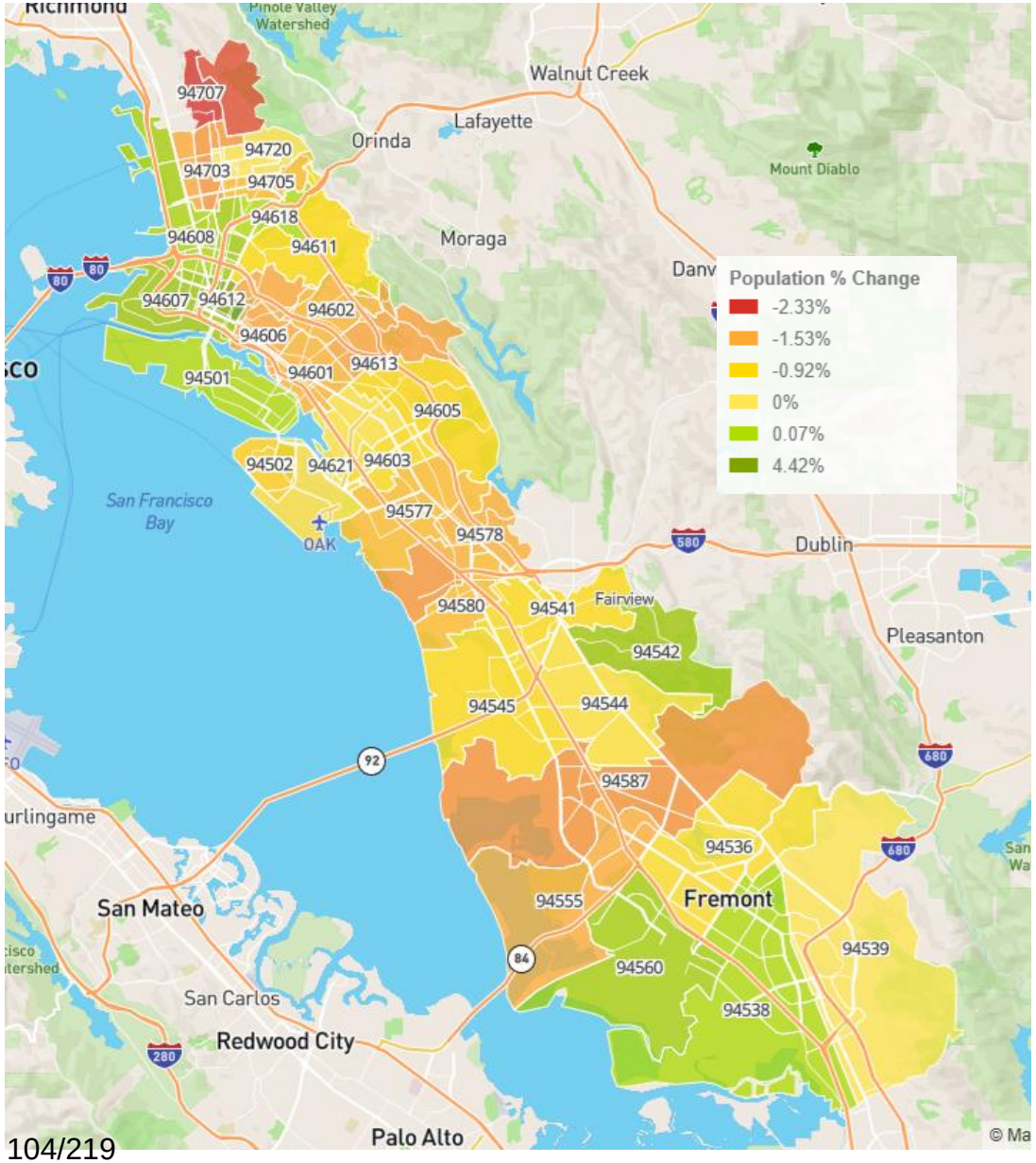
	# of Households				
Household Income	2024	% of Total	2029	% of Total	% Change
< $15,000	34,650	7.5%	29,495	6.3%	-14.9%
$15,000 - $24,999	21,215	4.6%	15,195	3.3%	-28.4%
$25,000 - $34,999	18,639	4.0%	14,473	3.1%	-22.4%
$35,000 - $49,999	26,255	5.7%	20,639	4.4%	-21.4%
$50,000 - $99,999	100,036	21.6%	90,061	19.3%	-10.0%
Over $100,000	262,207	56.6%	297,008	63.6%	13.3%
Total	463,002	100.0%	466,871	100.0%	0.8%

[BACK]

DEMOGRAPHIC SNAPSHOT – 5YR PROJECTED GROWTH

AHS Total Area

- Population is projected to grow under 1% over the next five years – except for parts of Oakland – expanding 1%-4% (94608 and 94612, respectively)
- Alameda, Newark and parts of Hayward and Oakland are growing by 1% or less
- Most of the service area is remaining flat or declining by nearly 2%



DEMOGRAPHIC SNAPSHOT

Alameda County

	Area	USA
2024 Total Population	1,692,200	338,440,954
2029 Total Population	1,721,012	344,873,411
% Change 2024 - 2029	1.7%	1.9%
2024 Average Household Income	$181,747	$113,185
2029 Average Household Income	$208,528	$130,580
2024 Per Capita Household Income	$63,708	$43,830

	2024	2029	% Change
Total Male Population	842,847	851,867	1.1%
Total Female Population	849,353	869,145	2.3%
Female Child Bearing Age (15 - 44)	365,337	358,554	-1.9%
Male Average Age	37.7	38.7	2.6%
Female Average Age	38.9	39.9	2.6%

	Age Distribution					USA
Age Group	**2024**	**% of Total**	**2029**	**% of Total**	**% Change**	**% Change**
Age 0-4	87,925	5.20%	85,054	4.9%	-3.3%	0.3%
Age 5-9	93,953	5.55%	88,476	5.1%	-5.8%	-5.4%
Age 10-14	93,605	5.53%	96,631	5.6%	3.2%	-1.9%
Age 15-19	98,989	5.85%	99,468	5.8%	0.5%	-4.3%
Age 20-24	111,412	6.58%	107,755	6.3%	-3.3%	-2.3%
Age 25-29	114,581	6.77%	117,341	6.8%	2.4%	7.5%
Age 30-34	140,941	8.33%	121,724	7.1%	-13.6%	-4.8%
Age 35-39	140,683	8.31%	139,319	8.1%	-1.0%	4.6%
Age 40-44	136,217	8.05%	137,065	8.0%	0.6%	1.5%
Age 45-49	114,907	6.79%	131,358	7.6%	14.3%	10.5%
Age 50-54	110,710	6.54%	110,155	6.4%	-0.5%	-4.9%
Age 55-59	96,587	5.71%	102,683	6.0%	6.3%	-0.8%
Age 60-64	93,648	5.53%	89,186	5.2%	-4.8%	-8.4%
Age 65-69	81,805	4.83%	85,671	5.0%	4.7%	3.8%
Age 70-74	66,003	3.90%	74,476	4.3%	12.8%	12.9%
Age 75-79	50,111	2.96%	58,606	3.4%	17.0%	15.8%
Age 80-84	29,444	1.74%	40,638	2.4%	38.0%	33.6%
Age 85+	30,679	1.81%	35,406	2.1%	15.4%	17.4%
Total	**1,692,200**	**100.00%**	**1,721,012**	**100.0%**	**1.7%**	**1.9%**

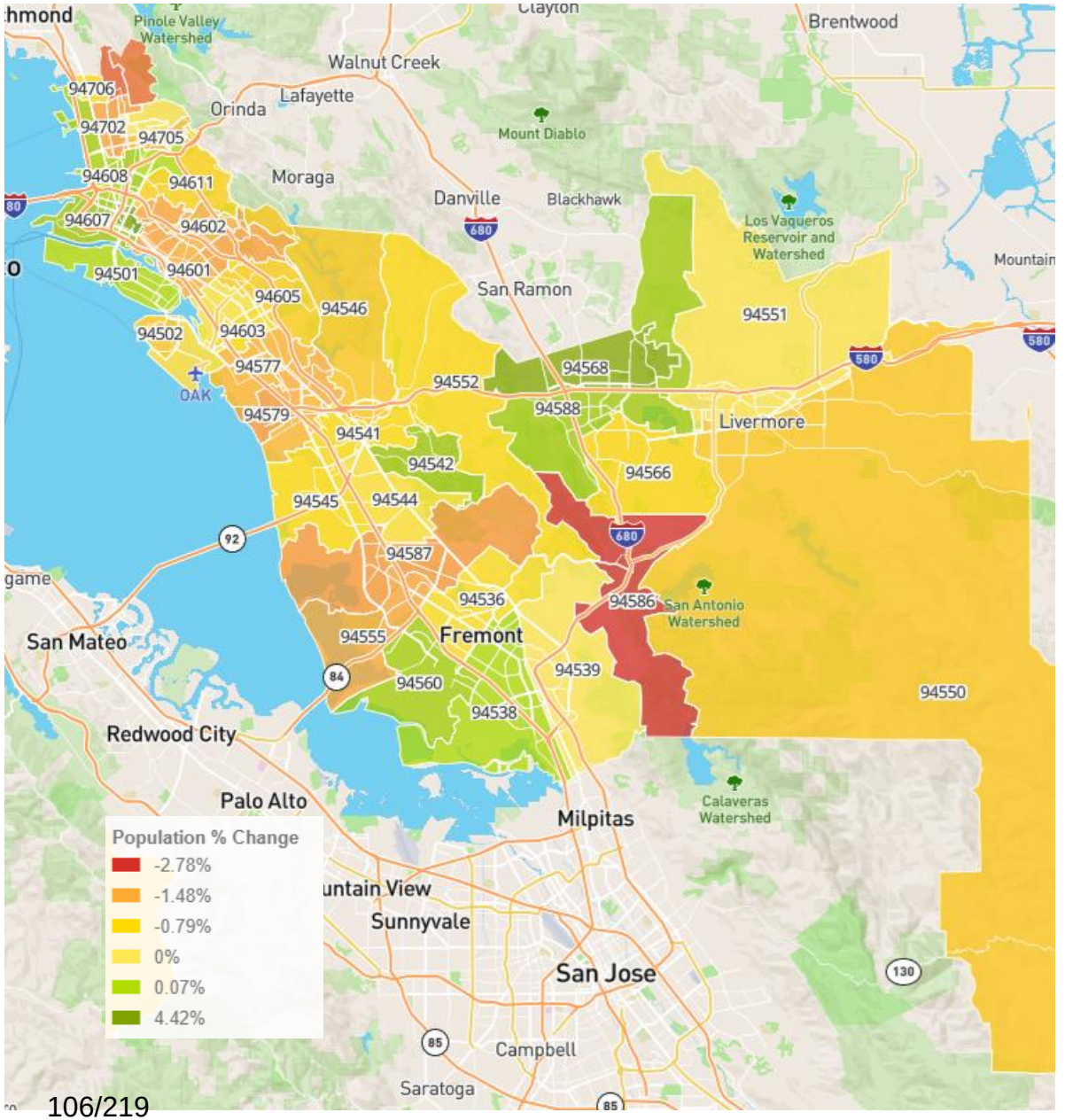
	Race / Ethnicity Distribution				
Race / Ethnicity	**2024**	**% of Total**	**2029**	**% of Total**	**% Change**
American Indian/Alaska Nati	20,206	1.2%	20,393	1.2%	0.9%
Asian	579,960	34.3%	616,943	35.8%	6.4%
Black/African American	158,955	9.4%	156,737	9.1%	-1.4%
Other Race	229,040	13.5%	239,387	13.9%	4.5%
Pacific Islander	14,063	0.8%	14,413	0.8%	2.5%
Population of 2 or More Rac	195,380	11.5%	202,884	11.8%	3.8%
White	494,596	29.2%	470,255	27.3%	-4.9%
Total	**1,692,200**	**100.0%**	**1,721,012**	**100.0%**	**1.7%**
Hispanic	401,924	23.8%	418,880	24.3%	4.2%

	# of Households				
Household Income	**2024**	**% of Total**	**2029**	**% of Total**	**% Change**
< $15,000	40,518	6.9%	34,280	5.8%	-15.4%
$15,000 - $24,999	24,410	4.1%	17,342	2.9%	-29.0%
$25,000 - $34,999	21,751	3.7%	16,732	2.8%	-23.1%
$35,000 - $49,999	31,053	5.3%	24,234	4.1%	-22.0%
$50,000 - $99,999	121,869	20.6%	108,159	18.1%	-11.2%
Over $100,000	351,707	59.5%	395,204	66.3%	12.4%
Total	**591,308**	**100.0%**	**595,951**	**100.0%**	**0.8%**

DEMOGRAPHIC SNAPSHOT – 5YR PROJECTED GROWTH

Alameda County

- Looking at broader Alameda County, growth trends are similar
- However, Dublin is growing by almost 4.5%



DEMOGRAPHIC SNAPSHOT

Contra Costa County

	Area	USA
2024 Total Population	1,173,306	338,440,954
2029 Total Population	1,186,197	344,873,411
% Change 2024 - 2029	1.1%	1.9%
2024 Average Household Income	$176,425	$113,185
2029 Average Household Income	$201,551	$130,580
2024 Per Capita Household Income	$61,265	$43,830

	2024	2029	% Change
Total Male Population	580,835	583,875	0.5%
Total Female Population	592,471	602,322	1.7%
Female Child Bearing Age (15 - 44)	222,672	221,084	-0.7%
Male Average Age	38.5	39.4	2.4%
Female Average Age	40.1	41.0	2.2%

	Age Distribution					USA
Age Group	2024	% of Total	2029	% of Total	% Change	% Change
Age 0-4	61,430	5.24%	60,286	5.1%	-1.9%	0.3%
Age 5-9	69,350	5.91%	64,983	5.5%	-6.3%	-5.4%
Age 10-14	74,169	6.32%	73,142	6.2%	-1.4%	-1.9%
Age 15-19	74,425	6.34%	70,846	6.0%	-4.8%	-4.3%
Age 20-24	69,994	5.97%	65,921	5.6%	-5.8%	-2.3%
Age 25-29	65,992	5.62%	74,253	6.3%	12.5%	7.5%
Age 30-34	74,765	6.37%	71,932	6.1%	-3.8%	-4.8%
Age 35-39	81,614	6.96%	79,775	6.7%	-2.3%	4.6%
Age 40-44	87,931	7.49%	84,127	7.1%	-4.3%	1.5%
Age 45-49	79,504	6.78%	87,015	7.3%	9.4%	10.5%
Age 50-54	79,521	6.78%	76,283	6.4%	-4.1%	-4.9%
Age 55-59	73,288	6.25%	73,527	6.2%	0.3%	-0.8%
Age 60-64	72,837	6.21%	67,690	5.7%	-7.1%	-8.4%
Age 65-69	64,009	5.46%	66,683	5.6%	4.2%	3.8%
Age 70-74	52,906	4.51%	58,992	5.0%	11.5%	12.9%
Age 75-79	41,868	3.57%	47,262	4.0%	12.9%	15.8%
Age 80-84	25,154	2.14%	34,393	2.9%	36.7%	33.6%
Age 85+	24,549	2.09%	29,087	2.5%	18.5%	17.4%
Total	1,173,306	100.00%	1,186,197	100.0%	1.1%	1.9%

	Race / Ethnicity Distribution				
Race / Ethnicity	2024	% of Total	2029	% of Total	% Change
American Indian/Alaska Nati	12,515	1.1%	12,702	1.1%	1.5%
Asian	239,692	20.4%	257,091	21.7%	7.3%
Black/African American	100,774	8.6%	100,161	8.4%	-0.6%
Other Race	182,457	15.6%	192,159	16.2%	5.3%
Pacific Islander	6,481	0.6%	6,685	0.6%	3.1%
Population of 2 or More Rac	159,523	13.6%	166,744	14.1%	4.5%
White	471,864	40.2%	450,655	38.0%	-4.5%
Total	1,173,306	100.0%	1,186,197	100.0%	1.1%
Hispanic	330,946	28.2%	347,634	29.3%	5.0%

	# of Households				
Household Income	2024	% of Total	2029	% of Total	% Change
< $15,000	24,995	6.1%	21,007	5.1%	-16.0%
$15,000 - $24,999	13,408	3.3%	9,432	2.3%	-29.7%
$25,000 - $34,999	15,498	3.8%	11,873	2.9%	-23.4%
$35,000 - $49,999	25,163	6.2%	19,468	4.8%	-22.6%
$50,000 - $99,999	79,594	19.5%	70,603	17.3%	-11.3%
Over $100,000	248,566	61.0%	276,251	67.6%	11.1%
Total	407,224	100.0%	408,634	100.0%	0.3%

DEMOGRAPHIC SNAPSHOT

Santa Clara County

	Area	USA
2024 Total Population	1,954,835	338,440,954
2029 Total Population	1,985,829	344,873,411
% Change 2024 - 2029	1.6%	1.9%
2024 Average Household Income	$212,303	$113,185
2029 Average Household Income	$239,530	$130,580
2024 Per Capita Household Income	$72,502	$43,830

	2024	2029	% Change
Total Male Population	1,001,510	1,009,932	0.8%
Total Female Population	953,325	975,897	2.4%
Female Child Bearing Age (15 - 44)	402,306	397,845	-1.1%
Male Average Age	37.4	38.5	2.9%
Female Average Age	38.6	39.6	2.6%

	Age Distribution					USA
Age Group	2024	% of Total	2029	% of Total	% Change	% Change
Age 0-4	100,922	5.16%	98,352	5.0%	-2.5%	0.3%
Age 5-9	109,384	5.60%	103,058	5.2%	-5.8%	-5.4%
Age 10-14	110,668	5.66%	113,816	5.7%	2.8%	-1.9%
Age 15-19	113,496	5.81%	111,308	5.6%	-1.9%	-4.3%
Age 20-24	126,514	6.47%	118,899	6.0%	-6.0%	-2.3%
Age 25-29	143,005	7.32%	144,436	7.3%	1.0%	7.5%
Age 30-34	167,958	8.59%	145,936	7.3%	-13.1%	-4.8%
Age 35-39	154,613	7.91%	164,231	8.3%	6.2%	4.6%
Age 40-44	152,460	7.80%	151,659	7.6%	-0.5%	1.5%
Age 45-49	130,993	6.70%	147,737	7.4%	12.8%	10.5%
Age 50-54	133,125	6.81%	127,129	6.4%	-4.5%	-4.9%
Age 55-59	116,523	5.96%	122,964	6.2%	5.5%	-0.8%
Age 60-64	109,213	5.59%	107,121	5.4%	-1.9%	-8.4%
Age 65-69	89,749	4.59%	97,194	4.9%	8.3%	3.8%
Age 70-74	69,250	3.54%	81,530	4.1%	17.7%	12.9%
Age 75-79	53,512	2.74%	62,726	3.2%	17.2%	15.8%
Age 80-84	35,313	1.81%	44,763	2.3%	26.8%	33.6%
Age 85+	38,137	1.95%	42,970	2.2%	12.7%	17.4%
Total	1,954,835	100.00%	1,985,829	100.0%	1.6%	1.9%

	Race / Ethnicity Distribution				
Race / Ethnicity	2024	% of Total	2029	% of Total	% Change
American Indian/Alaska Nati	22,517	1.2%	22,561	1.1%	0.2%
Asian	794,293	40.6%	839,877	42.3%	5.7%
Black/African American	47,799	2.4%	47,268	2.4%	-1.1%
Other Race	287,277	14.7%	297,754	15.0%	3.6%
Pacific Islander	8,713	0.4%	8,780	0.4%	0.8%
Population of 2 or More Rac	214,108	11.0%	220,914	11.1%	3.2%
White	580,128	29.7%	548,675	27.6%	-5.4%
Total	1,954,835	100.0%	1,985,829	100.0%	1.6%
Hispanic	507,598	26.0%	524,671	26.4%	3.4%

	# of Households				
Household Income	2024	% of Total	2029	% of Total	% Change
< $15,000	32,234	4.8%	26,990	3.9%	-16.3%
$15,000 - $24,999	21,911	3.3%	15,436	2.2%	-29.6%
$25,000 - $34,999	19,406	2.9%	14,857	2.2%	-23.4%
$35,000 - $49,999	27,830	4.2%	21,472	3.1%	-22.8%
$50,000 - $99,999	107,130	16.1%	94,570	13.8%	-11.7%
Over $100,000	458,261	68.7%	514,086	74.8%	12.2%
Total	666,772	100.0%	687,411	100.0%	3.1%

DEMOGRAPHIC SNAPSHOT

San Francisco County

	Area	USA
2024 Total Population	835,785	338,440,954
2029 Total Population	850,528	344,873,411
% Change 2024 - 2029	1.8%	1.9%
2024 Average Household Income	$199,264	$113,185
2029 Average Household Income	$228,715	$130,580
2024 Per Capita Household Income	$87,984	$43,830

	2024	2029	% Change
Total Male Population	433,001	436,364	0.8%
Total Female Population	402,784	414,164	2.8%
Female Child Bearing Age (15 - 44)	195,212	191,017	-2.1%
Male Average Age	40.0	41.2	3.0%
Female Average Age	40.3	41.4	2.7%

	Age Distribution					USA
Age Group	**2024**	**% of Total**	**2029**	**% of Total**	**% Change**	**% Change**
Age 0-4	32,930	3.94%	31,966	3.8%	-2.9%	0.3%
Age 5-9	30,152	3.61%	29,664	3.5%	-1.6%	-5.4%
Age 10-14	26,319	3.15%	30,205	3.6%	14.8%	-1.9%
Age 15-19	27,803	3.33%	29,136	3.4%	4.8%	-4.3%
Age 20-24	46,641	5.58%	45,149	5.3%	-3.2%	-2.3%
Age 25-29	85,307	10.21%	69,765	8.2%	-18.2%	7.5%
Age 30-34	106,945	12.80%	87,151	10.2%	-18.5%	-4.8%
Age 35-39	82,795	9.91%	92,638	10.9%	11.9%	4.6%
Age 40-44	64,128	7.67%	73,805	8.7%	15.1%	1.5%
Age 45-49	50,812	6.08%	60,732	7.1%	19.5%	10.5%
Age 50-54	51,727	6.19%	50,460	5.9%	-2.4%	-4.9%
Age 55-59	46,842	5.60%	49,246	5.8%	5.1%	-0.8%
Age 60-64	44,505	5.32%	44,386	5.2%	-0.3%	-8.4%
Age 65-69	40,349	4.83%	41,848	4.9%	3.7%	3.8%
Age 70-74	35,280	4.22%	37,886	4.5%	7.4%	12.9%
Age 75-79	26,663	3.19%	31,051	3.7%	16.5%	15.8%
Age 80-84	16,729	2.00%	23,409	2.8%	39.9%	33.6%
Age 85+	19,858	2.38%	22,031	2.6%	10.9%	17.4%
Total	**835,785**	**100.00%**	**850,528**	**100.0%**	**1.8%**	**1.9%**

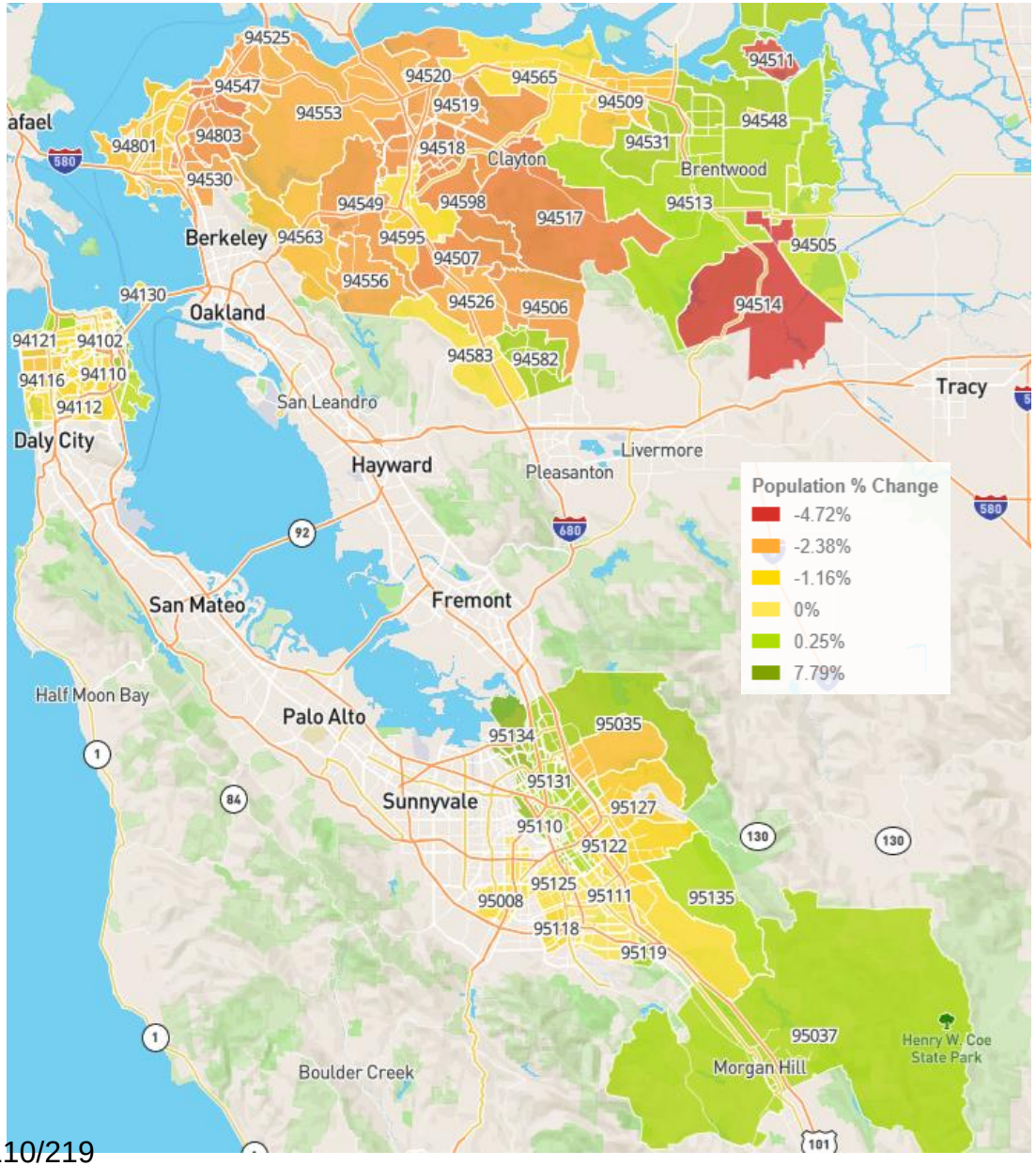
	Race / Ethnicity Distribution				
Race / Ethnicity	**2024**	**% of Total**	**2029**	**% of Total**	**% Change**
American Indian/Alaska Nati	6,653	0.8%	6,791	0.8%	2.1%
Asian	297,398	35.6%	318,069	37.4%	7.0%
Black/African American	44,578	5.3%	44,575	5.2%	-0.0%
Other Race	73,592	8.8%	77,749	9.1%	5.6%
Pacific Islander	3,335	0.4%	3,449	0.4%	3.4%
Population of 2 or More Rac	86,175	10.3%	90,440	10.6%	4.9%
White	324,054	38.8%	309,455	36.4%	-4.5%
Total	**835,785**	**100.0%**	**850,528**	**100.0%**	**1.8%**
Hispanic	137,905	16.5%	145,573	17.1%	5.6%

	# of Households				
Household Income	**2024**	**% of Total**	**2029**	**% of Total**	**% Change**
< $15,000	29,627	8.1%	25,034	6.7%	-15.5%
$15,000 - $24,999	16,785	4.6%	11,933	3.2%	-28.9%
$25,000 - $34,999	11,625	3.2%	8,892	2.4%	-23.5%
$35,000 - $49,999	16,165	4.4%	12,563	3.4%	-22.3%
$50,000 - $99,999	68,336	18.6%	61,140	16.3%	-10.5%
Over $100,000	225,102	61.2%	254,775	68.1%	13.2%
Total	**367,640**	**100.0%**	**374,337**	**100.0%**	**1.8%**

DEMOGRAPHIC SNAPSHOT – 5Yr PROJECTED GROWTH

Contra Costa, San Francisco, and Santa Clara Counties

- Counties surrounding Alameda County follow similar trends with only marginal expected growth over the next five years
- San Jose and parts of San Francisco are projected to growth more than 5%



MARKET ANALYSIS AND TRENDS

A thorough market analysis ensures services align with community needs, resources are used efficiently, and AHS remains responsive to changing health landscapes.

[BACK]

COMPETITIVE TRENDS OR THREATS

Market Competition
Larger Health Systems & Clinics

- Kaiser, Sutter dominate with scale and technology
- Access & seamless experience are a draw for pts.
- Urgent care, retail clinics, and specialty OP offer faster service, extended hrs. and lower out of pocket costs

Financial Pressures
Funding & Reimbursement Risks

- Heavy reliance on Medi-Cal/Medicare
- Competitors have more diversified revenue streams
- Value-based care demands investment – analytics and care coordination a must

Workforce & Technology
Talent and Tech Gaps

- Competitors lead in telehealth and AI
- Patients seek convenient, tech-enabled care
- Labor shortages & retention challenges given area's high cost of living

Patient & Policy Shifts
Changing Demographics and Policies

- Diverse patients seek modern facilities, shorter wait times, convenient scheduling
- Policy changes threaten funding

COMPETITIVE LANDSCAPE

KAISER PERMANENTE

By the Numbers
- 10 hospitals
- 2,500 – 3,500 licensed beds
- 100-150 clinics
- 400-500K members Alameda County
- 11,225 physicians
- Key acute care hubs include San Francisco Medical Center and Oakland Medical Center

Reputation/Recognition
- 2024–2025 U.S. News & World Report Top Hospitals
- 2024 NCQA Patient-Centered Medical Home (PCMH) Recognition
- 2024 Insure.com Best Health Insurance Companies
- DiversityInc Top 50 Hall of Fame
- Five-time honoree by the Ethisphere Institute for ethical practices
- CMS 5★ Pharmacy Quality Alliance Excellence in Quality 12 yrs. consecutive
- 2024 Computerworld Best Place to Work in IT

Services/Locations
- Major medical centers in San Francisco, Oakland, Richmond, South San Francisco, San Leandro, San Jose, Santa Clara, San Rafael, Santa Rosa, and Vallejo
- Oakland and Vallejo are Level II trauma centers
- 24/7 emergency departments are available at all listed hospitals
- Pediatric emergency care is available at Oakland and Santa Clara
- Affiliated facilities – Watsonville Community Hospital (Santa Cruz County) and East Bay Post-Acute (Castro Valley, CA)

News & Noteworthy Developments
- A March 2024, Lown Institute report criticized Kaiser for receiving $26 billion more in tax breaks than it spent on community benefits, with Kaiser challenging the analysis
- On August 14, 2024, Kaiser Permanente began using Abridge's AI software to transcribe patient-doctor conversations across its Bay Area hospitals, following a pilot program though it sparked protests by nurses
- The Post-Acute Care Center in San Leandro closed in November 2024 due to low bed usage, with patients transitioned to home care or other facilities
- On January 3, 2025, over 2,000 Northern California Kaiser Permanente mental health workers, part of the National Union of Healthcare Workers (NUHW)
- On January 29, 2025, the Bay Area News Group reported that Kaiser Permanente in Northern California disciplined two top clinicians for violating patient protections in a major research study
- In April 2025, layoffs were reported, affecting 11 employees in Oakland and Pleasonton
- On April 6, 2025, Kaiser Permanente fired its corporate security chief and several staff in Oakland following allegations that an Oakland police officer shared information from a criminal database, potentially violating privacy laws
- Kaiser's March 19, 2025, groundbreaking for a new Railyards Medical Center in Sacramento (310 beds, 70-treatment bay ER) signals regional investment in acute care infrastructure, potentially easing pressure on Bay Area facilities
- Kaiser's shift toward Care at Home programs, which provide acute and post-acute care in patients' homes via virtual monitoring and in-home visits, has reduced reliance on traditional post-acute care centers

SUTTER HEALTH

By the Numbers
- 13 hospitals, 3 in Alameda County
- 2,800 – 3,200 licensed beds
- 3 Post Acute Care centers
- Planned Emeryville Campus
- Over 200 Clinics
- Approximately 3.5M patients in a non-profit HMO
- 12,000+ affiliated physicians

Reputation/Recognition
- Sutter hospitals have received multiple honors from U.S. News & World Report
- Hospitals were recognized by Healthgrades for commitment to excellence in patient care, including designation as one of America's 50 Top Hospitals
- Sutter's Innovation Center, a dynamic hub where technology partners, leaders, clinicians and employees come together to collaborate and shape the future of healthcare
- Sutter settled a major antitrust lawsuit in March 2025; accused of using market power to inflate healthcare costs by over $400 million from 2011 to 2020

Services/Locations
- Sutter divides the Bay Area into regional service areas, each anchored by major hospitals and supported by clinics and medical groups
- Alameda/Contra Costa service area includes Alta Bates Summit Medical Centers and Eden Medical Center, supported by Sutter East Bay Medical Group (SEBMG)
- Offers Sutter Care at Home: home health and hospice services as a post-acute care alternative to traditional facilities
- Primary care and specialty clinics

News & Noteworthy Developments
- On March 28, 2024, Sutter Health launched a $1 billion East Bay medical campus to avert the closure of Alta Bates Summit Medical Center, enhancing acute care access
- Since April 2024, some Sutter Health doctors have used Abridge's AI software to transcribe patient-doctor conversations, streamlining workflows and improving patient experience
- In 2024, Sutter announced significant Investment in a New Advanced Multi-Specialty Neurosciences Care Complex in San Francisco's Mission Neighborhood; $442 million investment will expand services and increase patient access to neurological and neurosurgical treatment closer to home
- On December 27, 2024, Sutter Health announced an $800 million investment to renovate two vacant offices in Santa Clara into outpatient medical campuses, totaling 1 million square feet. The facilities, located near Great America Parkway, aim to address patient overflow and long emergency room wait times in Silicon Valley. Permits were issued in November 2024, with a staged opening approach
- The planned Emeryville campus ($1 billion investment, 200 beds by 2032) and Santa Clara campuses ($800 million) signal significant growth
- On April 18, 2025, received accreditation from the ACGME for a new neurology residency program at Sutter Roseville Medical Center (Placer County), starting July 2026
- 2025 – opened a new Arrhythmia Center in Palo Alto
- Investing in the construction and operation of Berkeley's Hope Center, a six-story, 150,000-square-foot building designed to serve the city's low-income, disabled and chronically homeless population

UCSF HEALTH

By the Numbers
- 12,000 employees (incl. physicians)
- 1,746 medical, dental, and pharmacy residents/fellows
- 100,000 annual clinic visits
- 1.7M OP & 45,000K IP visits/admissions/yr.
- 20–30% Medicare and 20–30% Medi-Cal (skews higher in Alameda County)

Reputation/Recognition
- Children's nationally ranked in 10 ped. specialties by U.S. News & World
- 2024-2025, tied for #1 in CA and #1 in the San Francisco Metro Area, in neurology/neurosurgery (#3 nationally), geriatric care (#3), and cancer care (#7 in Northern CA)
- UCSF is the second-largest public agency employer in the Bay Area
- The Champs Internship Program is widely regarded as a model for supporting minority youth in healthcare careers

Services/Locations
- UCSF Helen Diller Medical Center at Parnassus Heights
- UCSF Medical Centers at Mission Bay and Mount Zion
- UCSF Benioff Children's Hospitals in Oakland
- Langley Porter Psychiatric Hospital and Clinics
- UCSF Health Saint Francis Hospital and UCSF Health St. Mary's Hospital
- Bayfront Medical Building – 181,000-sq. ft. adult urgent care, primary care, same-day surgery, and specialties: cardiology, neurosurgery, and urology

News & Noteworthy Developments
- UCSF Health's 2024 acquisition of St. Mary's Hospital and Saint Francis Hospital expanded its footprint in the Bay Area
- In 2004, Alameda County launched the Community Assistance, Recovery, and Empowerment (CARE) Court which intersects with UCSF's Langley Porter Psychiatric Hospital
- Affiliations with community hospitals and clinics in Alameda County, such as through the San Francisco Bay Area Collaborative Research Network, enhance primary care and research partnership
- 2024 – received $815 million in NIH awards
- 2025 – announced a multi-year research collaboration with Visage Imaging to advance health imaging technologies
- In 2025, UCSF published in a study in JAMA Internal Medicine estimating that CT scans could contribute to 5% of U.S. cancer cases, tripling previous estimates due to overuse and high radiation doses

WASHINGTON HEALTH

By the Numbers
- 415-bed Acute Care hospital
- ~600 physicians and APPs
- 10-20 primary and specialty care clinics
- 11,000 inpatient admissions
- 330,000 outpatient visits
- 60,000 ED visits
- 1,500 deliveries
- 4,500 surgeries

Reputation/Recognition
- Magnet Designation since 2011
- Designated STEMI receiving center
- Healthgrades awards for multiple Orthopedics outcomes
- Beta Healthcare Group's Quest for Zero Quality Initiative for excellence in Emergency Department quality initiatives
- 2023–2025: TJC Spine Center Accreditation

Services/Locations
- Acute Care hospital with Level II Trauma
- Critical Care Pavilion
- Neuroscience Institute
- Radiation Oncology Center
- Outpatient Surgery Center
- Outpatient Rehabilitation Center
- Institute for Joint Restoration and Research
- Washington West houses the Washington Women's Center, Outpatient Imaging Center, Sandy Amos RN Infusion Center, UCSF-Washington Cancer Center, and additional outpatient and administrative services

News & Noteworthy Developments
- Received Level II Trauma designation in 2024
- This fall, Washington Health Urgent Care reopened in the shopping center adjacent to Washington West
- Recently updated equipment to optimize imaging for both inpatient and outpatient imaging services, including CT, MRI and PET scans, X-ray, and ultrasound
- Affiliated with UCSF Health through a community-focused model (funded by the Washington Township Health Care District)
- UCSF – Washington Cancer Center slated to debut in the Washington West building in January 2026
- Morris Hyman Critical Care Pavilion (MHCCP) is being redeveloped so emergency, critical care, and trauma services are located in one modern, seismically safe building
- Washington Hospital – UCSF Warm Springs Health Center is expected by 2027 near the Warm Springs BART station and will provide a full range of outpatient primary and specialty care, including an imaging and ambulatory surgical center
- Plans are currently in the works for a new 200,000-square-foot building adjacent to the MHCCP. Complementing the Pavilion and will house all Maternal Child Health-related departments such as the Birthing Center, Special Care Nursery, as well as medical surgical units and clinical services; expected by 2030
- WHHS has been recognized for its community health initiatives, such as pediatric care addressing childhood obesity and environmental health awareness campaigns tied to Earth Day 2025

STANFORD HEALTHCARE

By the Numbers
- 3,245 physicians
- 15,142 employees
- 613 Licensed beds
- 30K discharges
- 84K ED visits
- 500K outpatient visits
- 25K surgeries
- 80+ clinics and medical offices

Reputation/Recognition
- Consistently ranks among top hospitals – US News & World Report
- Leverages Silicon Valley location to pioneer medical advancements
- Attracts world renowned physicians and researchers as an academic medical center
- Magnet Recognition 2007, 2012, 2020
- "First US hospital certified as a Comprehensive Stroke Center (2012)
- Contributes ~$614 million annually to community benefits, including charity care and medical education

Services/Locations
- Peninsula: two hospitals in Stanford, separate adult and pediatric emergency hospitals in Palo Alto, 3 outpatient centers, 4 institutes, and imaging center in Palo Alto, and a patient care unit in Redwood City
- South Bay: a cancer center in San Jose
- East Bay: hospital in Emeryville and a medical group practice in Hayward
- Tri-Valley: medical center and ED in Pleasanton, urgent cares in Livermore and Dublin, three physician practices in Castro Valley, Pleasanton, and Danville

News & Noteworthy Developments
- 2024 Mitral Valve Repair Reference Center Award from the American Heart Association and Mitral Foundation for superior mitral valve repair outcomes
- Highest designation for geriatric care, recognized for its NICHE (Nurses Improving Care for Healthsystem Elders) program and "Senior Friendly" status, ensuring excellence for patients over 65
- Noted for exceptional outcomes in solid organ transplants
- Recognized for 13 years by the Digital Health Most Wired Program for advanced technology adoption in ambulatory and acute care, including telehealth and patient-facing systems
- 2024 – Stanford Health Care and Sequoia Hospital won the ISP Star Award for their innovative "hospital-within-a-hospital" model, enhancing care delivery through collaborative care integration
- 2025 – Stanford Health Care Emeryville Expansion project, designed by KMD Architects, won a 2025 Healthcare Environment Award from The Center for Health Design for design improvements in safety, patient experience, and operational efficiency
- 2025 – Stanford Health Care's intensive care units were honored for excellence in nursing by American Association of Critical Care Nurses' Beacon Awards for Excellence
- 2030 refreshed Strategic Plan identified 3 priorities: Regional Connectivity, Precision Health & Innovation, Health Equity.
- Reported a 6.2% revenue increase for the year ending August 31, 2024, despite a 20% drop in operating income due to rising expenses (8.2%). Healthcare services now account for 41% of Stanford Medicine's $9.7 billion projected revenue for 2024-25, up from 33% a decade ago

JOHN MUIR HEALTH

By the Numbers
- 799 licensed beds
- 1,350 primary and specialty physicians in John Muir Physician Network and John Muir Medica Group
- 6,000 employees
- Serves over 2M people in East Bay

Reputation/Recognition
- Partnerships with UCSF Health, Stanford Medicine, and Tenet Healthcare
- Leader in advanced treatments and minimally invasive robotic-assisted surgery, including robotic-assisted angioplasty, TAVR, MitraClip, and Hybrid AF for atrial fibrillation
- First in the nation accredited by the National Accreditation Program for Rectal Cancer (NAPRC)

Services/Locations
- John Muir Medical Center, Walnut Creek
- John Muir Medical Center, Concord
- 73-bed Psychiatric Hospital in Concord
- Urgent Care Centers in Berkeley and Walnut Creek
- 23 primary care locations from Brentwood to Pleasanton

News & Noteworthy Developments
- 2025 – Concord Medical Center received top recognition for exceptional survival rates following coronary artery bypass graft (CABG) surgery
- The UCSF-John Muir Health Jean and Ken Hofmann Cancer Center (155,000 sq. ft.) opened in February 2024
- The adolescent Partial Hospital and Intensive Outpatient program at the Concord Behavioral Health Center closed on December 13, 2024
- January 2024 – John Muir Health partnered with The Pennant Group to form Muir Home Health, a joint venture providing skilled nursing, therapy, and home health aide services across the Bay Area
- In 2025, John Muir Health expanded its in-network coverage with CalPERS health plans (e.g., Anthem Blue Cross HMO, Blue Shield PPO) and continued Medicare Advantage partnerships (e.g., Central Health Medicare HMO)
- Emphasizes integration with Covered California and other marketplaces to reach uninsured or underinsured populations

EL CAMINO HEALTH

By the Numbers
- 466 licensed beds
- 4,381 employees
- 1,552 physicians
- 22K admissions
- 270K outpatient visits
- 4,761 deliveries, making it one of CA's top hospitals for births

Reputation/Recognition
- 2022–2024 – named one of the World's Best Hospitals, ranking 84th in the U.S. in 2024 and the highest-ranked community hospital in the Bay Area
- Mountain View and Los Gatos hospitals "A" rated for patient safety from The Leapfrog Group
- In January 2024, the Mountain View hospital designated a High Performing hospital for maternity care by U.S. News & World Report
- Nationally recognized Stroke care excellence – Get With The Guidelines

Services/Locations
- Mountain View Hospital
- Los Gatos Hospital
- Sunnyvale Rehabilitation Hospital (Under Construction)
- Outpatient and Urgent Care Locations – Cupertino, Santa Clara, San Jose
- Specialty Clinics – Cancer Care, Cardiovascular Care, Orthopedics, Pulmonology, Urology, Mental Health, Women's Health Services

News & Noteworthy Developments
- In May 2025, El Camino Health broke ground on a 63,000-square-foot rehabilitation hospital in Sunnyvale; the facility will focus on acute adult inpatient care for conditions like strokes, spinal cord injuries, and traumatic brain injuries, featuring interdisciplinary gyms and a therapeutic courtyard
- In January 2025 announced a multi-year partnership with the San Jose Earthquakes, becoming the title sponsor of the California Clásico at Stanford Stadium
- Official Healthcare Partner of San José State Athletics
- In FY25, El Camino Health and the El Camino Healthcare District allocated $11.15M in grants to fund 104 community health programs, including 12 new initiatives to expand healthcare access

DIGNITY HEALTH (COMMONSPIRIT)

Dignity Health
A member of CommonSpirit

By the Numbers
- Dominican Hospital – Santa Cruz
  - 222 licensed beds
  - 1,560 employees
  - 520 active medical staff
  - 14 NICU beds
  - 20-bed ARU
- Sequoia Hospital – Redwood City
  - 208 licensed acute-beds
  - 917 employees
  - 530 active medical staff

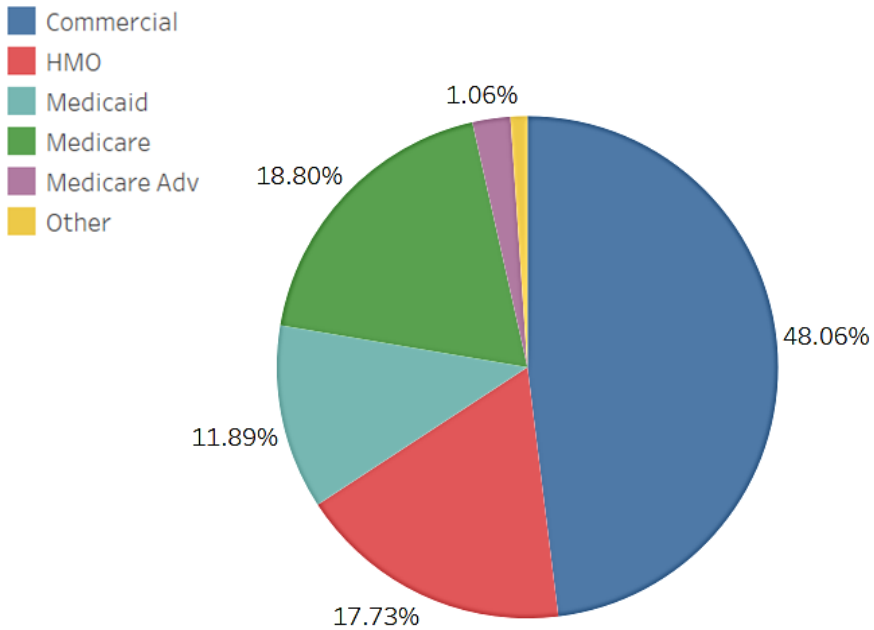
Reputation/Recognition
- Dominican Hospital earned an "A" Hospital Safety Grade from The Leapfrog Group
- Sequoia Hospital Earns 4th Consecutive 'A' Hospital Safety Grade from The Leapfrog Group

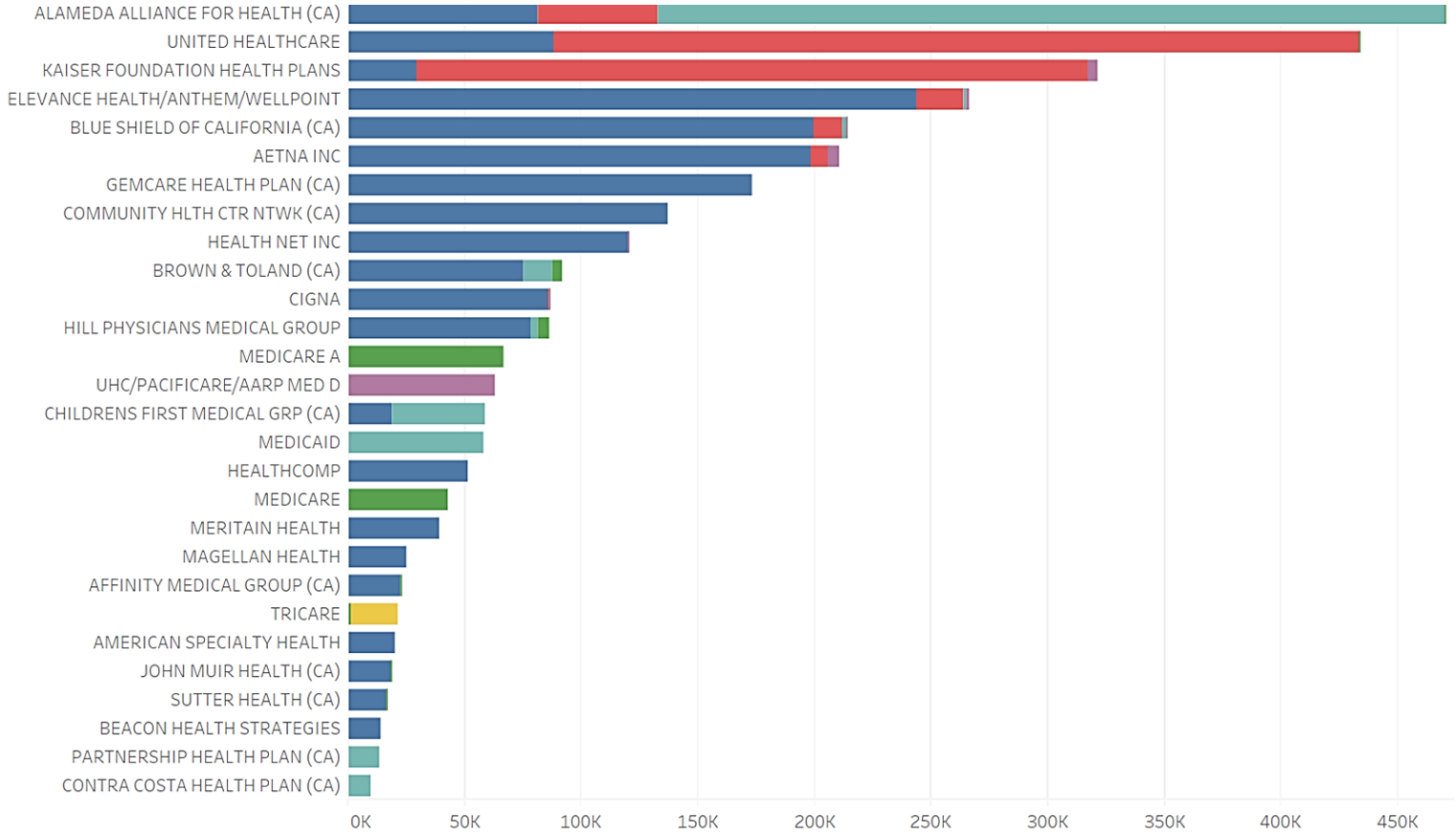
Services/Locations
- Dominican Hospital – Santa Cruz
  - ARU
  - Birth Center
  - Cancer Center
  - Cardiac Care
  - OP Rehab
  - Robotic Surgery
  - Orthopedics
  - Family Medicine Residency
- Sequoia Hospital – Redwood City
  - Birth Center
  - Breast Center
  - Health & Wellness Center
  - Heart & Vascular
  - Infusion
  - Orthopedics
  - Stroke Care

News & Noteworthy Developments
- April 2024 Dominican Hospital, in collaboration with Morehouse School of Medicine, announced the selection of its first cohort of residents
- March 2025 Dominican Hospital successfully performed the world's first procedure which combines an artificial talus bone with a total ankle replacement AND successfully performed the first Barostim™ implant in the region, marking a major advancement in heart failure treatment
- Dominican Hospital now offers a proven, non-invasive diagnostic option for individuals with suspected heart disease
- Dominican Hospital provided more than $4M during FY24 in patient financial assistance
- Sequoia Hospital has new state-of-the-art Pavilion offering inpatient and outpatient care and comprehensive physician services; the main hospital is being remodeled to meet state mandated seismic requirements
- Sequoia Hospital has affiliations with UCSF, Stanford Children's Health

MARKET ANALYSIS AND TRENDS

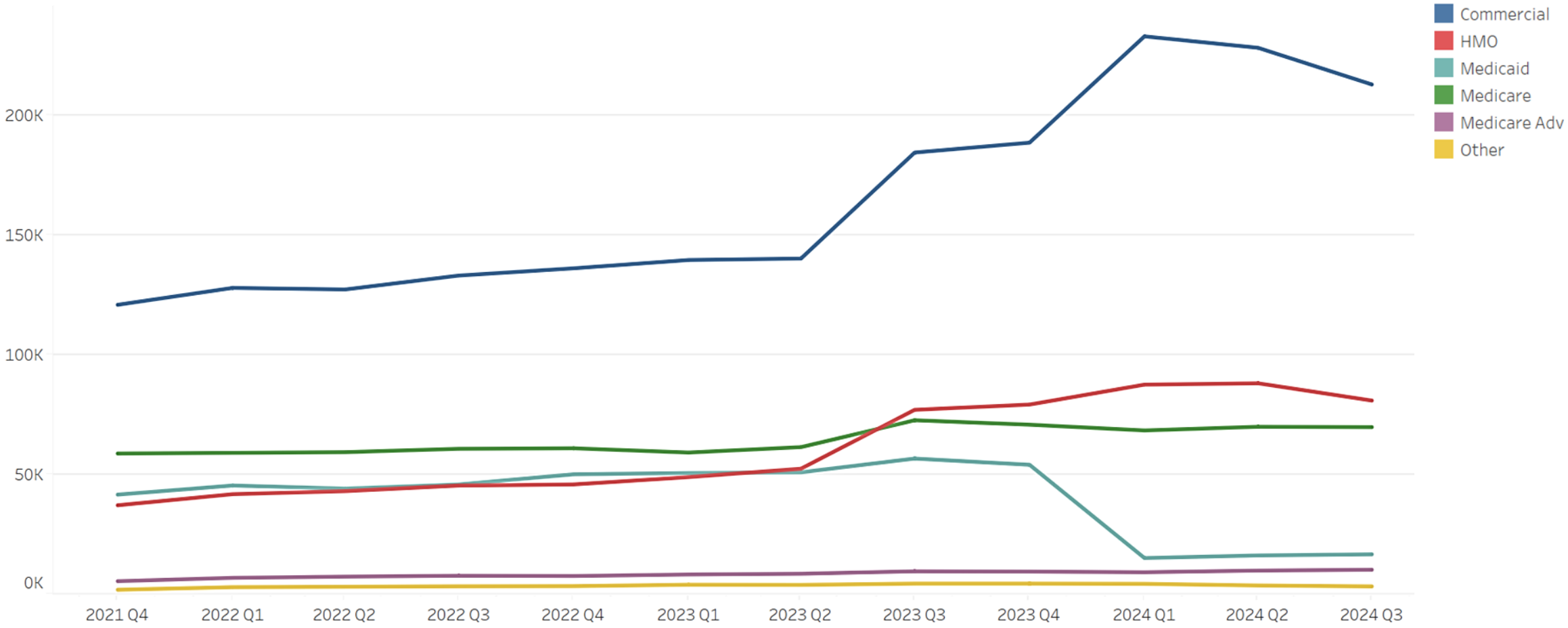
Payor Mix





MARKET ANALYSIS AND TRENDS

Payor Mix Trend



MARKET ANALYSIS AND TRENDS

Payor Mix Projection – Covered Lives

- Commercial covered lives are expected to remain relatively flat or decline across the AHS market
- Medicare and Medicare advantage will grow in proportion to expansion of ages 65+ age cohorts
- Medicaid growing under 1% over the next five years

	Commercial			Medicaid			Medicare			Medicare Adv			Other			Grand Total		
	Current Year Est. Lives	5-Year Projected Lives	Population Growth Rate	Current Year Est. Lives	5-Year Projected Lives	Population Growth Rate	Current Year Est. Lives	5-Year Projected Lives	Population Growth Rate	Current Year Est. Lives	5-Year Projected Lives	Population Growth Rate	Current Year Est. Lives	5-Year Projected Lives	Population Growth Rate	Current Year Est. Lives	5-Year Projected Lives	Population Growth Rate
Alameda	54,228	54,668	0.8%	11,060	11,378	2.9%	5,552	6,268	12.9%	6,562	7,483	12.3%	2,690	2,802	4.2%	**80,092**	**82,600**	**3.1%**
Berkeley	90,839	91,406	0.6%	17,963	18,139	1.0%	8,031	8,867	10.4%	9,586	10,645	9.9%	3,767	3,772	0.1%	**130,186**	**132,829**	**2.0%**
Fremont	172,714	170,755	-1.1%	30,073	30,809	2.4%	12,203	13,919	14.1%	14,162	16,301	13.1%	6,210	6,314	1.7%	**235,362**	**238,098**	**1.2%**
Hayward	122,146	120,391	-1.4%	42,844	42,975	0.3%	9,862	11,174	13.3%	11,424	13,115	12.9%	12,959	13,246	2.2%	**199,235**	**200,901**	**0.8%**
Newark	37,419	37,504	0.2%	5,687	5,924	4.2%	2,607	3,005	15.3%	3,037	3,535	14.1%	730	741	1.5%	**49,480**	**50,709**	**2.5%**
Oakland	278,511	279,672	0.4%	78,921	80,236	1.7%	22,993	26,001	13.1%	27,146	30,933	12.2%	21,061	21,661	2.8%	**428,632**	**438,503**	**2.3%**
San Leandro	59,590	58,168	-2.4%	31,648	31,511	-0.4%	6,453	7,303	13.2%	7,547	8,648	12.7%	4,213	4,271	1.4%	**109,451**	**409,901**	**0.4%**
San Lorenzo	17,471	16,924	-3.1%	7,920	7,678	-3.1%	1,702	1,954	14.8%	1,999	2,332	14.3%	382	399	4.5%	**29,474**	**29,287**	**-0.6%**
Union City	36,662	35,895	-2.1%	21,399	21,117	-1.3%	4,118	4,514	9.6%	4,845	5,374	9.8%	2,077	2,090	0.6%	**69,101**	**68,990**	**-0.2%**
Grand Total	**869,580**	**865,383**	**-0.5%**	**247,515**	**249,767**	**0.9%**	**73,521**	**83,005**	**12.9%**	**86,308**	**98,366**	**12.3%**	**54,089**	**55,296**	**2.2%**	**1,331,013**	**1,351,818**	**1.6%**

EMERGENCY SERVICES

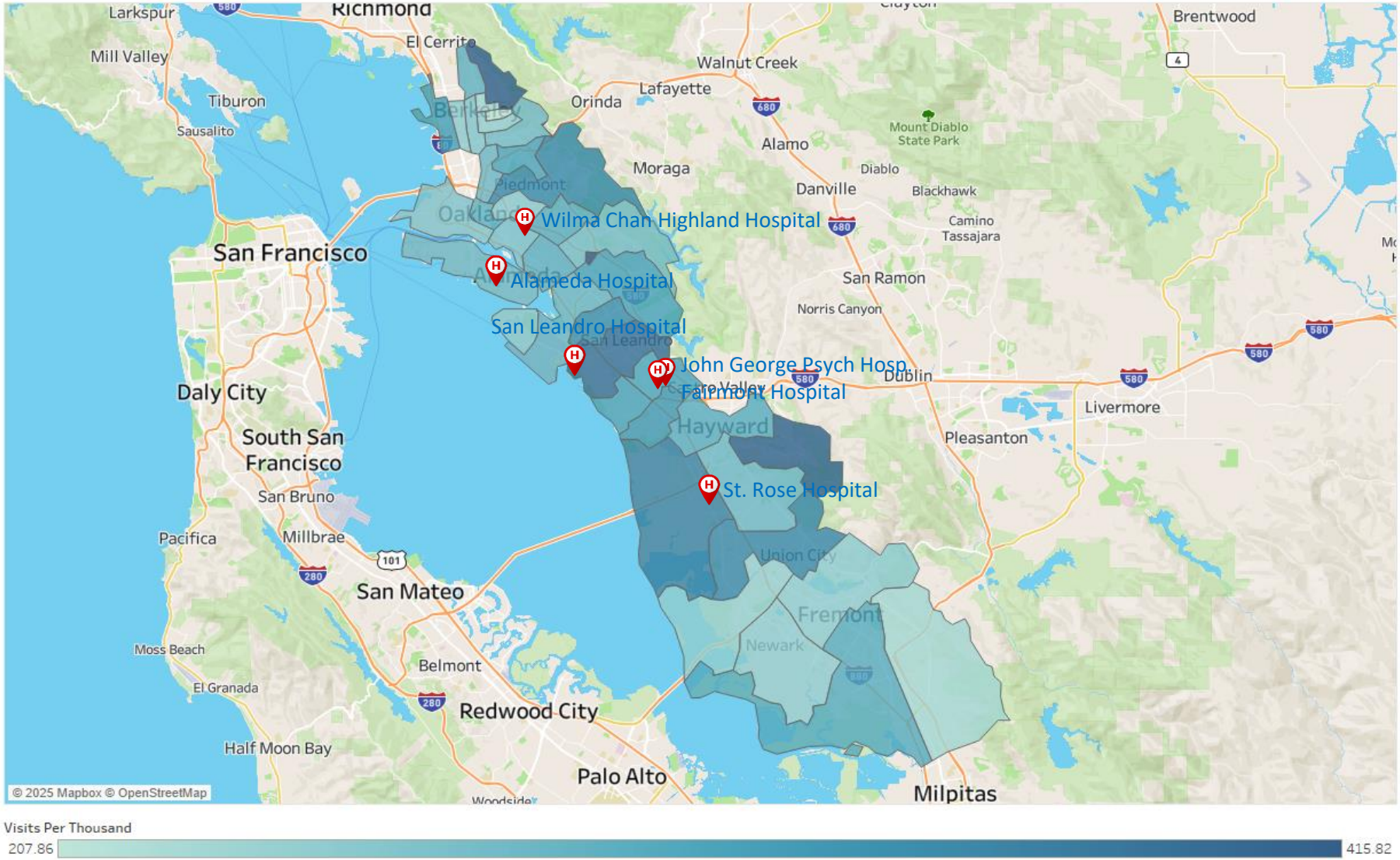
Emergency services are evaluated to ensure AHS is prepared, responsive, and equitable in providing life-saving care for our community, to include:

- Ensuring adequate capacity
- Optimizing response times
- Planning for surge capacity
- Coordinating with stakeholders to streamline response while avoiding service gaps

[BACK]

CURRENT ED VISITS

Total AHS Market



ED MARKET SHARE

Total AHS Market

Total ED Visits Originating in the Service Area

	Visits			Share			▲ Volume		Growth %	
	2021	2022	2023	2021	2022	2023	3 Yr.	1 Yr.	3 Yr.	1 Yr.
Total Service Area ED Visits	**326,416**	**372,979**	**402,503**	**100.0%**	**100.0%**	**100.0%**	**76,087**	**29,524**	**18.9%**	**7.3%**

Staying in the Service Area for ED Care

	Visits			Share			▲ Volume		Growth %	
Facility/System	2021	2022	2023	2021	2022	2023	3 Yr.	1 Yr.	3 Yr.	1 Yr.
Kaiser										
Kaiser Foundation Hospital - Oakland/Richmond	37,920	44,042	46,723	11.6%	11.8%	11.6%	8,803	2,681	18.8%	5.7%
Kaiser Foundation Hospital - San Leandro	48,942	57,337	60,079	15.0%	15.4%	14.9%	11,137	2,742	18.5%	4.6%
Kaiser Foundation Hospital - Fremont	27,140	32,456	34,985	8.3%	8.7%	8.7%	7,845	2,529	22.4%	7.2%
	114,002	**133,835**	**141,787**	**34.9%**	**35.9%**	**35.2%**	**27,785**	**7,952**	**19.6%**	**5.6%**
AHS										
Alameda Hospital	9,795	11,969	13,512	3.0%	3.2%	3.4%	3,717	1,543	27.5%	11.4%
Highland Hospital	52,785	54,833	60,199	16.2%	14.7%	15.0%	7,414	5,366	12.3%	8.9%
St Rose Hospital	15,595	17,677	18,890	4.8%	4.7%	4.7%	3,295	1,213	17.4%	6.4%
	78,175	**84,479**	**92,601**	**23.9%**	**22.6%**	**23.0%**	**14,426**	**8,122**	**15.6%**	**8.8%**
Sutter										
Alta Bates Summit Medical Center	19,884	20,557	22,609	6.1%	5.5%	5.6%	2,725	2,052	12.1%	9.1%
Alta Bates Summit Medical Center-Alta Bates Campus	14,798	16,321	17,784	4.5%	4.4%	4.4%	2,986	1,463	16.8%	8.2%
	34,682	**36,878**	**40,393**	**10.6%**	**9.9%**	**10.0%**	**5,711**	**3,515**	**14.1%**	**8.7%**
Washington Health										
Washington Hospital - Fremont	31,338	37,733	39,517	9.6%	10.1%	9.8%	8,179	1,784	20.7%	4.5%
	31,338	**37,733**	**39,517**	**9.6%**	**10.1%**	**9.8%**	**8,179**	**1,784**	**20.7%**	**4.5%**
UCSF										
Childrens Hospital and Research Center at Oakland	17,338	23,046	24,296	5.3%	6.2%	6.0%	6,958	1,250	28.6%	5.1%
	17,338	**23,046**	**24,296**	**5.3%**	**6.2%**	**6.0%**	**6,958**	**1,250**	**28.6%**	**5.1%**
Staying in the Service Area	**275,535**	**315,971**	**338,594**	**84.4%**	**84.7%**	**84.1%**	**63,059**	**22,623**	**18.6%**	**6.7%**

ED OUTMIGRATION

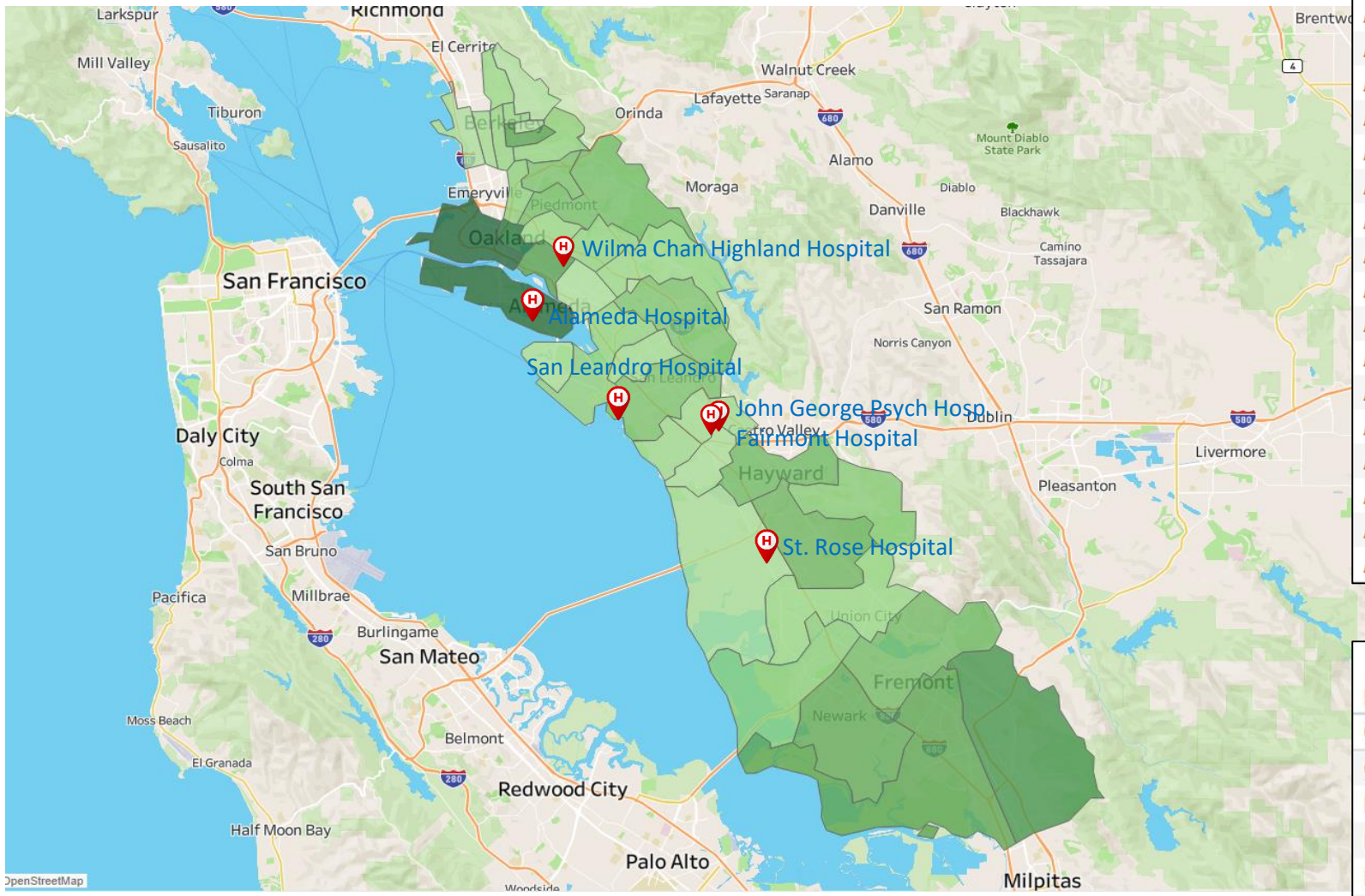
Residents Leaving the Service Area for ED Care

	Visits			Share			▲ Volume		Growth %	
Facility/System	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**3 Yr.**	**1 Yr.**	**3 Yr.**	**1 Yr.**
Kaiser Foundation Hospitals	9,260	10,727	11,336	2.8%	2.9%	2.8%	2,076	609	18.3%	5.4%
Sutter	22,551	25,142	30,486	6.9%	6.7%	7.6%	7,935	5,344	26.0%	17.5%
UC	2,211	2,544	2,648	0.7%	0.7%	0.7%	437	104	16.5%	3.9%
Adventist Health	487	486	456	0.1%	0.1%	0.1%	-31	-30	-6.8%	-6.6%
Dignity Commonspirit	1,783	1,896	2,214	0.5%	0.5%	0.6%	431	318	19.5%	14.4%
Stanford Health Care	5,223	5,875	6,166	1.6%	1.6%	1.5%	943	291	15.3%	4.7%
John Muir Health	1,903	2,054	2,153	0.6%	0.6%	0.5%	250	99	11.6%	4.6%
HCA	922	1,180	1,278	0.3%	0.3%	0.3%	356	98	27.9%	7.7%
Tenet	1,005	1,155	1,101	0.3%	0.3%	0.3%	96	-54	8.7%	-4.9%
El Camino Health	531	604	628	0.2%	0.2%	0.2%	97	24	15.4%	3.8%
Santa Clara Valley Medical Center	472	463	541	0.1%	0.1%	0.1%	69	78	12.8%	14.4%
Adventist Health	487	486	456	0.1%	0.1%	0.1%	-31	-30	-6.8%	-6.6%
Oconnor Hospital	297	377	423	0.1%	0.1%	0.1%	126	46	29.8%	10.9%
Contra Costa Regional Medical Center	420	464	397	0.1%	0.1%	0.1%	-23	-67	-5.8%	-16.9%
Providence St Joseph Health	277	292	320	0.1%	0.1%	0.1%	43	28	13.4%	8.8%
San Mateo Medical Center	277	280	310	0.1%	0.1%	0.1%	33	30	10.6%	9.7%
San Joaquin General Hospital	301	261	261	0.1%	0.1%	0.1%	-40	0	-15.3%	0.0%
North Bay Medical Center	200	224	242	0.1%	0.1%	0.1%	42	18	17.4%	7.4%
Marin General Hospital	221	217	233	0.1%	0.1%	0.1%	12	16	5.2%	6.9%
Tahoe Forest Hospital	217	247	200	0.1%	0.1%	0.0%	-17	-47	-8.5%	-23.5%
Verity Health System	148	187	188	0.0%	0.1%	0.0%	40	1	21.3%	0.5%
Barton Memorial Hospital	165	186	171	0.1%	0.0%	0.0%	6	-15	3.5%	-8.8%
Cottage Health	106	108	113	0.0%	0.0%	0.0%	7	5	6.2%	4.4%
All Others <50	1,417	1,553	1,588	0.4%	0.4%	0.4%	171	35	10.8%	2.2%
Total ED Outmigration	**50,881**	**57,008**	**63,909**	**15.6%**	**15.3%**	**15.9%**	**13,028**	**6,901**	**20.4%**	**10.8%**

ED PROJECTION - INCREMENTAL 5-YEAR VISTS

Total AHS Market

Incremental 5-Year Visits by Zip



Growth by Summary Age Group

Age Group	Current Year Annual ..	5-Year Projected Annual Vi..	Incremental Annual Visi..	Visits Growth Rate
Grand Total	392,663	403,780	11,117	2.8%
Age 00 through 04	28,966	28,011	-956	-3.3%
Age 05 through 09	16,257	15,416	-841	-5.2%
Age 10 through 14	13,326	13,959	632	4.7%
Age 15 through 19	19,753	19,796	43	0.2%
Age 20 through 24	25,472	24,499	-973	-3.8%
Age 25 through 29	25,330	25,411	81	0.3%
Age 30 through 34	30,697	26,448	-4,250	-13.8%
Age 35 through 39	29,459	29,486	27	0.1%
Age 40 through 44	28,587	29,348	762	2.7%
Age 45 through 49	22,365	25,669	3,304	14.8%
Age 50 through 54	22,997	22,678	-319	-1.4%
Age 55 through 59	20,969	22,047	1,079	5.1%
Age 60 through 64	20,319	19,169	-1,150	-5.7%
Age 65 through 69	20,441	21,211	770	3.8%
Age 70 through 74	18,364	20,520	2,156	11.7%
Age 75 through 79	17,928	21,066	3,139	17.5%
Age 80 through 84	12,836	17,819	4,983	38.8%
Age 85 and over	18,598	21,226	2,629	14.1%

Growth by Payor Group

Payor Group	Current Year An..	5-Year Project..	Incremental An..	Visits Growth ..
Grand Total	392,663	403,780	11,117	2.8%
Commercial	137,085	136,430	-655	-0.5%
Medicaid	151,393	150,844	-550	-0.4%
Medicare	38,814	44,270	5,456	14.1%
Medicare Adv	45,123	52,149	7,027	15.6%
Other	20,248	20,087	-161	-0.8%

ED PROJECTION - INCREMENTAL 5-YEAR VISTS

Total AHS Market

Forecast by Specialty by Patient Age Cohort

		Age 00 through 14				Age 15 through 34				Age 35 through 64				Age 65 and over			
		Current Year Annual Visits	5-Year Projected Annual Visits	Incremental Annual Visits in..	Visits Growth Rate	Current Year Annual Visits	5-Year Projected Annual Visits	Incremental Annual Visits in..	Visits Growth Rate	Current Year Annual Visits	5-Year Projected Annual Visits	Incremental Annual Visits in..	Visits Growth Rate	Current Year Annual Visits	5-Year Projected Annual Visits	Incremental Annual Visits in..	Visits Growth Rate
Grand Total		**58,549**	**57,385**	**-1,164**	**-2.0%**	**101,252**	**96,154**	**-5,098**	**-5.0%**	**144,696**	**148,398**	**3,702**	**2.6%**	**88,166**	**101,843**	**13,677**	**15.5%**
None	Behavioral	769	797	28	3.7%	6,865	6,525	-340	-4.9%	7,301	7,480	179	2.5%	1,311	1,458	147	11.2%
	Cardiology	557	560	3	0.5%	4,542	4,270	-271	-6.0%	14,714	15,064	351	2.4%	12,752	14,777	2,025	15.9%
	Dentistry	217	212	-5	-2.3%	880	825	-55	-6.2%	1,108	1,140	31	2.8%	183	206	24	13.0%
	Dermatology	1,586	1,561	-25	-1.6%	3,442	3,262	-180	-5.2%	5,265	5,398	133	2.5%	2,031	2,326	295	14.5%
	Emergent - Urgent Care	14,039	13,856	-183	-1.3%	20,386	19,438	-948	-4.7%	23,402	23,969	568	2.4%	15,452	17,902	2,450	15.9%
	Endocrinology	103	102	0	-0.3%	613	576	-37	-6.0%	2,135	2,180	46	2.1%	1,473	1,691	218	14.8%
	ENT	3,743	3,642	-101	-2.7%	2,798	2,673	-125	-4.5%	2,930	3,011	81	2.8%	1,045	1,195	151	14.4%
	Gastroenterology	1,882	1,842	-39	-2.1%	4,502	4,259	-243	-5.4%	8,428	8,652	224	2.7%	5,094	5,875	782	15.3%
	General Surgery	290	287	-3	-1.0%	541	511	-30	-5.5%	1,296	1,329	32	2.5%	932	1,079	147	15.8%
	Genetics	1	1	0	-2.6%	1	1	0	-2.4%	0	0	0	-0.9%	0	0	0	3.8%
	Hematology	104	103	-1	-1.3%	330	311	-19	-5.8%	854	882	28	3.3%	769	895	127	16.5%
	Infectious Disease	5,721	5,571	-150	-2.6%	5,319	5,044	-274	-5.2%	9,387	9,622	234	2.5%	8,312	9,665	1,353	16.3%
	Neonatology	522	505	-17	-3.3%	1	1	0	-5.8%	1	1	0	2.4%	0	0	0	11.7%
	Nephrology	10	10	0	-1.1%	90	83	-7	-7.3%	597	604	7	1.1%	1,246	1,453	206	16.6%
	Neurology	1,272	1,258	-14	-1.1%	4,074	3,861	-213	-5.2%	6,737	6,935	198	2.9%	3,379	3,891	513	15.2%
	Neurosurgery	94	92	-2	-2.4%	134	127	-7	-5.0%	129	132	3	2.3%	73	84	11	15.6%
	OBGYN	154	158	3	2.0%	11,347	10,772	-576	-5.1%	4,893	5,037	144	2.9%	225	255	30	13.2%
	Oncology	42	42	-1	-1.4%	180	168	-12	-6.6%	1,028	1,054	27	2.6%	1,029	1,191	162	15.7%
	Opthalmology	760	741	-19	-2.4%	861	816	-45	-5.3%	1,620	1,661	41	2.5%	662	756	93	14.1%
	Orthopedics	1,363	1,366	2	0.2%	5,028	4,750	-278	-5.5%	10,293	10,557	264	2.6%	5,182	5,934	752	14.5%
	Other	1,198	1,173	-25	-2.1%	2,651	2,504	-148	-5.6%	3,265	3,343	78	2.4%	1,346	1,543	197	14.7%
	Plastic Surgery	5	5	0	-1.9%	3	3	0	-4.3%	2	2	0	1.8%	0	0	0	19.2%
	Podiatry	1	1	0	0.6%	6	6	0	-6.2%	15	15	0	2.0%	8	9	1	13.1%
	Primary Care	11,624	11,357	-267	-2.3%	16,365	15,571	-794	-4.8%	23,840	24,473	633	2.7%	15,264	17,644	2,380	15.6%
	Pulmonology	11,097	10,779	-318	-2.9%	5,170	4,943	-227	-4.4%	5,913	6,056	143	2.4%	4,382	5,060	678	15.5%
	Social	17	17	0	-0.7%	95	89	-6	-6.2%	130	133	3	2.4%	38	43	5	13.9%
	Spine	115	114	0	-0.4%	925	866	-60	-6.4%	2,490	2,556	66	2.7%	1,169	1,336	167	14.3%
	Urology	1,263	1,234	-29	-2.3%	4,086	3,882	-204	-5.0%	6,902	7,088	186	2.7%	4,803	5,565	762	15.9%
	Vascular	2	2	0	-0.5%	17	16	-1	-6.3%	22	23	1	2.5%	8	9	1	14.5%

INPATIENT MARKET SHARE

By monitoring inpatient market share, AHS can identify trends, address competitive challenges, and make data-driven decisions to improve care delivery while protecting financial sustainability.

[BACK]

MARKET ANALYSIS AND TRENDS

Inpatient Market Share

Total Discharges Originating in the Service Area

	Visits			Share			▲ Volume		Growth %	
	2021	2022	2023	2021	2022	2023	3 Yr.	1 Yr.	3 Yr.	1 Yr.
Total Discharges Originating in the Service Area	**92,332**	**94,501**	**96,254**	**100.0%**	**100.0%**	**100.0%**	**3,922**	**1,753**	**4.1%**	**1.8%**

Staying in the Service Area for Inpatient Care

	Visits			Share			▲ Volume		Growth %	
Facility/System	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**3 Yr.**	**1 Yr.**	**3 Yr.**	**1 Yr.**
Kaiser										
Kaiser Foundation Hospital - Oakland/Richmond	10,676	11,093	10,582	11.6%	11.7%	11.0%	-94	-511	-0.9%	-4.8%
Kaiser Foundation Hospital - San Leandro	9,580	9,462	9,790	10.4%	10.0%	10.2%	210	328	2.1%	3.4%
Kaiser Foundation Hospital - Fremont	3,662	3,781	3,834	4.0%	4.0%	4.0%	172	53	4.5%	1.4%
	23,918	**24,336**	**24,206**	**25.9%**	**25.8%**	**25.1%**	**288**	**-130**	**1.2%**	**-0.5%**
AHS										
Alameda Hospital	2,142	2,422	2,483	2.3%	2.6%	2.6%	341	61	13.7%	2.5%
Highland Hospital	12,969	13,213	13,565	14.0%	14.0%	14.1%	596	352	4.4%	2.6%
St Rose Hospital	3,562	3,587	3,214	3.9%	3.8%	3.3%	-348	-373	-10.8%	-11.6%
	18,673	**19,222**	**19,262**	**20.2%**	**20.3%**	**20.0%**	**589**	**40**	**3.1%**	**0.2%**
Sutter										
Alta Bates Summit Medical Center-Herrick Campus	744	638	720	0.8%	0.7%	0.7%	-24	82	-3.3%	11.4%
Alta Bates Summit Medical Center	7,942	7,361	8,156	8.6%	7.8%	8.5%	214	795	2.6%	9.7%
Alta Bates Summit Medical Center-Alta Bates Campus	7,330	7,532	7,267	7.9%	8.0%	7.5%	-63	-265	-0.9%	-3.6%
	16,016	**15,531**	**16,143**	**17.3%**	**16.4%**	**16.8%**	**127**	**612**	**0.8%**	**3.8%**
Washington Health										
Washington Hospital - Fremont	8,005	9,382	9,587	8.7%	9.9%	10.0%	1,582	205	16.5%	2.1%
	8,005	**9,382**	**9,587**	**8.7%**	**9.9%**	**10.0%**	**1,582**	**205**	**16.5%**	**2.1%**
UCSF										
Childrens Hospital and Research Center at Oakland	2,578	2,589	2,689	2.8%	2.7%	2.8%	111	100	4.1%	3.7%
	2,578	**2,589**	**2,689**	**2.8%**	**2.7%**	**2.8%**	**111**	**100**	**4.1%**	**3.7%**
Staying in the Service Area	**69,190**	**71,060**	**71,887**	**74.9%**	**75.2%**	**74.7%**	**2,697**	**827**	**3.8%**	**1.2%**

MARKET ANALYSIS AND TRENDS

Outmigration

Total Discharges Originating in the Service Area

	Visits			Share			▲ Volume		Growth %	
	2021	2022	2023	2021	2022	2023	3 Yr.	1 Yr.	3 Yr.	1 Yr.
Total Discharges Originating in the Service Area	**92,332**	**94,501**	**96,254**	**100.0%**	**100.0%**	**100.0%**	**3,922**	**1,753**	**4.1%**	**1.8%**

Leaving the Service Area for Inpatient Care

	Visits			Share			▲ Volume		Growth %	
Facility/System	2021	2022	2023	2021	2022	2023	3 Yr.	1 Yr.	3 Yr.	1 Yr.
Sutter	7,660	7,541	7,527	8.3%	8.0%	7.8%	-133	-14	-1.8%	-0.2%
Kaiser Foundation Hospitals	3,492	3,655	3,615	3.8%	3.9%	3.8%	123	-40	3.4%	-1.1%
Stanford Health Care	3,160	3,456	3,511	3.4%	3.7%	3.6%	351	55	10.0%	1.6%
UC	2,954	2,928	3,060	3.2%	3.1%	3.2%	106	132	3.5%	4.3%
John Muir Health	1,176	1,169	1,148	1.3%	1.2%	1.2%	-28	-21	-2.4%	-1.8%
Dignity Commonspirit	655	608	610	0.7%	0.6%	0.6%	-45	2	-7.4%	0.3%
El Camino Health	535	580	577	0.6%	0.6%	0.6%	42	-3	7.3%	-0.5%
HCA	431	437	359	0.5%	0.5%	0.4%	-72	-78	-20.1%	-21.7%
Tenet	252	244	251	0.3%	0.3%	0.3%	-1	7	-0.4%	2.8%
Adventist Health	170	182	183	0.2%	0.2%	0.2%	13	1	7.1%	0.5%
All Others	2,657	2,641	3,526	2.9%	2.8%	3.7%	869	885	24.6%	25.1%
Total Outmigration	**23,142**	**23,441**	**24,367**	**25.1%**	**24.8%**	**25.3%**	**1,225**	**926**	**5.0%**	**3.8%**

SERVICE LINE ANALYSIS

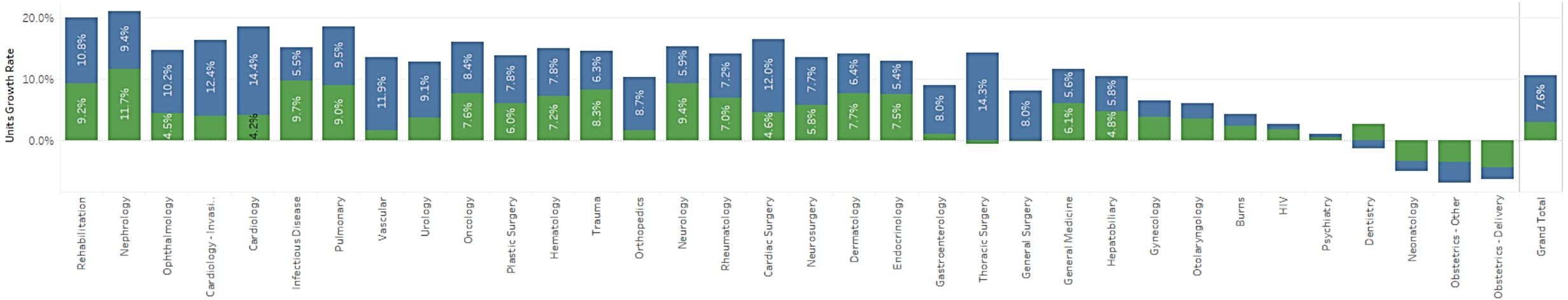
A service line analysis enables AHS to thoughtfully decide on service expansion, consolidation, or partnership. It is driven by demand, capacity, and market competition.

[BACK]

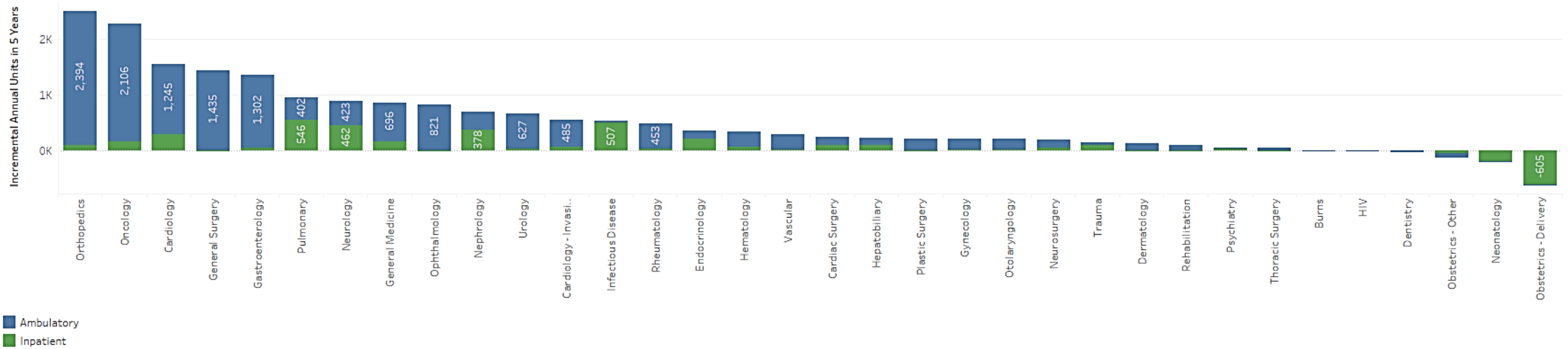
SERVICE LINE GROWTH TRENDS

Total AHS Market

Cases Growth Rates by Service Line



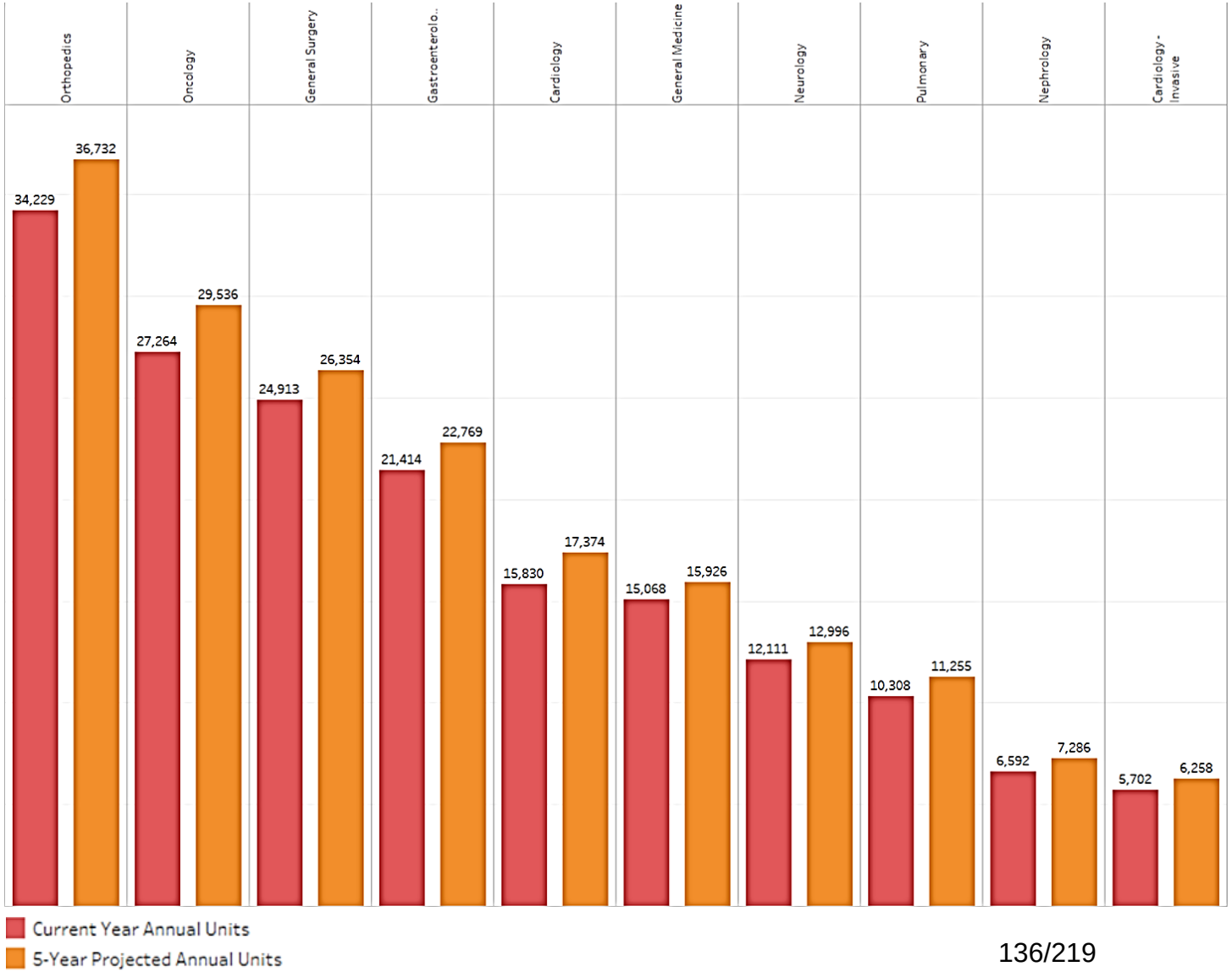
Cases Volume by Service Line



IP SERVICE LINE GROWTH TRENDS – TOP 10

Total AHS Market

Current and 5-Year Projected Annual Cases by Service Line



Cases Growth Summary by Age Group

Age Group	Current Year Annual ..	5-Year Projected Annual U..	Incremental Annual Unit..	Units Growth Rate
Grand Total	173,431	186,486	13,055	7.5%
Age 80 through 84	10,955	15,192	4,237	38.7%
Age 75 through 79	17,675	20,790	3,115	17.6%
Age 45 through 49	12,113	13,985	1,873	15.5%
Age 85 and over	11,123	12,590	1,466	13.2%
Age 70 through 74	18,682	20,942	2,260	12.1%
Age 55 through 59	13,865	14,696	830	6.0%
Age 10 through 14	1,891	1,976	85	4.5%
Age 65 through 69	17,829	18,562	733	4.1%
Age 40 through 44	10,637	10,974	337	3.2%
Age 25 through 29	3,737	3,772	34	0.9%
Age 15 through 19	3,260	3,281	21	0.7%
Age 35 through 39	7,924	7,964	40	0.5%
Age 50 through 54	14,321	14,263	-58	-0.4%
Age 20 through 24	3,147	3,046	-100	-3.1%
Age 00 through 04	2,318	2,240	-78	-3.3%
Age 05 through 09	1,507	1,431	-76	-5.0%
Age 60 through 64	16,169	15,357	-812	-5.0%
Age 30 through 34	6,277	5,424	-853	-13.6%

Current and 5-Yr. Cases Projection by Service Line

Custom Service Line	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	173,431	186,486	13,055	7.5%
Orthopedics	34,229	36,732	2,503	7.3%
Oncology	27,264	29,536	2,272	8.3%
Cardiology	15,830	17,374	1,543	9.7%
General Surgery	24,913	26,354	1,441	5.8%
Gastroenterology	21,414	22,769	1,354	6.3%
Pulmonary	10,308	11,255	947	9.2%
Neurology	12,111	12,996	885	7.3%
General Medicine	15,068	15,926	858	5.7%
Nephrology	6,592	7,286	695	10.5%
Cardiology - Invasive	5,702	6,258	556	9.8%

1. ORTHOPEDICS

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	34,229	36,732	2,503	7.3%
470 MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT ..	4,571	5,408	837	18.3%
552 MEDICAL BACK PROBLEMS WITHOUT MCC	7,483	7,965	482	6.4%
483 MAJOR JOINT OR LIMB REATTACHMENT PROCEDURES OF UPPER E..	732	890	158	21.6%
520 BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITHOUT C..	733	853	120	16.4%
489 KNEE PROCEDURES WITHOUT PRINCIPAL DIAGNOSIS OF INFECTIO..	2,088	2,199	112	5.4%
502 SOFT TISSUE PROCEDURES WITHOUT CC/MCC	2,455	2,534	79	3.2%
517 OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R..	1,328	1,400	72	5.3%
514 HAND OR WRIST PROCEDURES EXCEPT MAJOR THUMB OR JOINT P..	1,276	1,326	50	3.9%
512 SHOULDER ELBOW OR FOREARM PROCEDURES EXCEPT MAJOR JO..	1,026	1,072	45	4.4%
563 FRACTURE SPRAIN STRAIN AND DISLOCATION EXCEPT FEMUR HIP ..	905	942	37	4.1%
561 AFTERCARE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSU..	395	432	37	9.4%
560 AFTERCARE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSU..	315	351	36	11.5%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate	Incremental Value in 5-Years
Grand Total	34,229	36,732	2,503	7.3%	$12,619K
Commercial	13,589	13,916	327	2.4%	$923K
Medicaid	5,563	5,655	92	1.7%	$21K
Medicare	6,017	6,910	893	14.8%	$5,285K
Medicare Adv	7,199	8,348	1,148	15.9%	$6,372K
Other	1,861	1,904	43	2.3%	$18K

2. ONCOLOGY

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	27,264	29,536	2,272	8.3%
847 CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIA..	5,486	5,985	499	9.1%
848 CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIA..	2,086	2,263	177	8.5%
599 MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	1,974	2,108	134	6.8%
849 RADIOTHERAPY	1,502	1,636	134	8.9%
842 LYMPHOMA AND NON-ACUTE LEUKEMIA WITHOUT CC/MCC	1,437	1,560	123	8.5%
376 DIGESTIVE MALIGNANCY WITHOUT CC/MCC	1,376	1,494	118	8.6%
182 RESPIRATORY NEOPLASMS WITHOUT CC/MCC	940	1,040	99	10.5%
724 MALIGNANCY MALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	813	910	97	11.9%
437 MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITHOU..	636	699	63	9.9%
375 DIGESTIVE MALIGNANCY WITH CC	687	746	59	8.6%
181 RESPIRATORY NEOPLASMS WITH CC	553	612	59	10.7%
756 MALIGNANCY FEMALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	782	834	52	6.5%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in ..	Units Growth Rate	Incremental Value in 5-Years
Grand Total	27,264	29,536	2,272	8.3%	$9,918K
Commercial	8,915	9,057	142	1.6%	$1,011K
Medicaid	4,273	4,336	63	1.5%	$196K
Medicare	5,946	6,820	875	14.7%	$3,948K
Medicare Adv	7,149	8,278	1,128	15.8%	$4,677K
Other	981	1,045	64	6.5%	$87K

3. GENERAL SURGERY

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	24,913	26,354	1,441	5.8%
941 O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH H..	3,280	3,620	341	10.4%
349 ANAL AND STOMAL PROCEDURES WITHOUT CC/MCC	2,120	2,302	182	8.6%
352 INGUINAL AND FEMORAL HERNIA PROCEDURES WITHOUT CC/MCC	1,668	1,826	158	9.5%
419 LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITHOUT CC..	2,148	2,221	73	3.4%
940 O.R. PROCEDURES WITH DIAGNOSES OF OTHER CONTACT WITH H..	661	733	72	10.9%
355 HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITHOUT..	1,008	1,078	70	6.9%
581 OTHER SKIN SUBCUTANEOUS TISSUE AND BREAST PROCEDURES ..	1,096	1,154	58	5.3%
348 ANAL AND STOMAL PROCEDURES WITH CC	661	713	53	8.0%
829 MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED ..	296	343	46	15.5%
853 INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES W..	886	918	32	3.5%
830 MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED ..	181	210	28	15.5%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in ..	Units Growth Rate	Incremental Value in 5-Years
Grand Total	24,913	26,354	1,441	5.8%	$9,523K
Commercial	11,590	11,915	325	2.8%	$902K
Medicaid	5,375	5,434	59	1.1%	($256K)
Medicare	3,235	3,682	447	13.8%	$4,007K
Medicare Adv	3,802	4,375	573	15.1%	$4,830K
Other	911	949	38	4.2%	$40K

4. GASTROENTEROLOGY

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	21,414	22,769	1,354	6.3%
392 ESOPHAGITIS GASTROENTERITIS AND MISCELLANEOUS DIGESTIV..	9,739	10,421	683	7.0%
395 OTHER DIGESTIVE SYSTEM DIAGNOSES WITHOUT CC/MCC	2,396	2,583	187	7.8%
387 INFLAMMATORY BOWEL DISEASE WITHOUT CC/MCC	2,508	2,647	138	5.5%
379 GASTROINTESTINAL HEMORRHAGE WITHOUT CC/MCC	701	785	83	11.8%
394 OTHER DIGESTIVE SYSTEM DIAGNOSES WITH CC	1,027	1,089	61	5.9%
378 GASTROINTESTINAL HEMORRHAGE WITH CC	920	968	49	5.3%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in ..	Units Growth Rate	Incremental Value in 5-Years
Grand Total	21,414	22,769	1,354	6.3%	$3,787K
Commercial	9,078	9,313	235	2.6%	$500K
Medicaid	4,547	4,607	60	1.3%	($62K)
Medicare	3,301	3,752	451	13.7%	$1,511K
Medicare Adv	3,931	4,515	585	14.9%	$1,827K
Other	557	581	23	4.1%	$12K

5. CARDIOLOGY

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	15,830	17,374	1,543	9.7%
307 CARDIAC CONGENITAL AND VALVULAR DISORDERS WITHOUT MCC	1,520	1,848	327	21.5%
310 CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITHOUT C..	1,926	2,136	211	11.0%
291 HEART FAILURE AND SHOCK WITH MCC	2,655	2,844	189	7.1%
303 ATHEROSCLEROSIS WITHOUT MCC	1,171	1,347	176	15.0%
313 CHEST PAIN	1,508	1,641	134	8.9%
316 OTHER CIRCULATORY SYSTEM DIAGNOSES WITHOUT CC/MCC	745	845	99	13.3%
312 SYNCOPE AND COLLAPSE	782	860	78	10.0%
309 CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH CC	861	928	66	7.7%
305 HYPERTENSION WITHOUT MCC	612	645	33	5.4%
280 ACUTE MYOCARDIAL INFARCTION DISCHARGED ALIVE WITH MCC	784	816	32	4.1%
293 HEART FAILURE AND SHOCK WITHOUT CC/MCC	345	375	30	8.4%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in ..	Units Growth Rate	Incremental Value in 5-Years
Grand Total	15,830	17,374	1,543	9.7%	$5,151K
Commercial	3,126	3,162	36	1.2%	($239K)
Medicaid	2,732	2,734	1	0.0%	($129K)
Medicare	4,354	5,000	646	14.8%	$2,503K
Medicare Adv	5,202	6,032	830	16.0%	$2,993K
Other	416	447	31	7.5%	$23K

6. GENERAL MEDICINE

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	15,068	15,926	858	5.7%
951 OTHER FACTORS INFLUENCING HEALTH STATUS	8,203	8,670	466	5.7%
948 SIGNS AND SYMPTOMS WITHOUT MCC	1,284	1,379	96	7.5%
601 NON-MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	1,173	1,245	71	6.1%
603 CELLULITIS WITHOUT MCC	1,090	1,142	53	4.9%
950 AFTERCARE WITHOUT CC/MCC	532	569	37	7.0%
949 AFTERCARE WITH CC/MCC	591	625	33	5.6%
602 CELLULITIS WITH MCC	219	237	18	8.2%
947 SIGNS AND SYMPTOMS WITH MCC	173	190	18	10.5%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in ..	Units Growth Rate	Incremental Value in 5-Years
Grand Total	15,068	15,926	858	5.7%	$2,647K
Commercial	6,947	7,131	185	2.7%	$625K
Medicaid	2,750	2,780	30	1.1%	$57K
Medicare	2,199	2,472	273	12.5%	$894K
Medicare Adv	2,585	2,937	352	13.7%	$1,058K
Other	587	605	18	2.9%	$12K

7. NEUROLOGY

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	12,111	12,996	885	7.3%
057 DEGENERATIVE NERVOUS SYSTEM DISORDERS WITHOUT MCC	1,200	1,334	134	11.2%
065 INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH C..	834	930	96	11.5%
064 INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH M..	715	800	85	11.9%
093 OTHER DISORDERS OF NERVOUS SYSTEM WITHOUT CC/MCC	1,457	1,534	77	5.3%
074 CRANIAL AND PERIPHERAL NERVE DISORDERS WITHOUT MCC	1,286	1,360	75	5.8%
069 TRANSIENT ISCHEMIA WITHOUT THROMBOLYTIC	509	573	64	12.6%
066 INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITHO..	477	529	52	10.9%
091 OTHER DISORDERS OF NERVOUS SYSTEM WITH MCC	326	359	33	10.5%
056 DEGENERATIVE NERVOUS SYSTEM DISORDERS WITH MCC	284	313	29	10.2%
092 OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	369	397	28	7.6%
068 NONSPECIFIC CVA AND PRECEREBRAL OCCLUSION WITHOUT INFA..	230	258	28	12.2%
070 NONSPECIFIC CEREBROVASCULAR DISORDERS WITH MCC	204	232	27	13.2%
071 NONSPECIFIC CEREBROVASCULAR DISORDERS WITH CC	206	233	26	12.6%
060 MULTIPLE SCLEROSIS AND CEREBELLAR ATAXIA WITHOUT CC/MCC	1,107	1,130	23	2.1%
103 HEADACHES WITHOUT MCC	729	749	21	2.9%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in ..	Units Growth Rate	Incremental Value in 5-Years
Grand Total	12,111	12,996	885	7.3%	$5,262K
Commercial	3,894	3,932	38	1.0%	$269K
Medicaid	2,744	2,782	38	1.4%	$174K
Medicare	2,328	2,676	348	14.9%	$2,203K
Medicare Adv	2,756	3,204	448	16.3%	$2,595K
Other	388	402	14	3.4%	$22K

8. PULMONARY

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	10,308	11,255	947	9.2%
204 RESPIRATORY SIGNS AND SYMPTOMS	1,412	1,550	138	9.8%
177 RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC	1,050	1,184	134	12.8%
193 SIMPLE PNEUMONIA AND PLEURISY WITH MCC	867	969	102	11.8%
189 PULMONARY EDEMA AND RESPIRATORY FAILURE	1,027	1,115	89	8.7%
190 CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH MCC	508	565	57	11.4%
203 BRONCHITIS AND ASTHMA WITHOUT CC/MCC	998	1,055	57	5.8%
206 OTHER RESPIRATORY SYSTEM DIAGNOSES WITHOUT MCC	490	532	42	8.6%
194 SIMPLE PNEUMONIA AND PLEURISY WITH CC	424	465	41	9.7%
192 CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITHOUT CC/MCC	282	313	31	11.0%
178 RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH CC	267	296	29	10.9%
188 PLEURAL EFFUSION WITHOUT CC/MCC	178	203	25	14.0%
175 PULMONARY EMBOLISM WITH MCC OR ACUTE COR PULMONALE	236	260	25	10.6%
191 CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH CC	206	230	24	11.7%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in ..	Units Growth Rate	Incremental Value in 5-Years
Grand Total	10,308	11,255	947	9.2%	$5,875K
Commercial	2,148	2,155	7	0.3%	$6K
Medicaid	2,276	2,308	31	1.4%	$177K
Medicare	2,555	2,949	394	15.4%	$2,615K
Medicare Adv	3,041	3,543	502	16.5%	$3,055K
Other	287	301	14	4.5%	$24K

9. NEPHROLOGY

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	6,592	7,286	695	10.5%
690 KIDNEY AND URINARY TRACT INFECTIONS WITHOUT MCC	1,033	1,137	104	10.1%
682 RENAL FAILURE WITH MCC	663	744	81	12.2%
683 RENAL FAILURE WITH CC	757	837	80	10.6%
689 KIDNEY AND URINARY TRACT INFECTIONS WITH MCC	468	535	68	14.6%
698 OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITH MCC	566	631	66	11.7%
700 OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITHOUT CC/MCC	817	881	64	7.8%
688 KIDNEY AND URINARY TRACT NEOPLASMS WITHOUT CC/MCC	501	565	63	12.6%
696 KIDNEY AND URINARY TRACT SIGNS AND SYMPTOMS WITHOUT M..	627	685	59	9.4%
699 OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITH CC	510	554	43	8.4%
684 RENAL FAILURE WITHOUT CC/MCC	385	420	34	8.8%
687 KIDNEY AND URINARY TRACT NEOPLASMS WITH CC	213	240	27	12.7%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in ..	Units Growth Rate	Incremental Value in 5-Years
Grand Total	6,592	7,286	695	10.5%	$3,358K
Commercial	1,237	1,246	9	0.8%	$65K
Medicaid	1,297	1,325	27	2.1%	$105K
Medicare	1,772	2,055	284	16.0%	$1,464K
Medicare Adv	2,089	2,451	362	17.3%	$1,708K
Other	196	209	12	6.1%	$16K

10. INVASIVE CARDIOLOGY

Total AHS Market

Largest Growth Expected by MS-DRG

Ms-Drg	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in 5 Years	Units Growth Rate
Grand Total	5,702	6,258	556	9.8%
287 CIRCULATORY DISORDERS EXCEPT AMI WITH CARDIAC CATHETERI..	2,255	2,508	253	11.2%
247 PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH DRUG-ELU..	933	994	61	6.5%
262 CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W..	349	389	40	11.2%
259 CARDIAC PACEMAKER DEVICE REPLACEMENT WITHOUT MCC	288	326	38	13.2%
246 PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH DRUG-ELU..	565	598	32	5.7%
286 CIRCULATORY DISORDERS EXCEPT AMI WITH CARDIAC CATHETERI..	347	373	26	7.5%
261 CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W..	205	231	26	12.2%
243 PERMANENT CARDIAC PACEMAKER IMPLANT WITH CC	189	212	23	12.2%
245 AICD GENERATOR PROCEDURES	145	159	14	9.7%
244 PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT CC/MCC	118	132	14	11.0%
242 PERMANENT CARDIAC PACEMAKER IMPLANT WITH MCC	108	121	12	11.1%

Cases Growth by Payor Group

Payor Group	Current Year Annual Units	5-Year Projected Annual Units	Incremental Annual Units in ..	Units Growth Rate	Incremental Value in 5-Years
Grand Total	5,702	6,258	556	9.8%	$3,420K
Commercial	1,213	1,206	-7	-0.5%	($402K)
Medicaid	710	716	5	0.7%	($18K)
Medicare	1,628	1,865	237	14.5%	$1,738K
Medicare Adv	1,951	2,255	304	15.6%	$2,069K
Other	200	217	17	9.0%	$32K

AMBULATORY SURGERY/PROCEDURES

Ambulatory surgery/procedure data is examined to determine the distribution of outpatient procedures in hospital outpatient departments (HOPDs) and freestanding ASCs in the service area.

[BACK]

AMBULATORY SURGERY MARKET SHARE

Total AHS Market

Total Ambulatory Surgery Center Cases Originating in the Service Area

	Visits			Proc.			Proc./Visit		
	2021	2022	2023	2021	2022	2023	2021	2022	2023
Total Ambulatory Surgery from the Service Area	**68,486**	**68,355**	**75,765**	**158,223**	**150,556**	**163,940**	**2.3**	**2.2**	**2.2**

Staying in the Service Area for Ambulatory Surgery Center Care

	Visits			Proc.			Proc./Visit			% Share Visits			% Share Proc.		
Facility/System	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
Kaiser															
Kaiser Foundation Hospital - Oakland/Richmond	10,428	10,218	6,922	13,910	13,571	9,707	1.3	1.3	1.4	15.2%	14.9%	9.1%	8.8%	9.0%	5.9%
Kaiser Foundation Hospital - San Leandro	10,033	9,873	11,617	13,723	13,219	15,365	1.4	1.3	1.3	14.6%	14.4%	15.3%	8.7%	8.8%	9.4%
Kaiser Foundation Hospital - Fremont	6,554	6,702	9,694	9,282	9,422	12,895	1.4	1.4	1.3	9.6%	9.8%	12.8%	5.9%	6.3%	7.9%
	27,015	**26,793**	**28,233**	**36,915**	**36,212**	**37,967**	**1.4**	**1.4**	**1.3**	**39.4%**	**39.2%**	**37.3%**	**23.3%**	**24.1%**	**23.2%**
AHS															
Alameda Hospital	1,289	847	1,254	1,639	7,431	1,567	1.3	8.8	1.2	1.9%	1.2%	1.7%	1.0%	4.9%	1.0%
Highland Hospital	5,191	6,062	6,623	6,342	3,912	8,103	1.2	0.6	1.2	7.6%	8.9%	8.7%	4.0%	2.6%	4.9%
St Rose Hospital	1,004	1,172	692	3,734	1,468	3,094	3.7	1.3	4.5	1.5%	1.7%	0.9%	2.4%	1.0%	1.9%
	7,484	**8,081**	**8,569**	**11,715**	**12,811**	**12,764**	**1.6**	**1.6**	**1.5**	**10.9%**	**11.8%**	**11.3%**	**7.4%**	**8.5%**	**7.8%**
Sutter															
Alta Bates Summit Medical Center	3,453	3,254	3,186	18,407	15,756	15,514	5.3	4.8	4.9	5.0%	4.8%	4.2%	11.6%	10.5%	9.5%
Alta Bates Summit Medical Center-Alta Bates Campus	2,739	2,500	2,935	8,747	7,592	8,424	3.2	3.0	2.9	4.0%	3.7%	3.9%	5.5%	5.0%	5.1%
	6,192	**5,754**	**6,121**	**27,154**	**23,348**	**23,938**	**4.4**	**4.1**	**3.9**	**9.0%**	**8.4%**	**8.1%**	**17.2%**	**15.5%**	**14.6%**
Washington Health															
Washington Hospital - Fremont	1,679	1,528	1,515	2,454	2,496	2,304	1.5	1.6	1.5	2.5%	2.2%	2.0%	1.6%	1.7%	1.4%
	1,679	**1,528**	**1,515**	**2,454**	**2,496**	**2,304**	**1.5**	**1.6**	**1.5**	**2.5%**	**2.2%**	**2.0%**	**1.6%**	**1.7%**	**1.4%**
UCSF															
Childrens Hospital and Research Center at Oakland	1,792	1,691	2,036	2,566	2,387	2,873	1.4	1.4	1.4	2.6%	2.5%	2.7%	1.6%	1.6%	1.8%
	1,792	**1,691**	**2,036**	**2,566**	**2,387**	**2,873**	**1.4**	**1.4**	**1.4**	**2.6%**	**2.5%**	**2.7%**	**1.6%**	**1.6%**	**1.8%**
Staying in the Service Area	**44,162**	**43,847**	**46,474**	**80,804**	**77,254**	**79,846**	**1.8**	**1.8**	**1.7**	**64.5%**	**64.1%**	**61.3%**	**51.1%**	**51.3%**	**48.7%**

AMBULATORY SURGERY OUTMIGRATION

Residents Leaving the Service Area for Ambulatory Surgery Care

	Visits			Proc.			Proc./Visit			% Share Visits			% Share Proc.		
Facility/System	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
Stanford Health Care	3,790	3,940	6,722	20,542	20,597	27,442	5.4	5.2	4.1	5.5%	5.8%	8.9%	13.0%	13.7%	16.7%
Sutter Health	3,066	2,807	3,049	17,491	14,109	15,280	5.7	5.0	5.0	4.5%	4.1%	4.0%	11.1%	9.4%	9.3%
University of California Systemwide Administration	4,656	4,730	5,184	6,948	6,944	7,684	1.5	1.5	1.5	6.8%	6.9%	6.8%	4.4%	4.6%	4.7%
Kaiser Foundation Hospitals	2,703	2,734	3,157	4,254	4,072	4,610	1.6	1.5	1.5	3.9%	4.0%	4.2%	2.7%	2.7%	2.8%
Commonspirit Health	666	673	698	3,818	4,767	4,490	5.7	7.1	6.4	1.0%	1.0%	0.9%	2.4%	3.2%	2.7%
John Muir Health	604	827	908	1,212	1,628	1,820	2.0	2.0	2.0	0.9%	1.2%	1.2%	0.8%	1.1%	1.1%
Surgecenter of Palo Alto	365	371	428	974	931	1,035	2.7	2.5	2.4	0.5%	0.5%	0.6%	0.6%	0.6%	0.6%
Palo Alto Med Foundation - Camino	350	334	334	942	880	850	2.7	2.6	2.5	0.5%	0.5%	0.4%	0.6%	0.6%	0.5%
Hca Healthcare	168	130	138	861	672	725	5.1	5.2	5.3	0.2%	0.2%	0.2%	0.5%	0.4%	0.4%
El Camino Hospital	503	496	570	805	756	915	1.6	1.5	1.6	0.7%	0.7%	0.8%	0.5%	0.5%	0.6%
Lucile Salter Packard Childrens Hosp at Stanford	432	439	495	733	740	778	1.7	1.7	1.6	0.6%	0.6%	0.7%	0.5%	0.5%	0.5%
Surgery Center San Carlos	238	221	227	666	579	620	2.8	2.6	2.7	0.3%	0.3%	0.3%	0.4%	0.4%	0.4%
Surgery Center San Jose	227	229	218	588	548	528	2.6	2.4	2.4	0.3%	0.3%	0.3%	0.4%	0.4%	0.3%
Bay Area Dental Surgery Center	262	138	165	524	276	330	2.0	2.0	2.0	0.4%	0.2%	0.2%	0.3%	0.2%	0.2%
Marin General Hospital	86	84	81	503	327	136	5.8	3.9	1.7	0.1%	0.1%	0.1%	0.3%	0.2%	0.1%
Tenet Healthcare Corporation	313	254	237	461	382	359	1.5	1.5	1.5	0.5%	0.4%	0.3%	0.3%	0.3%	0.2%
Priscilla Chan Mark Zuckerberg	68	88	68	247	310	255	3.6	3.5	3.8	0.1%	0.1%	0.1%	0.2%	0.2%	0.2%
San Jose Dental Surgery Center	203	220	241	203	220	241	1.0	1.0	1.0	0.3%	0.3%	0.3%	0.1%	0.1%	0.1%
Santa Clara Valley Medical Center	112	113	112	144	141	133	1.3	1.2	1.2	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
All Others	5,512	5,680	6,259	15,503	14,423	15,863	2.8	2.5	2.5	8.0%	8.3%	8.3%	9.8%	9.6%	9.7%
Total Ambulatory Surgery Outmigration	**24,324**	**24,508**	**29,291**	**77,419**	**73,302**	**84,094**	**3.2**	**3.0**	**2.9**	**35.5%**	**35.9%**	**38.7%**	**48.9%**	**48.7%**	**51.3%**

CHRONIC CONDITIONS

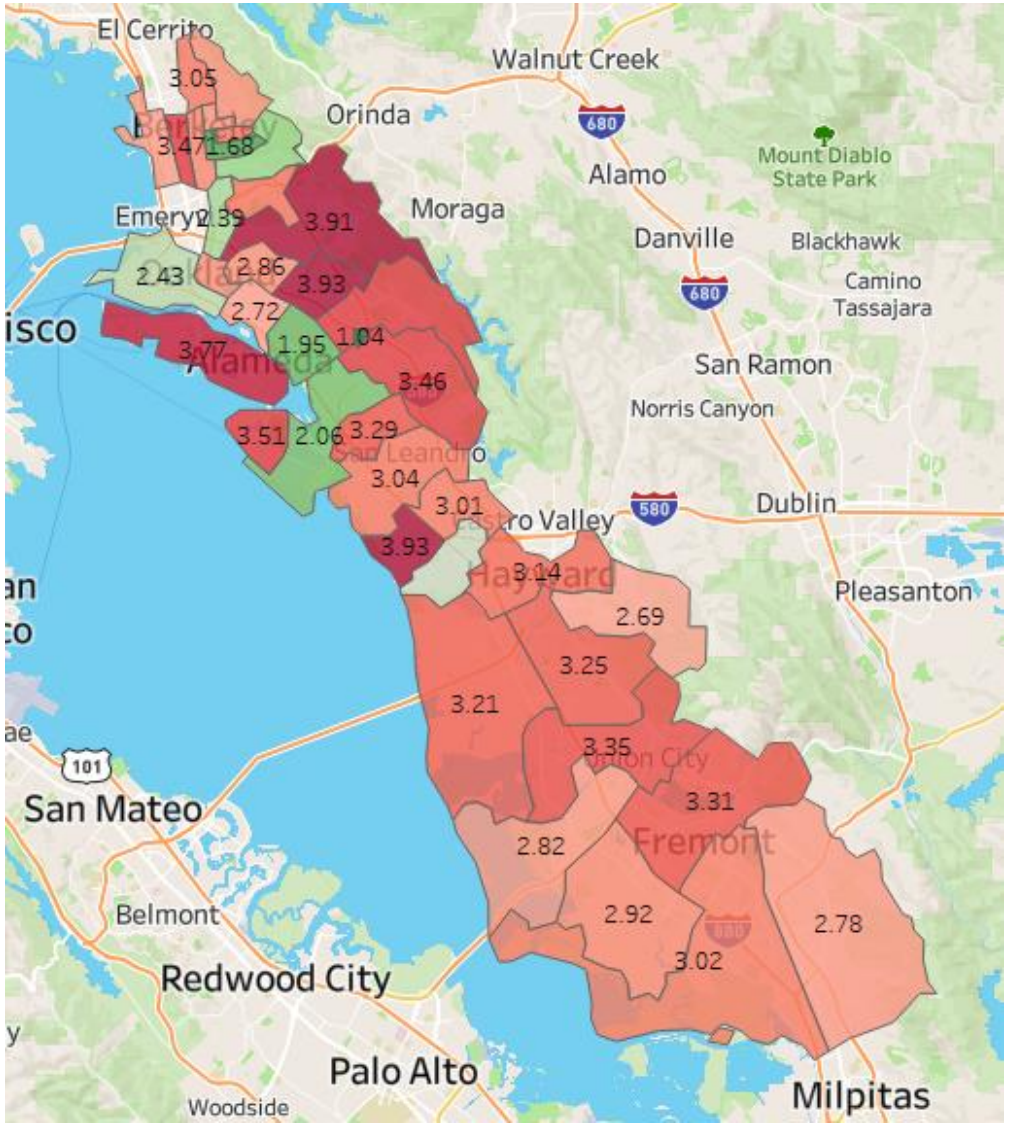
The chronic conditions forecast helps anticipate the future burden of diseases on the healthcare system, economies, and the population we serve. AHS can act strategically to reduce costs, improve care, and enhance population health.

[BACK]

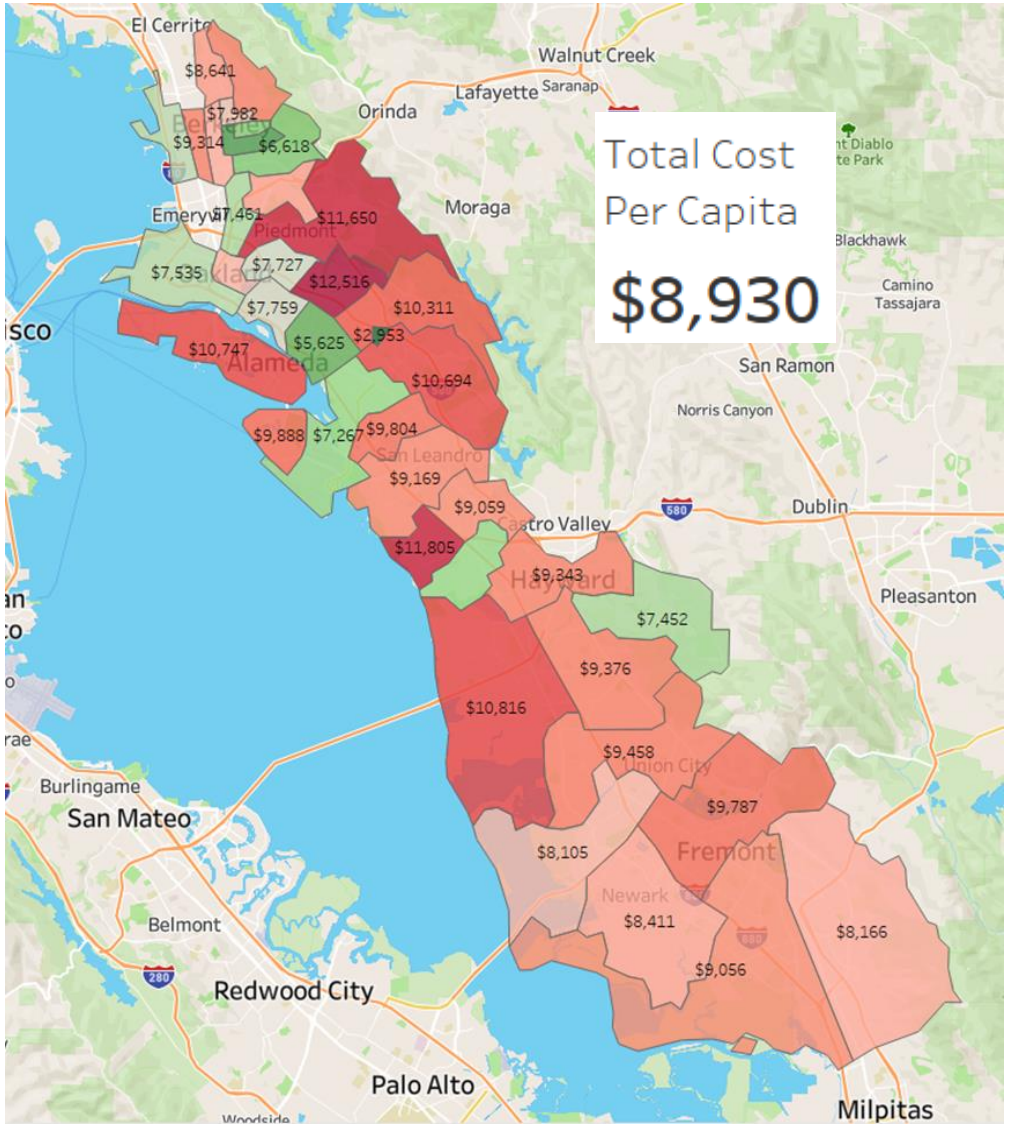
CHRONIC CONDITIONS

Total AHS Market

Conditions Per Capita by Zip Code



Current Annual Cost Per Capita by Zip Code



CHRONIC CONDITIONS

Total AHS Market

Forecast by Group by Patient Age Cohort

		Age 00 through 14			Age 15 through 34			Age 35 through 64			Age 65 and over			Grand Total		
		Estimated CY Conditions	5Y Projected Conditions	Conditions Growth Rate	Estimated CY Conditions	5Y Projected Conditions	Conditions Growth Rate	Estimated CY Conditions	5Y Projected Conditions	Conditions Growth Rate	Estimated CY Conditions	5Y Projected Conditions	Conditions Growth Rate	Estimated CY Conditions	5Y Projected Conditions	Conditions Growth Rate
Grand Total		**348,023**	**342,046**	**-1.7%**	**736,274**	**697,470**	**-5.3%**	**1,763,541**	**1,805,518**	**2.4%**	**1,334,410**	**1,531,374**	**14.8%**	**4,182,247**	**4,376,408**	**4.6%**
	Behavioral Disorders	39,053	38,842	-0.5%	155,193	148,290	-4.4%	150,466	154,505	2.7%	36,682	41,419	12.9%	381,394	383,055	0.4%
	Blood Diseases	6,800	6,695	-1.5%	15,919	15,075	-5.3%	44,609	45,895	2.9%	40,025	46,328	15.7%	107,353	113,994	6.2%
	Circulatory Diseases	4,382	4,332	-1.1%	23,578	22,051	-6.5%	202,081	204,853	1.4%	286,385	332,277	16.0%	516,425	563,513	9.1%
	Congenital Disorders	15,124	14,736	-2.6%	6,924	6,616	-4.4%	6,658	6,851	2.9%	2,445	2,783	13.8%	31,150	30,987	-0.5%
	Digestive Diseases	20,874	20,442	-2.1%	46,405	43,588	-6.1%	126,512	130,069	2.8%	73,832	84,052	13.8%	267,622	278,151	3.9%
	Ear Diseases	32,158	31,226	-2.9%	17,629	16,793	-4.7%	28,868	29,557	2.4%	21,037	24,120	14.7%	99,692	101,696	2.0%
	Endocrine and Metabolic Diseases	22,456	22,499	0.2%	66,555	62,348	-6.3%	270,790	276,064	1.9%	220,551	252,140	14.3%	580,352	613,052	5.6%
	Eye Diseases	26,461	25,814	-2.4%	21,110	19,975	-5.4%	63,630	65,315	2.6%	81,154	93,380	15.1%	192,355	204,484	6.3%
	Genitourinary Diseases	12,003	11,836	-1.4%	69,184	65,771	-4.9%	144,663	148,398	2.6%	117,370	135,601	15.5%	343,220	361,606	5.4%
	Infectious Diseases	21,223	20,659	-2.7%	22,056	20,907	-5.2%	41,103	42,367	3.1%	21,692	24,745	14.1%	106,073	108,678	2.5%
	Musculoskeletal Diseases	12,271	12,343	0.6%	66,707	62,595	-6.2%	220,636	225,701	2.3%	146,772	167,134	13.9%	446,386	467,773	4.8%
	Neoplasms	3,154	3,126	-0.9%	13,485	12,748	-5.5%	75,062	77,552	3.3%	58,545	67,006	14.5%	150,246	160,432	6.8%
	Nervous System Diseases	17,311	17,052	-1.5%	58,587	55,212	-5.8%	161,155	165,201	2.5%	99,890	114,367	14.5%	336,942	351,832	4.4%
	Respiratory Diseases	83,777	81,905	-2.2%	77,603	74,087	-4.5%	105,985	108,671	2.5%	72,676	83,492	14.9%	340,040	348,155	2.4%
	Skin Diseases	30,684	30,227	-1.5%	51,580	49,272	-4.5%	72,698	74,644	2.7%	38,993	44,445	14.0%	193,954	198,588	2.4%
	Substance Abuse	294	311	5.5%	23,761	22,140	-6.8%	48,625	49,876	2.6%	16,361	18,085	10.5%	89,041	90,413	1.5%

PHYSICIAN OUTLOOK

AHS evaluates two markers to balance provider resource allocation with healthcare needs:

- Physician supply and demand
- Leakage and retention of volumes that originate in the service area

[BACK]

PHYSICIAN SUPPLY AND DEMAND

AHS Total Service Area

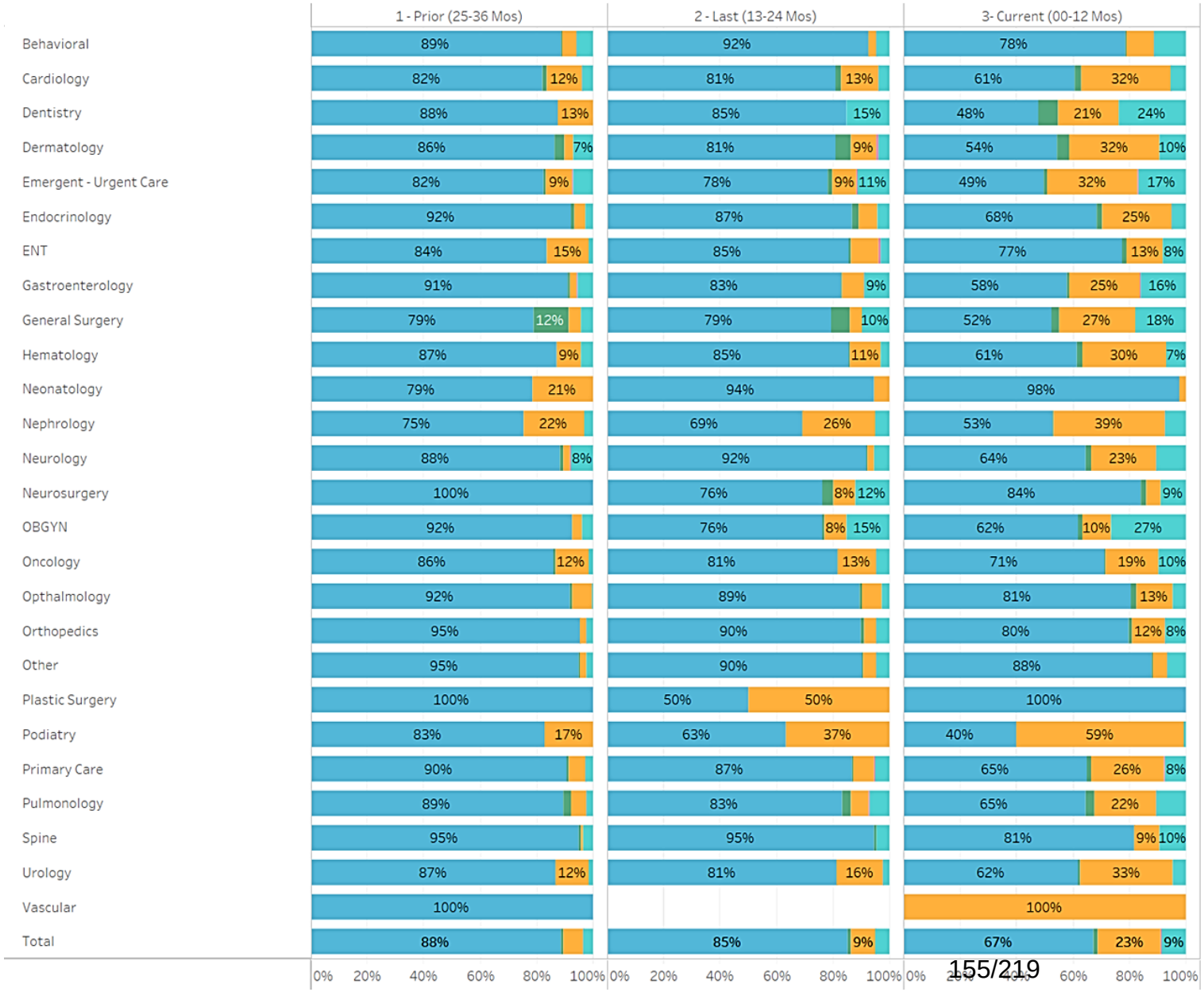
Population	
2024	1,332,813
2029	1,355,653
Growth	1.714%

	Physician Need Rates = 1/n				Supply	Demand		Demand Variance	
	AMA	**Medical Economics**	**GMENAC**	**INTELLIMED Age & Sex Adj.**	**Current Supply**	**CY**	**CY+5**	**CY**	**CY + 5**
Allergy/Immunology	68,027	125,000	118,800	60,757	25.0	21.9	22.3	(3.1)	(2.7)
Cardiology	22,222	25,000	31,420	24,643	101.0	54.1	55.0	(46.9)	(46.0)
Family Practice	4,347	2,000	4,000	3,148	524.0	423.4	430.6	(100.6)	(93.4)
Gastroenterology	45,454	50,000	37,460	45,159	65.0	29.5	30.0	(35.5)	(35.0)
General Surgery	10,309	10,000	10,350	11,576	156.0	115.1	117.1	(40.9)	(38.9)
Internal Medicine	3,922	5,000	3,500	5,260	1,216.0	253.4	257.7	(962.6)	(958.3)
Neurology	40,000	60,000	44,275	34,434	58.0	38.7	39.4	(19.3)	(18.6)
Neurosurgery	76,923	57,000	100,000	82,033	18.0	16.2	16.5	(1.8)	(1.5)
Obstetrics/Gyn	9,434	11,000	10,150	9,679	306.0	137.7	140.1	(168.3)	(165.9)
Oncology	34,014	34,013	28,571	56,186	80.0	23.7	24.1	(56.3)	(55.9)
Ophthalmology	18,519	20,000	20,990	25,953	133.0	51.4	52.2	(81.6)	(80.8)
Oral & Maxillofacial Surgery	66,225	66,225	50,000	-	56.0	26.7	27.1	(29.3)	(28.9)
Orthopedics	16,129	25,000	16,130	15,486	165.0	86.1	87.5	(78.9)	(77.5)
Otolaryngology	38,462	25,000	30,400	36,429	50.0	36.6	37.2	(13.4)	(12.8)
Pediatrics	8,621	10,000	8,100	10,908	781.0	122.2	124.3	(658.8)	(656.7)
Plastic Surgery	46,729	50,000	50,000	49,022	33.0	27.2	27.7	(5.8)	(5.3)
Psychiatry	10,309	10,000	6,325	12,417	2,030.0	107.3	109.2	(1,922.7)	(1,920.8)
Pulmonary	62,500	100,000	67,640	75,927	39.0	17.6	17.9	(21.4)	(21.1)
Thoracic Surgery	74,074	71,429	83,333	105,410	22.0	12.6	12.9	(9.4)	(9.1)
Urology	33,333	30,000	31,625	39,149	46.0	34.0	34.6	(12.0)	(11.4)

Physician Need Assessment
INTELLIMED Forecasting Module

PHYSICIAN LEAKAGE AND RETENTION

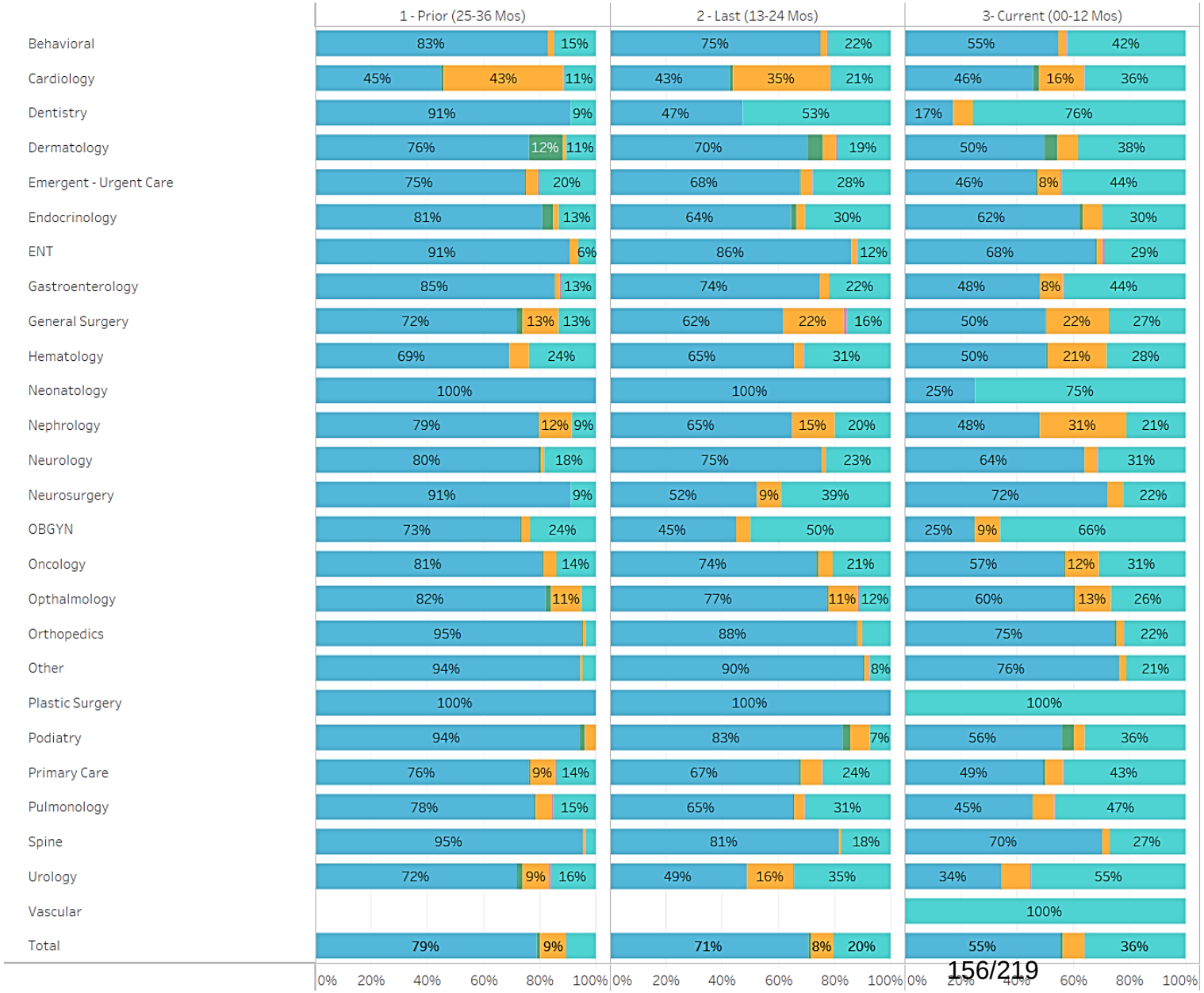
Contracted Providers



	25-36 Mos	13-24 Mos	00-12 Mos
Total Encounters	24,714	30,862	43,598
Total Est. Net Revenue	$12.6M	$15.4M	$18.3M
Out of Network Encounters	21,855	24,262	29,250
Revenue Opportunity	$11.0M	$12.9M	$12.1M

PHYSICIAN LEAKAGE AND RETENTION

Employed Providers



	25-36 Mos	13-24 Mos	00-12 Mos
Total Encounters	19,136	26,864	40,853
Total Est. Net Revenue	$8.75M	$12.2M	$19.6M
Out of Network Encounters	15,121	19,018	22,629
Revenue Opportunity	$6.47M	$7.82M	$8.76M

SUMMARY CONCLUSIONS: WHAT THE DATA IS TELLING US

1. The service area population remains largely unchanged with only marginal year-over-year growth; persons 65 and older are increasing with matched declines in the younger age cohorts.

2. Competitor expansion could weaken performance of AHS's key service lines, impacting their effectiveness or reach.

3. AHS's service mix is heavily inpatient focused while market growth is projected in outpatient services.

4. AHS's financial sustainability hinges on preparedness to address reliably anticipated reimbursement shifts.

5. There is an increasing need for behavioral health services to support the aging population, homeless individuals, and those affected by substance abuse disorders within the community.

6. Data reveals a significant oversupply of physicians in the market, coupled with a concerning trend of patient encounters being referred out of network. This imbalance suggests an inefficient allocation of resources, increased healthcare costs, fragmented patient care, and underutilization of in-network providers.

[BACK]

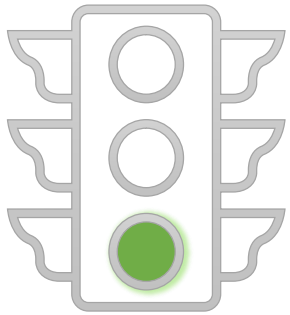
KEY OPERATIONAL FOCUS AREAS

Key planning focus areas with 3–5-year goals

Optimize Operations
Target internal processes to improve efficiency and reduce costs; leverage existing resources and avoid investment unrelated to the immediate and unmet health needs of the community.

Inpatient Care
Strengthen inpatient care delivery by ensuring service lines align with regional demographic demands, strategically positioning facilities and programs to enhance accessibility and outcomes.

Outpatient Care
Enhance outpatient services to meet purchasers' demand for convenient, cost-effective care; leverage access, efficiency, and innovation while ensuring financial sustainability and quality delivery.



Ancillary Services
Strengthen patient care delivery by expanding and integrating ancillary healthcare services to ensure accessibility and support patient needs across the entirety of the care continuum.

Post Acute Care/Rehabilitation
Improve function, quality of life, and independence of patients through post-acute and rehabilitation services expansion, ensuring access to services which support seamless transitions from acute care to long term wellness.

Behavioral Health
Reinforce the care continuum by embedding behavioral health services into the broader AHS healthcare network – primary care clinics, emergency, acute care, and outpatient services – through programmatic expansion efforts.

KEY OPERATIONAL FOCUS AREAS

Key focus areas with initiatives

	Operational Optimization Aemal Aminy [Physician Leader]	**Inpatient** Chris Adams [Physician Leader]	**Outpatient** Terrence Shaw [Physician Leader]	**Ancillary** Harold Glenn [Physician Leader]	**Behavioral Health** Patty Espeseth [Physician Leader]	**Post Acute Care/Rehab** Richard Espinosa [Physician Leader]
	Alameda Seismic Retrofit and Infrastructure	SLH DaVinci Surgical Robot	Urgent Care Clinic	OP Imaging and Ancillary, e.g. Lab, Pharm	Long Term Locked Mental Health	Alameda SNF
	SRH Epic Implementation	SLH Sterile Processing Room	Dentistry at SRH, including Pediatric Dentistry	OP Imaging and Lab, Hayward Wellness	SRH Gero-Psych and Medi-Psych SLH Medical Detox	Fairmont SNF
	SRH Seismic Retrofit	SRH Cath Lab Renovation	Ambulatory Surgery Center at SRH	PET Scan	Mental Health Urgent Care	OP Ortho Rehab, San Leandro and Hayward Clinic
	Patient Transportation Services	SRH Growth Initiatives	Relocation of Highland Primary and Specialty Care		Bridge Clinic at SLH	
	Centralized Scheduling	Highland Cardiac Overflow to SRH	Pediatrics and Women's Health in South County		Level 1&2 Severity Integrated Mental Health Model	
	Partnership Opportunities: Make vs. Buy	Consolidation of Orthopedics at San Leandro	Primary Care/Multispecialty Care in South County		Relocation of PES to Highland – BHCIP Round 2	
	Facilities Assessment & Consolidation	Focused growth in top service lines: Orthopedics, Oncology, General Surgery, Gastroenterology, Cardiology	Focused growth in top service lines: Orthopedics, Oncology, General Surgery, Gastroenterology, Cardiology			

KEY OPERATIONAL FOCUS AREAS, CONT.

Key focus areas with initiatives

	Operational Optimization Aemal Aminy [Physician Leader]	**Inpatient** Chris Adams [Physician Leader]	**Outpatient** Terrence Shaw [Physician Leader]	**Ancillary** Harold Glenn [Physician Leader]	**Behavioral Health** Patty Espeseth [Physician Leader]	**Post Acute Care/Rehab** Richard Espinosa [Physician Leader]
	PMO and Business Intelligence Resource Alignment/ Reporting					
	Reevaluate Long Term Capital Initiatives to Account for SRH Capacity					
	Medicare Advantage and Dual Eligibles (Medi-Medi) Contracts					
	Replace AHS Enterprise Resource Planning (ERP) System					

RISK MANAGEMENT AND MITIGATION STRATEGIES

Potential risks and strategies for mitigation

RISK IDENTIFICATION	
IDENTIFIED RISK	RISK MITIGATION STRATEGIES
Political Environment	Engage with policymakers, monitor legislation, ensure planning is agile and flexible, rally community, patient, and stakeholder support
Increasing Labor Expenses	Consider, cross training staff, implement efficiency-based technology solutions, adopt flexible scheduling, and invest in staff retention through non-monetary benefits
Diminishing Capital for Investment	Lease vs. buy, seek grants and donations, form strategic partnerships, prioritize critical upgrades and phase investments over time
Logistical Challenges	Phased transitions: gradual shifts, ensuring minimal disruption with clear communication.
Market Misalignment	Follow recommendations of community health needs assessment to ensure growth aligns with demand and monitor resource distribution to prevent neglect of non-priority areas
Coordination Gaps	Cross-functional teams, standardized protocols, templates, and communication tools
Underutilization	Promote services through community outreach, ensuring patients know about available resources
Integration Challenges	Integrate services with primary care through shared records and multidisciplinary teams Strong coordination to avoid silos. Establish a cross-functional task force to oversee integration.

[BACK]

INTEGRATED STRATEGIC AND FINANCIAL PLANNING (ISFP)

Effectively integrates strategic and financial planning by aligning and sequencing initiative planning, capital planning, and budgeting activities.

This interconnected approach ensures a cohesive framework, supported by ongoing review and refinement to optimize outcomes.

[BACK]

INTEGRATED STRATEGIC AND FINANCIAL PLANNING

Sequencing of Processes

ISFP FRAMEWORK AND TIMELINE

Month	Initiative Planning	Capital Planning	Budgeting
Q1: Execution			
Jul	(Prior plan in action) Launch fiscal year, execute goals	Capital deployment begins (e.g., purchasing equipment, projects start)	Operational and capital funds allocated and spent in accordance with project timelines
Aug	(Prior plan) Monitor early progress, support teams	Monitor initial capital spend, ensure alignment with goals	Track budget adherence, report early variances
Sep	(Prior plan) Q1 review, assess progress, refine tactics	Review capital project progress, make minor adjustments if needed	Assess spending vs. plan, adjustments made accordingly
Q2: Planning			
Oct	Review past fiscal year, conduct environmental scan	Initial capital assessment: identify past successes/gaps	Maintain focus on current fiscal year
Nov	Gather stakeholder input, draft objectives, set OKRs	Identify capital needs for new initiatives (e.g., rough estimates)	Assess current year and potential carryover/ adjustments impacting next fiscal year
Dec	Finalize strategic plan: approve goals, action plans	Forecast capital requirements, align with strategic priorities	Pre-budget prep: informally review prior year budget outcomes
Q3: Budgeting			
Jan	Communicate new plan to teams, prep for execution	Detailed capital planning: refining costs, timelines, ROI projections	Budgeting begins
Feb	Train teams, align resources for next fiscal year	Finalize capital budget for July 1 implementation	Gather input, detail operational and capital costs
Mar	Final prep for fiscal year start, monitor current progress	Pre-launch prep: secure funds, issue orders for July execution	Draft initial budget based on strategic plan; align with revenue forecasts
Q4: Approval and Transition			
Apr	Execute current year goals, push toward year-end targets	Monitor ongoing capital projects, adjust if critical	Refine budget: detail line items for ops and capital spend
May	Continue execution, gather mid-year feedback	Mid-year capital review: assessment of spending and ROI	Final budget prep: incorporate feedback, prepare for board review
Jun	Close out current fiscal year, celebrate wins	Finalize mid-year capital assessment, note changes for next cycle	Board approval: finalize and approve budget; operational and capital allocations locked in

G1. Chief Financial Officer Report, April Financial Report

ALAMEDA HEALTH SYSTEM

May 2025 Financial Report
Finance Committee: July 2, 2025

May 2025 Financial Report
YTD Finance Dashboard

May-2025

	Metric	FY2025 Goal YTD	Actual YTD	YTD	Trend Lines
Volume					
	Total Adjusted Discharges	29,994	28,630		
	Total Adjusted Patient Days	322,222	335,017		
Revenue Cycle					
	Collection Ratio	19.3%	19.3%		
	Cash as % of Net Revenue	100.0%	101.9%		
	Gross Days in Patient Receivables	65.0	60.5		
Labor					
	Productivity %	100.0%	102.3%		
	Registry as % of Total FTEs	3.8%	4.7%		
	Total FTEs	4,902	5,143		
	FTE per Adjusted Discharge	0.16	0.18		
	*Labor Cost/FTE w/o GASB	$198,978	$205,495		
Profitability					
	Total Cost per Adjusted Discharge	$44,476	$50,538		
	Total Cost per Adjusted Patient Days	$4,140	$4,319		
	Net Income	$10,123	$4,080		
	EBIDA Margin	3.2%	2.9%		
	NNB (Net Negative Balance)	<$100M	$52,400		
	Net Position	>$0	-$75,527		
Capital					
	Capital Spent	$31,782	$15,816		
	% of Capital Spent		49.8%		

*Labor costs excludes contracted physicians; Includes Registry travel & housing costs

May 2025 Financial Report
Volume Highlights – Part 1

	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: AHS ALL CAMPUS											
Total Adjusted Patient Days	31,278	30,623	655	2.1%	335,017	322,222	12,795	4.0%	320,907	14,110	4.4%
Total Adjusted Discharges	2,586	2,789	(203)	-7.3%	28,630	29,994	(1,364)	-4.5%	29,148	(518)	-1.8%
GENERAL ACUTE											
GA Patient Days	6,387	6,556	(169)	-2.6%	70,916	74,562	(3,646)	-4.9%	73,419	(2,503)	-3.4%
GA Discharges	1,172	1,326	(154)	-11.6%	13,394	15,054	(1,660)	-11.0%	14,406	(1,012)	-7.0%
Average Daily Census	206	211.5	(5.5)	-2.6%	211.7	222.6	(10.9)	-4.9%	218.5	(7)	-3.1%
Average Length of Stay	5.4	4.9	0.5	10.2%	5.3	5	0.3	6.9%	5.1	0	3.9%
Adjusted Patient Days	11,991	11,864	127	1.1%	130,538	127,132	3,406	2.7%	126,839	3,699	2.9%
Adjusted Discharges	2,200	2,400	(200)	-8.3%	24,655	25,668	(1,013)	-3.9%	24,888	(233)	-0.9%
GA CMI MTD	1.610	1.615	(0.006)	-0.4%	1.636	1.596	0.04	2.5%	1.565	0	4.6%
Emergency Visits	9,546	9,570	(24)	-0.3%	100,655	96,265	4,390	4.6%	95,974	4,681	4.9%
Left Without Being Seen (LWBS)	464	735	271	58.4%	6,604	7,407	803	12.2%	7,041	437	6.6%
Trauma Cases	353	296	57	19.3%	3,383	3,189	194	6.1%	3,103	280	9.0%
Observation Equivalent Days	715	254	461	181.2%	7,107	3,005	4,102	136.5%	2,448	4,659	190.3%
IP Surgeries	307	299	8	2.7%	3,331	3,795	(464)	-12.2%	3,609	(278)	-7.7%
OP Surgeries	386	505	(119)	-23.5%	4,555	4,785	(230)	-4.8%	4,709	(154)	-3.3%
Total Surgeries	693	804	(111)	-13.8%	7,886	8,580	(694)	-8.1%	8,318	(432)	-5.2%
Deliveries	114	132	(18)	-13.6%	1,430	1,365	65	4.7%	1,420	10	0.7%
PSYCH											
Psych Patient Days	2,101	1,973	128	6.5%	21,761	22,231	(470)	-2.1%	21,938	(177)	-0.8%
Psych Discharges	229	217	12	5.5%	2,290	2,443	(153)	-6.3%	2,425	(135)	-5.6%
Average Daily Census	67.8	63.6	4	6.4%	65	66.4	(1.4)	-2.1%	65.3	(0)	-0.5%
Average Length of Stay	9.2	9.1	(0.1)	-1.1%	9.5	9.1	(0.4)	-4.4%	9	(1)	-5.0%
Adjusted Patient Days	2,472	2,373	99	4.2%	25,974	26,409	(435)	-1.6%	26,004	(30)	-0.1%
Adjusted Discharges	269	261	8	3.1%	2,731	2,902	(171)	-5.9%	2,875	(144)	-5.0%
PES Equivalent Days	819	568	251	44.2%	7,648	7,489	159	2.1%	7,366	281	3.8%
REHAB											
Rehab Patient Days	676	731	(55)	-7.5%	7,708	7,898	(190)	-2.4%	7,332	376	5.1%
Rehab Discharges	56	53	3	5.7%	575	568	7	1.2%	536	39	7.3%
Average Daily Census	21.8	23.6	(1.8)	-7.5%	23	23.6	(0.6)	-2.4%	21.8	1	5.4%
Average Length of Stay	12.1	13.9	(1.8)	-13.2%	13.4	13.9	(0.5)	-3.6%	13.7	(0)	-2.0%
Adjusted Patient Days	676	731	(55)	-7.5%	7,708	7,898	(190)	-2.4%	7,332	376	5.1%
Adjusted Discharges	56	53	3	6.5%	575	568	7	1.2%	536	39	7.3%

May 2025 Financial Report
Volume Highlights – Part 2

	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
SNF with Sub-Acute											
SNF Patient Days	8,577	8,546	31	0.4%	92,150	92,349	(199)	-0.2%	91,610	540	0.6%
SNF Discharges	10	26	(16)	-61.5%	195	279	(84)	-30.0%	281	(86)	-30.6%
Average Daily Census	276.7	275.7	1	0.4%	275.1	275.7	(0.6)	-0.2%	272.6	2	0.9%
Average Length of Stay	857.7	331.4	526	158.8%	472.6	331.4	141.2	42.6%	326	147	45.0%
Adjusted Patient Days	8,848	8,836	12	0.1%	94,983	95,446	(463)	-0.5%	94,562	421	0.4%
Adjusted Discharges	10	27	(17)	-63.0%	201	288	(87)	-30.2%	290	(89)	-30.7%
Bed Holds	80	78	2	2.4%	927	1031.56	(105)	-10.1%	945	(18)	-1.9%
CLINICVISITS	34,636	35,756	(1,120)	-3.1%	379,473	360,951	18,522	5.1%	360,280	19,193	5.3%
Clinic Visits	28,644	29,237	(593)	-2.0%	317,213	297,120	20,093	6.8%	296,671	20,542	6.9%
Telehealth Visits	5,992	6,519	(527)	-8.1%	62,260	63,831	(1,571)	-2.5%	63,609	(1,349)	-2.1%
FQHC Visits	29,227	30,585	(1,358)	-4.4%	318,112	307,177	10,935	3.6%	305,138	12,974	4.3%
Clinic Visits	24,204	25,079	(875)	-3.5%	265,817	253,118	12,699	5.0%	251,466	14,351	5.7%
Telehealth Visits	5,023	5,506	(483)	-8.8%	52,295	54,059	(1,764)	-3.3%	53,672	(1,377)	-2.6%
Non-FQHC Visits	5,409	5,171	238	4.6%	61,361	53,774	7,587	14.1%	55,142	6,219	11.3%
Clinic Visits	4,440	4,158	282	6.8%	51,396	44,002	7,394	16.8%	45,205	6,191	13.7%
Telehealth Visits	969	- 1,013	(44)	-4.3%	9,965	9,772	193	2.0%	9,937	28	0.3%
Physician wRVU	135,633	136,477	(844)	-0.6%	1,569,475	1,354,249	215,226	15.9%	1,281,512	287,963	22.5%
PAYOR MIX											
Insurance %	6.3%	7.3%	-1.0%	-14.1%	6.8%	7.3%	-0.5%	-6.9%	6.8%	-0.1%	-0.7%
Medi-Cal %	7.3%	13.0%	-5.7%	-43.8%	8.7%	13.1%	-4.4%	-33.4%	18.0%	-9.3%	-51.5%
Medi-Cal MC %	53.3%	45.9%	7.4%	16.1%	51.8%	45.5%	6.3%	13.8%	42.1%	9.8%	23.2%
Medicare %	22.7%	19.7%	3.0%	15.3%	21.3%	20.0%	1.3%	6.4%	20.6%	0.7%	3.2%
Medicare MC %	6.6%	6.8%	-0.2%	-3.1%	7.1%	6.9%	0.2%	2.5%	6.7%	0.4%	5.3%
Other Govt %	1.5%	4.0%	-2.6%	-63.8%	1.8%	3.8%	-2.1%	-54.4%	2.9%	-1.2%	-40.5%
Self-Pay %	2.5%	3.4%	-0.9%	-27.2%	2.5%	3.3%	-0.8%	-23.3%	2.8%	-0.3%	-10.0%
Total Payor Mix %	100.0%	100.0%	0.0%	0.0%	100.00%	100.00%	0.00%	0.0%	100.0%	0.0%	0.0%

May 2025 Financial Report
Financial Summary and YTD Highlights

- Favorable YTD revenue variance of $110.2M.
  - Higher volumes for outpatient and professional fees resulting in higher net patient revenue ($46.0M). Collections at than plan.
  - Distinct Part Nursing Facility Pass-Through CY23, new supplemental program ($19.2M).
  - EPP FY25 accrual increased based on CMS pre-print notification ($9.2M).
  - QIP FY25 accrual increased based on CMS pre-print notification ($23.2M).
  - FEMA revenue based on paid claims ($5.8M).

- Unfavorable YTD expense variance of $112.9M.
  - Labor costs unfavorable ($81.5M) - FTE utilization higher than planned (241 FTE, $36.3M), higher wage rates ($20.4M), and higher benefit/retirement ($24.8M).
  - St. Rose Hospital contribution for IGT funding ($12.2M) and prior year settlements ($2.1M).
  - Materials and supplies driven by volumes

	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 128,078	$ 125,245	$ 2,833	2.3%	$ 1,455,158	$ 1,344,927	$ 110,231	8.2%	$ 1,308,089	11.2%
Operating expense	135,063	123,258	(11,805)	(9.6)%	1,446,907	1,334,037	(112,870)	(8.5)%	1,319,653	(9.6)%
Operating income (loss)	**(6,985)**	**1,987**	**(8,972)**	**(451.5)%**	**8,251**	**10,890**	**(2,639)**	**(24.2)%**	**(11,564)**	**171.4%**
Other non-operating activity	(241)	(80)	(161)	(201.3)%	(4,171)	(767)	(3,404)	(443.8)%	(2,156)	(93.5)%
Net Income (loss)	**$ (7,226)**	**$ 1,907**	**$ (9,133)**	**(478.9)%**	**$ 4,080**	**$ 10,123**	**$ (6,043)**	**(59.7)%**	**$ (13,720)**	**129.7%**
EBIDA adjustments	2,506	2,086	420		38,472	32,606	5,866		38,096	
EBIDA	**$ (4,720)**	**$ 3,993**	**$ (8,713)**		**$ 42,552**	**$ 42,729**	**$ (177)**		**$ 24,376**	
Operating Margin	(5.5)%	1.6%	(7.1)%		0.6%	0.8%	(0.2)%		(0.9)%	
EBIDA Margin	(3.7)%	3.2%	(6.9)%		2.9%	3.2%	(0.3)%		1.9%	

May 2025 Financial Report
Net Patient Services Revenue Highlights

- Gross patient service revenue is favorable driven by outpatient and professional services.
  - General acute inpatient days below budget; Length of Stay (LOS) exceeding budget and PY.
    - CMI at budget and higher YTD by 2.5%.
    - Trauma 19.4% above budget and 6.1% YTD.
    - Inpatient surgery 2.7% above budget and below 12.2% YTD.
  - Observation exceeded budget at HGH, SLH, and AH.
  - ED visits 0.3% below budget and above 4.6% YTD.
  - Outpatient surgery unfavorable 23.5% and 4.8% YTD.
  - SNF and JGP census exceeding budget.
  - SLH Rehab census below budget by 7.5%
- NPSR Collection ratio approximates budget for month and YTD.

	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 220,049	$ 216,330	$ 3,719	1.7%	$ 2,362,240	$ 2,415,083	$ (52,843)	(2.2)%	$ 2,295,543	2.9%
Outpatient service revenue	152,886	139,963	12,922	9.2%	1,586,852	1,376,590	210,262	15.3%	1,344,289	18.0%
Professional service revenue	43,390	41,089	2,301	5.6%	471,543	400,527	71,017	17.7%	396,733	18.9%
Gross patient service revenue	416,325	397,383	18,942	4.8%	4,420,636	4,192,199	228,437	5.4%	4,036,565	9.5%
Deductions from revenue	(335,619)	(320,854)	(14,765)	(4.6)%	(3,565,596)	(3,383,150)	(182,446)	(5.4)%	(3,267,501)	9.1%
Net patient service revenue	**80,706**	**76,529**	**4,177**	**5.5%**	**855,039**	**809,049**	**45,991**	**5.7%**	**769,064**	**(11.2)%**
Collection % - NPSR	19.4%	19.3%	0.1%		19.3%	19.3%	0.0%		19.1%	
Capitation and HPAC	4,626	4,136	489	11.8%	50,790	45,500	5,290	11.6%	45,760	11.0%
Other government programs	36,303	40,060	(3,757)	(9.4)%	491,811	440,660	51,151	11.6%	441,105	11.5%
Other operating revenue	6,443	4,520	1,924	42.6%	57,518	49,718	7,801	15.7%	52,160	10.3%
Total operating revenue	**$ 128,078**	**$ 125,245**	**$ 2,833**	**2.3%**	**$ 1,455,158**	**$ 1,344,926**	**$ 110,232**	**8.2%**	**$ 1,308,089**	**11.2%**

May 2025 Financial Report
Governmental and Other Revenue Highlights

- Other government programs unfavorable from Measure A FY2025 Q3 ($4.4M), CalAIM ($0.3M) offset by Parcel Tax ($1.0M). YTD, significant favorable variances are from SNF DP-NF CY2023 ($19.3M), QIP CY2023/CY2025 ($24.7M), EPP CY2023/CY2025 ($12.1M), FEMA ($5.8M), offset by AB915 FY2024 ($4.0), Prop 56 recoupment 1/01/22 through 10/14/24 ($1.9M), SNF Supplemental FY2020 recoupment ($1.3M), and Measure A Q1-Q3 ($5.7M). So far, AHS has received FEMA COVID recovery totaling $6.9M.
- Other operating revenue favorable from SRH management fees for November 2024 through May 2025 ($1.9M), retail pharmacy receipts ($0.3M) offset by timing differences in grant and other operating revenue ($0.3M). YTD, higher retail pharmacy receipts ($6.1M), SRH management fee November 2024 through May 2025 not included in budget ($1.9M), grant revenue ($3.5M) offset by timing differences in other operating revenue ($1.2M) and recording of payor settlements into NPSR ($2.5M).

	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Net patient service revenue	80,706	76,529	4,177	5.5%	855,039	809,049	45,991	5.7%	769,064	(11.2)%
Capitation and HPAC	4,626	4,136	489	11.8%	50,790	45,500	5,290	11.6%	45,760	11.0%
Medi-Cal Waiver	9,054	9,289	(235)	(2.5)%	102,120	102,180	(61)	(0.1)%	89,683	13.9%
Measure A and parcel tax	9,435	12,785	(3,350)	(26.2)%	137,546	140,639	(3,093)	(2.2)%	140,834	(2.3)%
Supplemental Programs	17,814	17,986	(171)	(1.0)%	252,144	197,841	54,303	27.4%	210,588	19.7%
Covid-19	-	-	-	0.0%	-	-	-	0.0%	-	0.0%
Other government programs	**36,303**	**40,060**	**(3,757)**	**(9.4)%**	**491,810**	**440,660**	**51,150**	**11.6%**	**441,105**	**11.5%**
Grant Revenue	933	986	(54)	(5.4)%	14,384	10,850	3,534	32.6%	14,030	2.5%
Other Operating Revenue	5,511	3,533	1,977	56.0%	43,134	38,867	4,267	11.0%	38,130	13.1%
Other operating revenue	**6,443**	**4,520**	**1,924**	**42.6%**	**57,518**	**49,718**	**7,801**	**15.7%**	**52,160**	**10.3%**
Total operating revenue	**$ 128,078**	**$ 125,245**	**$ 2,833**	**2.3%**	**$ 1,455,157**	**$ 1,344,926**	**$ 110,231**	**8.2%**	**$ 1,308,089**	**11.2%**

May 2025 Financial Report
Expense Highlights excluding Labor

- Physician contract services at budget with offsetting variances under $0.1M by specialty. YTD, unfavorable with negative variances over $0.4M in General Surgery, OMFS, Hospitalist, Psychiatry, Neurosurgery, Radiology, and Rehab.
- Purchased services unfavorable from outside medical services ($0.4M), software licenses ($0.3M), clinical services ($0.2M), security ($0.2M), and remaining variance ($0.3M) spread across many cost centers. YTD, unfavorable from security ($1.2M), emergency food/shelter ($1.0M), clinical services ($0.9M), software licenses ($0.8M), laundry ($0.6M), refuge services ($0.5M), interpretive services ($0.2M) offset by favorable management consultants ($0.4M) and billing/collection fees ($0.4M).
- Material and supplies unfavorable from pharmaceuticals ($0.8M), surgical/medical supplies ($0.2M) offset by non-medical supplies ($0.1M). YTD, unfavorable from pharmaceuticals ($3.9M), retail pharmaceuticals ($3.1M), surgical/medical supplies ($2.1M), and non-medical supplies ($0.2M). The retail pharmacy has a positive margin.

	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 99,388	$ 90,794	$ (8,594)	(9.5)%	$ 1,056,888	$ 975,390	$ (81,498)	(8.4)%	$ 958,790	(10.2)%
Physician contract services	3,377	3,358	(19)	(0.6)%	38,797	36,940	(1,857)	(5.0)%	43,618	11.1%
Purchased services	9,843	8,414	(1,429)	(17.0)%	96,154	91,789	(4,365)	(4.8)%	94,818	(1.4)%
Materials and supplies	13,595	12,682	(913)	(7.2)%	141,799	132,466	(9,333)	(7.0)%	126,741	(11.9)%
Facilities	3,755	3,451	(304)	(8.8)%	35,750	37,524	1,774	4.7%	34,350	(4.1)%
Depreciation and amortization	2,254	1,993	(261)	(13.1)%	34,564	31,699	(2,865)	(9.0)%	35,797	3.4%
General and administrative	2,851	2,566	(285)	(11.1)%	42,955	28,229	(14,726)	(52.2)%	25,539	(68.2)%
Total operating expense	**$ 135,063**	**$ 123,258**	**$ (11,805)**	**(9.6)%**	**$ 1,446,907**	**$ 1,334,037**	**$ (112,870)**	**(8.5)%**	**$ 1,319,653**	**(9.6)%**

May 2025 Financial Report
Expense Highlights excluding Labor (part 2)

- Facilities unfavorable from timing of building/equipment repairs ($0.6M) offset by utilities ($0.3M). YTD, favorable due to timing of facility/equipment repairs ($1.2M), utilities ($0.4M), and rental equipment ($0.2M).
- Depreciation and amortization unfavorable from lease/software amortization ($0.3M). YTD, unfavorable from timing of lease/software amortization ($2.8M) and building/equipment depreciation ($0.1M).
- General and administrative favorable from insurance ($0.2M) and other expenditures ($0.1M). YTD, unfavorable from St. Rose Hospital contribution ($12.2M), settlements ($2.1M), insurance ($1.6M) offset by lower legal fees ($0.4M), recruiting ($0.4M), and remaining variance ($0.4M) is spread across many cost centers.

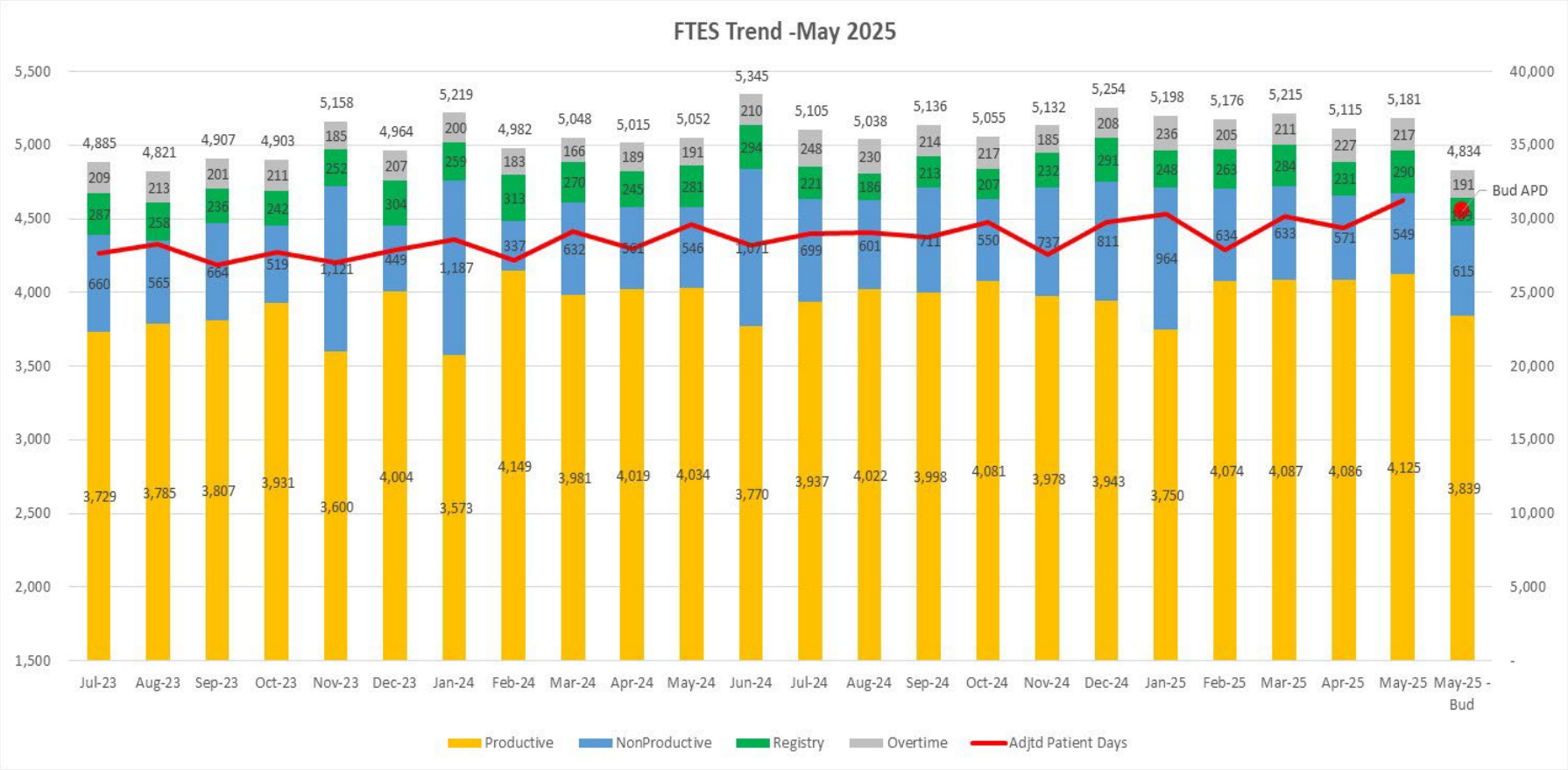
	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 99,388	$ 90,794	$ (8,594)	(9.5)%	$ 1,056,888	$ 975,390	$ (81,498)	(8.4)%	$ 958,790	(10.2)%
Physician contract services	3,377	3,358	(19)	(0.6)%	38,797	36,940	(1,857)	(5.0)%	43,618	11.1%
Purchased services	9,843	8,414	(1,429)	(17.0)%	96,154	91,789	(4,365)	(4.8)%	94,818	(1.4)%
Materials and supplies	13,595	12,682	(913)	(7.2)%	141,799	132,466	(9,333)	(7.0)%	126,741	(11.9)%
Facilities	3,755	3,451	(304)	(8.8)%	35,750	37,524	1,774	4.7%	34,350	(4.1)%
Depreciation and amortization	2,254	1,993	(261)	(13.1)%	34,564	31,699	(2,865)	(9.0)%	35,797	3.4%
General and administrative	2,851	2,566	(285)	(11.1)%	42,955	28,229	(14,726)	(52.2)%	25,539	(68.2)%
Total operating expense	**$ 135,063**	**$ 123,258**	**$ (11,805)**	**(9.6)%**	**$ 1,446,907**	**$ 1,334,037**	**$ (112,870)**	**(8.5)%**	**$ 1,319,653**	**(9.6)%**

May 2025 Financial Report
Expense Highlights – Labor and Benefits

- Staff, physician and registry labor costs were unfavorable to budget by $4.6 million and 6.8% driven by higher FTE volume (347 FTEs/$4.9 million) and lower rates ($0.2 million). Implementation of UKG and registry clocking in causing monthly fluctuations.
- YTD, staff, physician and registry labor costs were unfavorable to budget by $56.7 million and 7.7% driven by higher FTE volume (241 FTEs/$36.3 million) and higher rates ($20.4million).
  - Budget was understated approximately $7.4 million for the year due to higher than budget raises provided to staff and underestimating PTO and holiday pay.
  - YTD registry is 53 FTE over budget. Demand for registry continues; however, overall rates have decreased from pandemic levels.
  - YTD physician FTEs are unfavorable by 15 FTE as the result of recruiting. Physician salaries included the payout of the paternity benefit under the SEIU MOU of $1.6 million.
- Employee Benefits unfavorable from self-funded health ($2.7M month, $10.2M YTD), FICA ($0.4M month, $6.3M YTD), workers compensation ($0.1M month, $1.2M YTD) offset by other benefit plans ($0.3M month, $2.3M YTD).
- Retirement unfavorable from ACERA ($0.8M) and other AHS plans ($0.3M). YTD, ACERA ($5.8M), AHS plan ($3.2M) and AHMG ($0.5M) exceed budget.

	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 58,017	$ 54,305	$ (3,712)	(6.8)%	$ 631,190	$ 588,449	$ (42,741)	(7.3)%	$ 570,910	(10.6)%
Salaries and wages (physicians)	10,378	9,568	(810)	(8.5)%	114,330	103,516	(10,814)	(10.4)%	97,972	(16.7)%
Registry	4,252	4,132	(120)	(2.9)%	47,399	44,284	(3,115)	(7.0)%	58,512	19.0%
Employee benefits (taxes, insurance)	18,351	15,472	(2,879)	(18.6)%	176,359	160,989	(15,370)	(9.5)%	151,589	(16.3)%
Retirement	8,390	7,317	(1,073)	(14.7)%	87,610	78,152	(9,458)	(12.1)%	79,807	(9.8)%
Total labor costs	**$ 99,388**	**$ 90,794**	**$ (8,594)**	**(9.5)%**	**$ 1,056,888**	**$ 975,390**	**$ (81,498)**	**(8.4)%**	**$ 958,790**	**(10.2)%**
Compensation ratio	77.6%	72.5%	-5.1%		72.6%	72.5%	-0.1%		73.3%	
Paid FTEs	5,181	4,834	(347)	(7.2)%	5,143	4,902	(241)	(4.9)%	5,001	(2.8)%

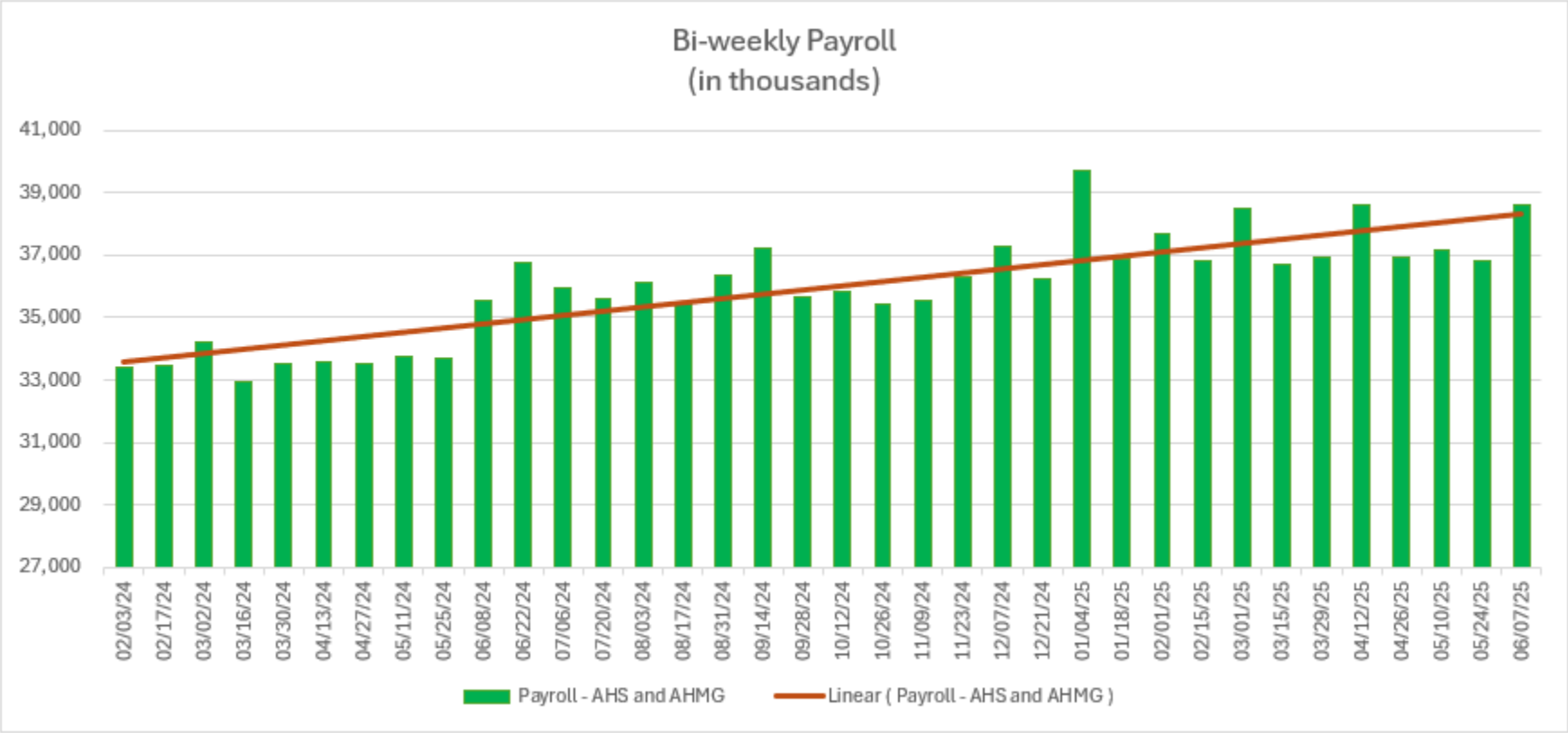
May 2025 Financial Report
Analysis of Total Labor Expense



For the month,

- Paid FTEs exceeded budget by 347 (5,181-4,834) and 7.2% for the month.
- Higher hours in productive, overtime, and registry offset by lower hours in non-productive hours.
- Total adjusted patient days above budget 2.5%; total adjusted discharges below budget by 7.3%.

May 2025 Financial Report
Bi-weekly Payroll Trend



- Average payroll in FY2024 was $33.4M; FY2025 was $37.1M.
- 11.1% increase between fiscal years; equating to an additional $96.3M.
    - FTEs in FY2024 was 5,022; FY2025 was 5,143, increase of 121 FTE.
- Defined pension (GASB), AIPLS, paternity, and significant retro adjustments not included.
- Government fee schedules are not rising at the same rate as costs.

May 2025 Financial Report
Physician Expenses Variance

Budget Variances by Physician Specialty
(in thousands)

	Current Month - May 2025			Year to Date		
Specialty	**Salaries**	**Contract**	**Total**	**Salaries**	**Contract**	**Total**
Radiology	(162)	(57)	(220)	(2,306)	(358)	(2,664)
Hospitalist	(134)	(39)	(173)	(1,225)	(510)	(1,735)
ED	(123)	0	(123)	(1,385)	(62)	(1,447)
Cardiology	(99)	9	(90)	(909)	87	(822)
Orthopedic	(98)	60	(37)	(1,218)	446	(772)
General Surgery	0	(52)	(52)	0	(633)	(633)
Rehab	(18)	(9)	(26)	(153)	(426)	(579)
Psychiatry	(22)	(4)	(26)	55	(535)	(480)
Hospice	(50)	0	(50)	(442)	0	(442)
Nephrology	(45)	3	(42)	(384)	(24)	(408)
Pediatrics	(24)	(2)	(26)	(381)	(16)	(397)
General Dentistry	(68)	0	(68)	(375)	1	(374)
Neurosurgery	0	(64)	(64)	0	(366)	(366)
Wellness Centers	30	(3)	27	(208)	(131)	(339)
OB/GYN	136	(6)	130	(179)	(143)	(321)
Pulmonology	(29)	17	(12)	(461)	147	(314)
OMFS	51	(39)	12	290	(581)	(291)
Medical Oncology	0	0	0	0	(281)	(281)
Anesthesia	(60)	0	(60)	(78)	(119)	(197)
Pathology	(14)	0	(14)	(170)	0	(170)
Podiatry	(5)	0	(5)	(164)	0	(164)
Plastic Surgery	(22)	0	(22)	(108)	0	(108)
Gastroenterology	(2)	0	(2)	(102)	0	(102)
Other	(51)	167	116	(913)	1,648	735
	$ (810)	**$ (19)**	**$ (828)**	**$ (10,814)**	**$ (1,857)**	**$ (12,671)**

**Variances less than ($100k) in "Other"*

May 2025 Financial Report
Balance Sheet Key Metrics

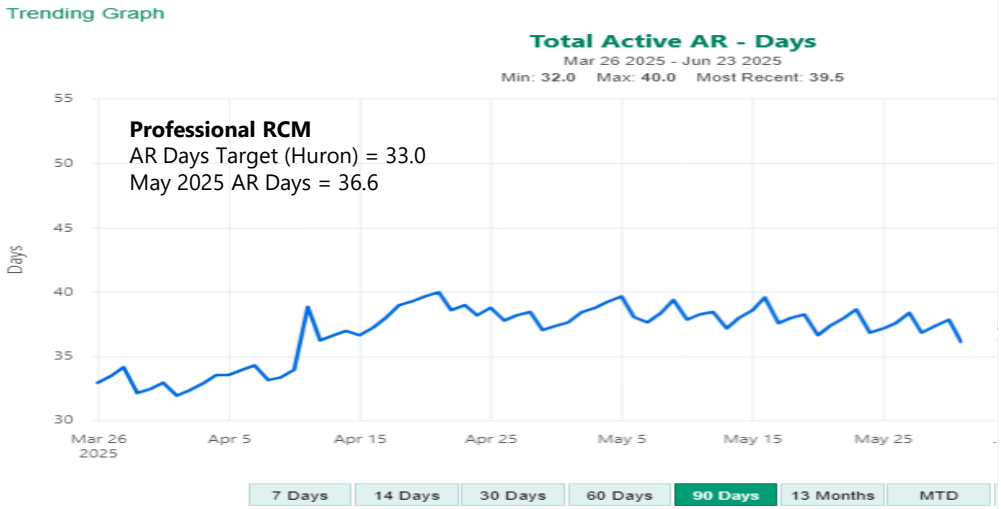
- Days in Cash are 3.0 and higher than year-end; typically, run below 5.0 days.
- Gross AR Days decreased 3.1 days and Net AR Days increased 5.2 days. See next slide for additional detail.
- Days in Accounts Payable decreased due to timing of check run. The target is 30 days. The % of AP over 60 days consistent with prior month at 3%.
- Net Position is negative $75.5M and improved $5.1M from June 30, 2024 reflecting YTD Net Income.
- Net Negative Balance is a receivable of $52.4M. NNB consists of the liquidity facility (receivable) of $25.3M increased by the restricted cash of $27.1M; and is expected to be below the June 30, 2025 credit ceiling of $100.0M at the end of the fiscal year.

	May-25	Apr-25	FY 2024
Days in cash	3.0	2.7	1.3
Gross days in patient receivable	60.5	63.6	69.0
Net days in patient receivable	44.7	39.5	41.1
Due from/(to) third-party payors	$ 106,014	$ 131,400	$ 145,333
Due from/(to) County	$ 22,606	$ 19,002	$ 24,800
Days in accounts payable	31.5	34.5	39.3
% of AP over 60 days	3.0%	3.0%	10.6%
Net position - fund balance/(deficit)	$ (75,526)	$ (68,300)	$ (80,622)
Net negative balance - receivable/(payable)	$ 52,400	$ 33,609	$ 21,227

May 2025 Financial Report
AR Trending

Hospital Revenue Cycle Key Indicators

- HB AR Days decreased by 1.1 days compared to prior month. April AR Days 65.7, May AR Days 64.6
- May collections were $62.3M. Consistent with the prior twelve months at $62.4M.
- Candidate for Billing (CFB) was increased by 0.2 days. April CFB was 8.6 and May CFB ended at 8.8 days.



Professional Revenue Cycle Key Indicators

- PB AR Days decreased by 1.0 days compared to prior month. April AR Days 37.6 days, May AR Days 36.6
- May collections were $12.1M. Higher than average of the prior twelve months at $11.8M.
- Enterprise CDI launched to address provider clinical documentation along with charge automation and usage of Epic tools. Pilot project in progress with Obstetrics & Gynecology, Neurology, Optometry, Pediatrics, and Critical Care. Project completed in Orthopedics and Otolaryngologists (ENT).

May 2025 Financial Report
Patient Collections

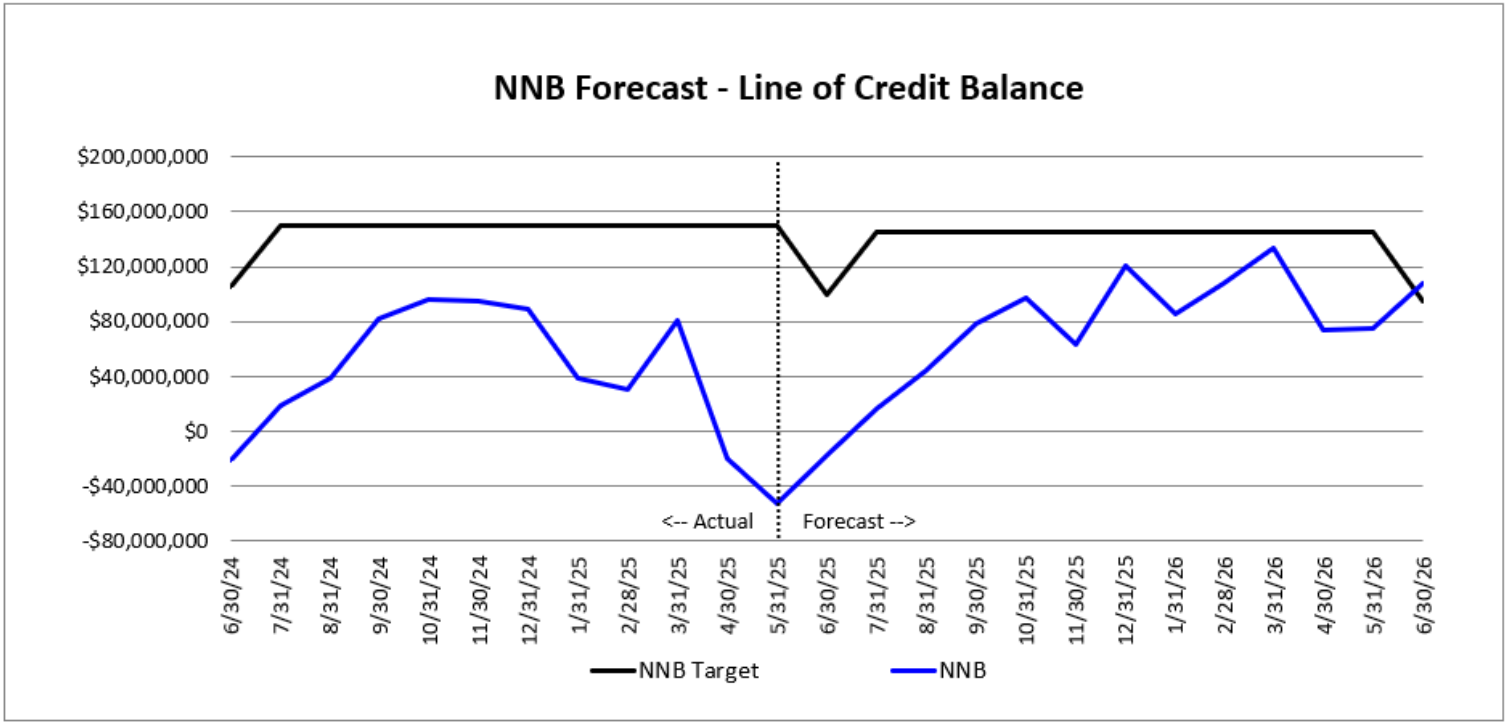
- FY25 Patient collections approximately 14.6% higher than the same period in FY24.
- JGP FY25 contract with the County was amended from $49.2M to $74.2M; total FY25 contract payments through February is $40.0M. As a reminder, AHS is accruing revenue at $72.1M consistent with the FY23 contract.
- JGP FY24 2nd amendment was completed from $61.2M to $73.6M. Invoices were resubmitted for the $12.4M outstanding balance.

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2025	FY 2024	FY 2023	FY 2022	FY 2021
Jul	4,941	67,753	72,694	79,592	74,260	59,732	41,373
Aug	4,628	75,140	79,768	69,313	58,590	57,374	53,893
Sep	2,493	67,248	69,741	63,322	76,063	61,968	64,484
Oct	-	76,783	76,783	63,122	59,796	49,923	51,514
Nov	5,073	73,674	78,747	57,781	56,939	52,057	49,499
Dec	12,050	82,581	94,631	63,867	67,018	68,121	53,274
Jan	9,227	79,787	89,014	68,757	71,452	62,292	34,443
Feb	5,194	63,317	68,511	75,852	57,886	52,269	49,157
Mar	16,378	75,473	91,851	54,720	65,320	62,888	58,922
Apr	5,259	69,633	74,892	61,895	55,307	56,235	55,646
May	-	74,339	74,339	102,015	63,795	69,591	44,005
Jun	-	-	-	71,208	70,027	53,187	43,889
Total	**65,243**	**805,728**	**870,971**	**831,444**	**776,453**	**705,637**	**600,099**
% change between fiscal years			14.6%	7.1%	10.0%	17.6%	

May 2025 Financial Report
Line of Credit (NNB) Forecast through 6/30/25

- NNB (at 6/30/25) improved over the prior month from increased patient receipts ($10.7M) and projected to end as a receivable of $20.1M this fiscal year.
- SNF DP-NF funding is available for a 3-year period, CY2023 through CY2025.
  - CY2023 funding was received ($19.2M) in January 2025 and included in the NNB forecast.
  - CY2024 funding ($25.5M) and CY2025 funding ($26.0M) is expected in Fall 2025 and Fall 2026, respectively. These funds will likely be needed to stay below the NNB ceiling at 12/31/2026.
- The projection assumes that the St. Rose Hospital will not have a balance on the line of credit and AHS operations are consistent with the preliminary budget.



May 2025 Financial Report
Material Items Impacting NNB Forecast

- St. Rose Hospital accessed $11.0M of the $15.0M LOC by May 31st; repayment was made in June 2025.
  - St. Rose Hospital is projecting to access the line of credit in October 2025, which was not included in the AHS forecast.
  - St. Rose Hospital budget planning is underway for FY2027.
- SNF DP-NF funding for CY2024 and CY2025 will be adjusted during the audit. FY2023 cash received, $19.2M, was recognized, swept to the County Treasurer, and included in the NNB in February 2025.
- Prior year activity for the old Waiver, Medi-Cal FQHC and Physician SPA settlements are reflected in bottom table as the final settlement and timing are unknown. Amounts are excluded from the forecast.

Material Items Included in NNB Forecast
(in thousands)

	Jun-25	Jul-25	Aug-25	Sep-25	FY26 Q2	FY26 Q3	FY26 Q4
GPP (quarterly)	$ -	$ -	$ 25,700	$ -	$ 25,700	$ 25,700	$ 25,700
EPP (semi-annual)	-	-	-	-	21,000	-	21,000
QIP	-	-	-	-	34,364	-	34,364
Medi-Cal Rate Range	-	-	-	-	-	42,700	-
BHCS (JGP/Alameda County) - fy25	8,200	7,100	7,100	7,000	-	-	-
BHCS (JGP/Alameda County) - fy26	-	-	-	6,084	18,251	18,251	18,251
HPAC	-	-	-	-	21,600	10,800	10,800
AB85 Realignment	-	-	-	-	(41,670)	-	-
St. Rose Hospital LOC	11,000	-	-	-	-	-	-
	$ 19,200	$ 7,100	$ 32,800	$ 13,084	$ 79,245	$ 97,451	$ 110,115

Prior Year Reimbursement Settlements

Waiver recoupment (fy11)	$ (4,796)	TBD
Medi-Cal FQHC recoupment (fy08 - fy13)	(40,000)	TBD
Physician SPA (fy08 - fy13)	(25,000)	TBD
	$ (69,796)	

April 2025
Financial Summary & YTD Highlights

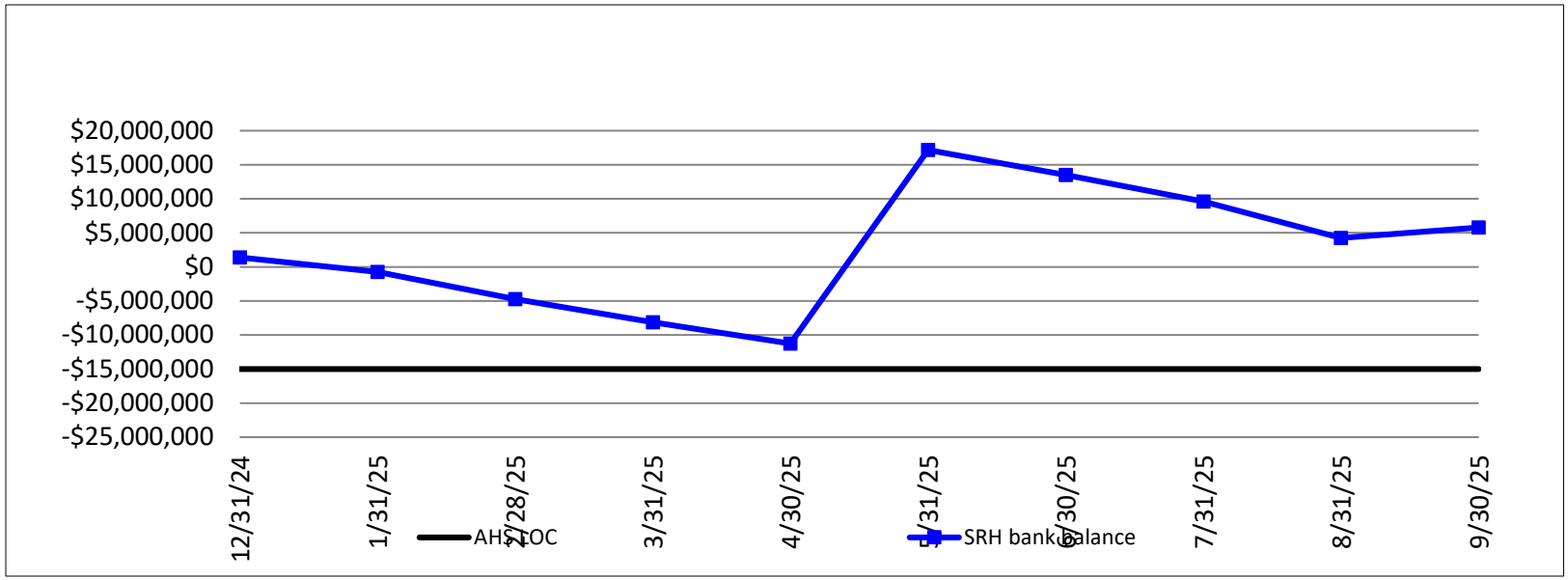
- SRH net income below budget
  - Unfavorable revenue variance of 13.7% during the month, 4.6% YTD, driven by lower than expected volume.
  - Favorable expense variance of 5.9% below budget during the month, tracking consistent YTD, driven by lower materials and supply cost associated with lower volume.
  - Subacute unit budget was based on full occupancy starting April. The unit is providing SNF level of care with census averaging 5 with 7 the highest so far. Licensing is expected to be completed by July, census expected to pick up by then.
- MOB's net income exceeding budget by $70K (37%) YTD
  - Rent revenue higher than budget from La Familia's tenancy
  - Still deferring repairs and lower than budget property taxes

- Foundation is exceeding YTD budget by $302K mainly driven by The Dee Jordan Trust

	April 30, 2025				Year-To-Date			
	Actual	**Budget**	**Var ($)**	**Var (%)**	**Actual**	**Budget**	**Var ($)**	**Var (%)**
Total Net Patient Service Revenue	$8,183	$8,742	($560)	-6.4%	$58,467	$57,738	$729	1.3%
Total Other Revenue	$157	$922	($764)	-82.9%	$9,507	$13,479	(3,972)	-29.5%
TOTAL OPERATING REVENUE	**$8,340**	**$9,664**	**($1,324)**	**-13.7%**	**$67,974**	**$71,217**	**($3,243)**	**-4.6%**
Less: Operating Expenses	$10,848	$11,522	$674	5.9%	$80,382	$80,711	329	0.4%
EBITDA	**($2,508)**	**($1,858)**	**($650)**	**35.0%**	**($12,408)**	**($9,494)**	**($2,914)**	**30.7%**
Total Non-Operating Exp/(Income	($576)	$392	($969)	-246.8%	$2,071	$2,769	($699)	-25.2%
Restr Donation - AA Geropscych)	$0	$292	($292)	-100.0%	$0	$2,042	(2,042)	-100.0%
NET INCOME/(LOSS)	**($1,932)**	**($1,959)**	**$27**	**-1.4%**	**($14,479)**	**($10,222)**	**($4,257)**	**41.6%**

April 2025
Cash Flow Projection

- SRH started drawing down from AHS LOC in January and has borrowed $11M through May 6th, 2025. Interest has been accruing on the County's cost of fund rate. Total amount drawn, along with the interest incurred to date was paid off on June 12th.
    - SRF donated $1M to SRH on April 16th.
    - Great news! The IGT funding has been received. A check for $30,332,000 arrived on May 28th. Currently catching up paying vendors.
- The current projection indicates that no further drawing is necessary until October 2025. Currently onboarding an Accountant and start working on FY2026 budget.



ALAMEDA HEALTH SYSTEM

1411 East 31st Street
Oakland, CA 94602

MEMORANDUM

TO: AHS Finance Committee
FROM: Kim Miranda, CFO
DATE: June 27, 2025
SUBJECT: May 2025 Financial Report

Financial Summary

Net Income for the month was a loss of $7.2 million compared to a budget of $1.9 million and unfavorable to budget by $9.1 million and 478.9%. Operating Revenue was $128.1 million and favorable to budget by $2.8 million and 2.3%. Operating Expense was $135.1 million and unfavorable to budget by $11.8 million and 9.6%. Earnings before interest, depreciation, and amortization (EBIDA) was a negative $4.7 million and the EBIDA Margin was a negative 3.7% compared to a budget EBIDA of $4.0 million and a budget EBIDA Margin of 3.2%. For the month, EBIDA was unfavorable to budget by $8.7 million.

	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 128,078	$ 125,245	$ 2,833	2.3%	$ 1,455,158	$ 1,344,927	$ 110,231	8.2%	$ 1,308,089	11.2%
Operating expense	135,063	123,258	(11,805)	(9.6)%	1,446,907	1,334,037	(112,870)	(8.5)%	1,319,653	(9.6)%
Operating income (loss)	**(6,985)**	**1,987**	**(8,972)**	**(451.5)%**	**8,251**	**10,890**	**(2,639)**	**(24.2)%**	**(11,564)**	**171.4%**
Other non-operating activity	(241)	(80)	(161)	(201.3)%	(4,171)	(767)	(3,404)	(443.8)%	(2,156)	(93.5)%
Net Income (loss)	**$ (7,226)**	**$ 1,907**	**$ (9,133)**	**(478.9)%**	**$ 4,080**	**$ 10,123**	**$ (6,043)**	**(59.7)%**	**$ (13,720)**	**129.7%**
EBIDA adjustments	2,506	2,086	420		38,472	32,606	5,866		38,096	
EBIDA	**$ (4,720)**	**$ 3,993**	**$ (8,713)**		**$ 42,552**	**$ 42,729**	**$ (177)**		**$ 24,376**	
Operating Margin	(5.5)%	1.6%	(7.1)%		0.6%	0.8%	(0.2)%		(0.9)%	
EBIDA Margin	(3.7)%	3.2%	(6.9)%		2.9%	3.2%	(0.3)%		1.9%	

Net Income year-to-date (YTD) was $4.1 million compared to a budget of $10.1 million and unfavorable to budget by $6.0 million and 59.7%. Operating Revenue was $1.5 billion and favorable to budget by $110.2 million and 8.2%. Operating Expense was $1.4 billion and unfavorable to budget by $112.9 million and 8.5%. EBIDA was $42.6 million and the EBIDA Margin was 2.9% compared to the budget EBIDA of $42.7 million and a budget EBIDA Margin of 3.2%. For the year, EBIDA is unfavorable to budget $0.2 million.

Operating Revenue

Gross Patient Service Revenue (patient charges) was $416.3 million for the month and favorable to budget by $18.9 million and 4.8%. Inpatient, Outpatient and Professional Fee charges were above budget by 1.7%, 9.2% and 5.6%, respectively. For the year, Gross Patient Service Revenue was $4.4 billion and favorable $228.4

million and 5.4%. Inpatient charges fell below budget by 2.2%; and Outpatient and Professional Fee charges were above budget by 15.3% and 17.7%, respectively. Inpatient charges were favorable in the month driven by inpatient surgery and trauma. Acute patient days were below budget for the month and YTD by 2.6% and 4.9%, respectively. General Acute Length of Stay (LOS) is 5.4 which exceeded budget for the month, YTD and prior year. Discharges are lower for all time periods while observation status has increased. The case mix index (CMI) was at budget for the month and above YTD and prior year. CMI is an indicator of the overall complexity of inpatient illness and services being provided. The favorable outpatient charge variance was driven by observation charges at Highland Hospital and San Leandro Hospital and emergency visits, which continue to exceed the YTD budget and prior year. Outpatient surgeries were below budget for the month and YTD by 23.5% and 4.8%, respectively. Clinic visits were below budget for the month by 3.1% and above YTD by 5.1%. Physician wRVU are below budget by 2.4% for the month and above budget YTD by 17.7%. Retroactive posting of PES professional fees done early in the year is causing the YTD variance to be high. Overall, on an adjusted day basis, volumes were above budget for the month and YTD driven by outpatient charges. Adjusted discharges are behind budget due to higher LOS and fewer discharges.

	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 220,049	$ 216,330	$ 3,719	1.7%	$ 2,362,240	$ 2,415,083	$ (52,843)	(2.2)%	$ 2,295,543	2.9%
Outpatient service revenue	152,886	139,963	12,922	9.2%	1,586,852	1,376,590	210,262	15.3%	1,344,289	18.0%
Professional service revenue	43,390	41,089	2,301	5.6%	471,543	400,527	71,017	17.7%	396,733	18.9%
Gross patient service revenue	416,325	397,383	18,942	4.8%	4,420,636	4,192,199	228,437	5.4%	4,036,565	9.5%
Deductions from revenue	(335,619)	(320,854)	(14,765)	(4.6)%	(3,565,596)	(3,383,150)	(182,446)	(5.4)%	(3,267,501)	9.1%
Net patient service revenue	**80,706**	**76,529**	**4,177**	**5.5%**	**855,039**	**809,049**	**45,991**	**5.7%**	**769,064**	**(11.2)%**
Collection % - NPSR	19.4%	19.3%	0.1%		19.3%	19.3%	0.0%		19.1%	
Capitation and HPAC	4,626	4,136	489	11.8%	50,790	45,500	5,290	11.6%	45,760	11.0%
Other government programs	36,303	40,060	(3,757)	(9.4)%	491,811	440,660	51,151	11.6%	441,105	11.5%
Other operating revenue	6,443	4,520	1,924	42.6%	57,518	49,718	7,801	15.7%	52,160	10.3%
Total operating revenue	**$ 128,078**	**$ 125,245**	**$ 2,833**	**2.3%**	**$ 1,455,158**	**$ 1,344,926**	**$ 110,232**	**8.2%**	**$ 1,308,089**	**11.2%**

Net Patient Revenue

Net Patient Service Revenue (NPSR) was $80.7 million for the month and favorable to budget by $4.2 million and 5.5% driven by higher volume. The current month collection ratio was 19.4% and favorable by 0.1% to budget. Collections on fully reserved accounts (over 270 days) were consistent with the trend. For the year, NPSR was $855.0 million and favorable to budget by $46.0 million and 5.7%. The collection ratio was 19.3% and at plan. The impact on higher than trend collections on fully reserve accounts remains at $8.2 million and 0.3% which include Sac Law settlements which are part of the GRIT (Growing Responsibly Through Innovation and Teamwork.

Other Government Program Revenue

Other Government Program Revenue for the month was $36.3 million and unfavorable to budget by $3.8 million and 9.4% based on the transactions below.

- Measure A FY2025 Q3 decreased based on receipts by $4.4 million.
- Parcel Tax revenue, from the City of Alameda Health Care District, increased based on receipts by $1.0 million.
- CalAIM Enhanced Care Management decreased from lower receipts of $0.3 million.
- The remaining variance, netting to a negative $0.1 million, is spread across many programs.

For the year, the Other Government Program Revenue is $491.8 million and favorable to budget by $51.2 million and 11.6% based on the transactions below.

- Measure A FY2025 Q1-Q2 below budget based on lower receipts of $5.7 million.
- Parcel Tax revenue, from City of Alameda Health Care District, increased based on receipts by $2.5 million.
- GPP CY2023 increased from filing final report by $1.1 million.
- EPP CY2023 revenue increased from final reconciliation by $2.9 million.
- EPP CY2025 revenue increased from CMS pre-print notification by $9.2 million.
- QIP CY2023 revenue increased from final reconciliation by $1.5 million.
- QIP CY2025 revenue increased from CMS pre-print notification by $23.2 million.
- SNF DP-NF CY2023 recognized revenue of $19.3 million.
- Rate Range CY2023 revenue decreased from final filing by $0.6 million.
- AB915 FY2024 revenue decreased from report submission by $4.0 million.
- SNF Supplemental FY2020 recoupment for AHS and Alameda Hospital of $1.3 million.
- Prop 56 recoupment for January 1, 2022 through October 14, 2024 of $1.9 million.
- FEMA revenue received in FY2025 for successful filing of Covid-related expenditure is $5.8 million. Total FEMA receipts, received starting in FY2024, are $6.9 million.
- The remaining variance, netting to a negative $0.8 million, is spread across many programs.

Other Operating Revenue

Other Operating Revenue for the month was $6.4 million and favorable $1.9 million and 42.6%. Grant revenue was unfavorable from timing differences ($0.1 million). Other Operating revenue was favorable driven from by St. Rose Hospital management fee for November 2024 through May 2025 ($1.9 million), retail pharmacy ($0.3 million) offset by timing of differences for payer settlements ($0.2 million). YTD, Other Operating Revenue was $57.5 million and favorable $7.8 million and 15.7%. Higher retail pharmacy receipts ($6.1 million), St. Rose Hospital management fees not part of the budget ($1.9 million), grant receipts ($3.6 million) were offset by timing differences between actual and budget for payor settlements ($2.3 million) which were posted to NPSR, cafeteria sales ($0.7 million), and IT fee revenue ($0.6 million). Payor settlements included in NPSR are part of the GRIT initiative.

Operating Expense

Operating Expense was $135.1 million for the month and unfavorable to budget by $11.8 million and 9.6%. Labor costs are discussed in a subsequent section.

	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 99,388	$ 90,794	$ (8,594)	(9.5)%	$ 1,056,888	$ 975,390	$ (81,498)	(8.4)%	$ 958,790	(10.2)%
Physician contract services	3,377	3,358	(19)	(0.6)%	38,797	36,940	(1,857)	(5.0)%	43,618	11.1%
Purchased services	9,843	8,414	(1,429)	(17.0)%	96,154	91,789	(4,365)	(4.8)%	94,818	(1.4)%
Materials and supplies	13,595	12,682	(913)	(7.2)%	141,799	132,466	(9,333)	(7.0)%	126,741	(11.9)%
Facilities	3,755	3,451	(304)	(8.8)%	35,750	37,524	1,774	4.7%	34,350	(4.1)%
Depreciation and amortization	2,254	1,993	(261)	(13.1)%	34,564	31,699	(2,865)	(9.0)%	35,797	3.4%
General and administrative	2,851	2,566	(285)	(11.1)%	42,955	28,229	(14,726)	(52.2)%	25,539	(68.2)%
Total operating expense	**$ 135,063**	**$ 123,258**	**$ (11,805)**	**(9.6)%**	**$ 1,446,907**	**$ 1,334,037**	**$ (112,870)**	**(8.5)%**	**$ 1,319,653**	**(9.6)%**

Non-labor expense variances net to an unfavorable variance of $3.2 million as follows.

- Physician contract services approximate budget. The largest negative variances in General Surgery, Radiology, and Neurosurgery but all variances were under $0.1 million.
- Purchased services were unfavorable to budget by $1.4 million and 17.0% driven by unfavorable variances in outside medical services ($0.4 million), software licenses ($0.3 million), clinical services ($0.2 million), security ($0.2 million) and the remaining variance ($0.3 million) spread across many cost centers.
- Materials and supplies were unfavorable to budget by $0.9 million and 7.2% driven by unfavorable variances in pharmaceuticals ($0.8 million), surgical supplies ($0.4 million) offset favorable variance in medical supplies ($0.2 million) and non-medical supplies ($0.1 million). Retail pharmaceuticals approximated budget for the month.
- Facilities were unfavorable to budget by $0.3 million and 8.8% driven by timing of building/equipment repairs ($0.6 million) offset by utilities ($0.3 million).
- Depreciation and amortization were unfavorable to budget by $0.3 million and 13.1% driven by lease/software amortization ($0.3 million). Depreciation approximated budget.
- General and administrative costs were unfavorable to budget by $0.3 million and 11.1% driven by insurance ($0.2 million) and remaining variance ($0.1 million) is spread across many cost centers.

For the year, Operating Expense was $1.4 billion and unfavorable to budget by $112.9 million and 8.5%. Labor costs are discussed in a subsequent section. Non-labor expense variances net to an unfavorable variance of $31.4 million as follows.

- Physician contract services were unfavorable to budget by $1.9 million and 5.0% with the largest unfavorable variances driven by General Surgery ($0.6 million), OMFS ($0.6 million), Hospitalist ($0.5 million), Psychiatry ($0.5 million), Neurosurgery ($0.4 million), Radiology ($0.4 million), Rehab ($0.4 million) offset by positive variance for Ophthalmology ($0.4 million) and Orthopedic ($0.4 million).
- Purchased services were unfavorable to budget by $4.4 million and 4.8% driven by unfavorable variances in security ($1.2 million), emergency food/services ($1.0 million), clinical services ($0.9 million), software licenses ($0.8 million), laundry ($0.6 million), refuge services ($0.5 million), interpretive services ($0.2 million) offset by favorable variances in management services/consultants ($0.4 million) and billing/collection fees ($0.4 million).
- Materials and supplies were unfavorable to budget by $9.3 million and 7.0% driven by unfavorable variances in pharmaceuticals ($3.9 million), retail pharmaceuticals ($3.1 million), medical supplies ($1.2 million), surgery supplies ($0.9 million), and non-medical supplies ($0.2 million). Retail pharmacy continues to a favorable profit margin as discussed as part of Other Operating Revenue.
- Facilities were favorable to budget by $1.8 million and 4.7% driven by favorable variances for facility repairs ($0.8 million), equipment repairs ($0.4 million), utilities ($0.4 million) and rental equipment ($0.2 million). The favorable variance for facility repairs was in Fairmont ($0.4 million), Eastmont ($0.3 million), and San Leandro ($0.1 million).
- Depreciation and amortization were unfavorable to budget by $2.9 million and 9.0%. Amortization of leases and software agreements is unfavorable ($2.8 million), which is expected to continue for the remainder of the fiscal year. Building and equipment depreciation was over budget ($0.1 million).
- General and administrative costs were unfavorable to budget by $14.7 million and 52.2% driven by St. Rose Hospital contribution ($12.2 million), prior period Medicare settlements ($2.1 million), and insurance ($1.6 million) offset by lower legal fees ($0.4 million), recruiting ($0.4 million), and remaining variance ($0.4 million) is spread across many cost centers.

Labor Costs

Labor costs for the month was $99.4 million and unfavorable to budget by $8.6 million and 9.5%. YTD, labor cost was $1.1 billion and unfavorable to budget by $81.5 million and 8.4%.

	May 2025				Year-To-Date				FY 2024	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 58,017	$ 54,305	$ (3,712)	(6.8)%	$ 631,190	$ 588,449	$ (42,741)	(7.3)%	$ 570,910	(10.6)%
Salaries and wages (physicians)	10,378	9,568	(810)	(8.5)%	114,330	103,516	(10,814)	(10.4)%	97,972	(16.7)%
Registry	4,252	4,132	(120)	(2.9)%	47,399	44,284	(3,115)	(7.0)%	58,512	19.0%
Employee benefits (taxes, insurance)	18,351	15,472	(2,879)	(18.6)%	176,359	160,989	(15,370)	(9.5)%	151,589	(16.3)%
Retirement	8,390	7,317	(1,073)	(14.7)%	87,610	78,152	(9,458)	(12.1)%	79,807	(9.8)%
Total labor costs	**$ 99,388**	**$ 90,794**	**$ (8,594)**	**(9.5)%**	**$ 1,056,888**	**$ 975,390**	**$ (81,498)**	**(8.4)%**	**$ 958,790**	**(10.2)%**
Compensation ratio	77.6%	72.5%	-5.1%		72.6%	72.5%	-0.1%		73.3%	
Paid FTEs	5,181	4,834	(347)	(7.2)%	5,143	4,902	(241)	(4.9)%	5,001	(2.8)%

For the month, staff, physician and registry labor costs were unfavorable to budget by $4.6 million and 6.8% driven by higher FTE volume (347 FTEs/$4.9 million) and lower rates ($0.2 million). AHS continues to roll out UKG timekeeping to registry. At this point, timing differences occur between when invoices are paid, and the hours are included to calculate FTE causing variances for the month. YTD, staff, physicians, and registry labor costs were unfavorable to budget by $56.7 million and 7.7% driven by higher FTE volume (241 FTEs/$36.3 million) and higher rates ($20.4 million). The salary budget was understated approximately $7.4 million for the year due to higher than budget raises provided to staff and underestimating PTO and holiday pay. YTD, Staff FTE is unfavorable by 173, and overtime is unfavorable by 21.6 FTEs. YTD, registry is 53 FTE over budget. Demand for registry continues; however, overall rates have decreased from pandemic levels. YTD physician FTEs are unfavorable by 15 FTE as the result of recruitment. Physician salaries also include the payout of the paternity benefit under the SEIU MOU of $1.6 million.

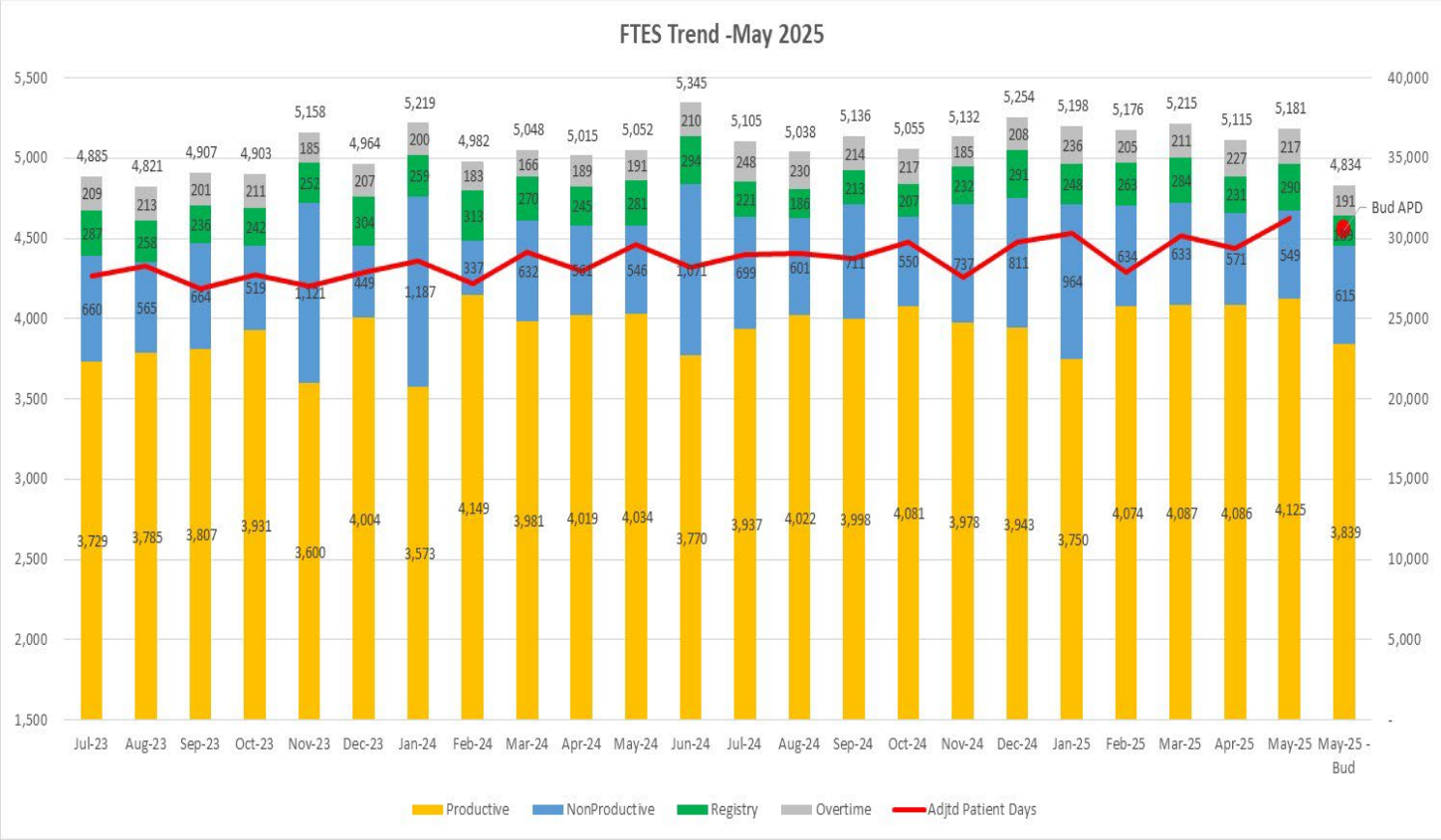
Employee benefits were unfavorable $2.9 million and 18.6% driven by self-funded health insurance ($2.7 million), FICA ($0.4 million), workers compensation ($0.1 million) offset by positive variance driven by Kaiser insurance plan ($0.3 million). YTD, employee benefits were unfavorable $15.4 million and 9.5% driven by self-funded health ($10.2 million), FICA ($6.3 million), workers compensation ($1.2 million) offset by positive variances for Kaiser insurance plan ($1.7 million) and other benefits ($0.6 million).

Retirement expense was unfavorable $1.1 million and 14.7% from ACERA ($0.8 million) and other AHS plans ($0.3 million). YTD, retirement was unfavorable $9.5 million and 12.1% from ACERA ($5.8 million), other AHS plans ($3.2 million), and AHMG plan ($0.5 million).

FTE Trending

For the month, Paid FTE was 5,181 compared to a budget of 4,834 which was unfavorable to budget by 347 and 7.2%. YTD, Paid FTE was 5,143 compared to a budget of 4,902 which was unfavorable to budget by 241 and 4.9%. The FTE trend graph below reflects paid FTE and adjusted patient days (Total Gross Revenues / Inpatient Revenues = Outpatient Factor x Patient Days) by the month beginning in July, 2023. Overall, adjusted patient days (red line) exceeded budget this month. The bars reflect Paid FTE for each month and are stacked to include each paid labor component represented by color within the bars. The

current month actual and budget are reflected in the last columns on the right of the graph. For the month, overtime (grey), registry (green), and productive (yellow) exceeded budget resulting in an unfavorable FTE variance. Non-productive (blue) was lower than budget.



Balance Sheet and Financial Condition

The Balance Sheet key financial metrics are reflected in the table below.

	May-25	Apr-25	FY 2024
Days in cash	3.0	2.7	1.3
Gross days in patient receivable	60.5	63.6	69.0
Net days in patient receivable	44.7	39.5	41.1
Due from/(to) third-party payors	$ 106,014	$ 131,400	$ 145,333
Due from/(to) County	$ 22,606	$ 19,002	$ 24,800
Days in accounts payable	31.5	34.5	39.3
% of AP over 60 days	3.0%	3.0%	10.6%
Net position - fund balance/(deficit)	$ (75,526)	$ (68,300)	$ (80,622)
Net negative balance - receivable/(payable)	$ 52,400	$ 33,609	$ 21,227

Days in Cash
Days in Cash are low as all AHS cash receipts are swept to the County Treasury. The Days in Cash can fluctuate based on timing of cash draws from the County treasury and timing of vendor payments and payroll.

Accounts Receivable (AR)
The Gross Days in AR were 60.5 days and 3.1 days lower than last month due to higher cash receipts. Net Days in AR were 44.7 and 5.2 days higher than the previous month from higher net revenue per calendar day by 2.9%. The calculation reflects 90 days versus actual days for the quarter to standardize the calculation. Utilizing a 90-day period does lead to more fluctuations. Key updates on work in progress within Revenue Cycle are noted below:

- Settlements through arbitration using Sac Law continue to support GRIT.
- Enterprise CDI team addressing clinical documentation and EPIC tool improvement. Pilot project in progress with Obstetrics & Gynecology (GYN), Neurology, Optometry, Pediatrics, and Critical Care. Orthopedics and Otolaryngologists (ENT) projects were completed.

Patient collections are reflected in the table below. Behavioral Health represents the County receipts under contract for JGP services which total $65.2 million. The final payment of $11.7 million was received in March 2025 for the FY2024 contract maximum of $61.2 million. AHS and the County executed in May 2025 the 2nd amendment increasing the contract total from $61.2 million to $73.6 million. Invoices were submitted to the County for the remaining $12.4 million. Payments under the FY2025 contract for July 2024 through February 2025 total $40.0 million. An amendment to the FY2025 contract was completed in May 2025 increasing the maximum contract from $49.2 million to 74.2 million. As a reminder the FY2023 contract was $72.1 million, and AHS continues to accrue at this higher level of reimbursement, which is now supported by the recent amendments.

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2025	FY 2024	FY 2023	FY 2022	FY 2021
Jul	4,941	67,753	72,694	79,592	74,260	59,732	41,373
Aug	4,628	75,140	79,768	69,313	58,590	57,374	53,893
Sep	2,493	67,248	69,741	63,322	76,063	61,968	64,484
Oct	-	76,783	76,783	63,122	59,796	49,923	51,514
Nov	5,073	73,674	78,747	57,781	56,939	52,057	49,499
Dec	12,050	82,581	94,631	63,867	67,018	68,121	53,274
Jan	9,227	79,787	89,014	68,757	71,452	62,292	34,443
Feb	5,194	63,317	68,511	75,852	57,886	52,269	49,157
Mar	16,378	75,473	91,851	54,720	65,320	62,888	58,922
Apr	5,259	69,633	74,892	61,895	55,307	56,235	55,646
May	-	74,339	74,339	102,015	63,795	69,591	44,005
Jun	-	-	-	71,208	70,027	53,187	43,889
Total	**65,243**	**805,728**	**870,971**	**831,444**	**776,453**	**705,637**	**600,099**
	% change between fiscal years		14.6%	7.1%	10.0%	17.6%	

Accounts Payable

Days in Accounts Payable are 31.5 at the end of the month and decreased 3.0 days over the prior month from timing of recurring check runs versus the last day of the calendar month and resolution of ongoing implementation issues with OnBase. The Percent over 60 Days is 3.0% and is below the 5% target. Purchasing and Accounts Payable teams are making positive progress resolving older invoices held in work queues.

Supplemental Program Revenue Receivable/Payable

Net Reimbursement Supplemental Programs
as of 5/31/2025

Programs	FY97-20	FY21-24	FY25	Net Balance	Comments
Medicare Cost Report	(1,657)	(3,434)	(1,139)	(6,229)	Older years pending disputed SSI ratio and outlier holds for both OPPS / IPPS services from CMS.
Medi-Cal P14 Waiver	7,087	9,424	(8,626)	7,884	P14 audits are in various stages of completion. Currently DHCS has finalized up to FY18.
Current Waiver (GPP & CalAIM)	-	(2,569)	16,383	13,814	Global Payment Program (GPP) subsidizing remaining uninsured. GPP extended to 2026 as CalAIM.
AB85 Realignment	0	(40,822)	(41,800)	(82,622)	Realignment reserves for HPAC amendment passing through the County for physical health for Medi-Cal and Indigent populations.
Physician SPA	(6,000)	1,201	3,269	(1,529)	Reconciliation based on P14 utilization file with the State. FY14-FY16 Finalized. Catch-up ACA interim payments began during FY22.
FQHC	(7,922)	(12,565)	(4,583)	(25,071)	Negotiating settlement for a new FQ rate. The difference between the new FQ rate and FFS rate will determine the settlement for the impacted years. AHS started billing as a FQ in March 2022.
Medi-Cal Managed Care EPP	0	45,844	56,843	102,687	EPP (Enhanced Payment Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care QIP	0	27,536	80,420	107,956	QIP (Quality Incentive Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care Rate Range	(0)	24,213	42,400	66,612	Subsidize rates for Medi-Cal Managed Care members in Alameda County.
Medi-Cal Managed Care GME	0	399	1,449	1,848	CMS approved in March 2020. GME is paying concurrently with fiscal year.
Medi-Cal Managed Care DP-NF Pass-Through	-	-	-	-	New payment program assisting AHS with LTC carve-in from FFS to managed care, time-limited CY2023 through CY2025. First year disclosed and received Jan 2025, further years TBA
Medi-Cal SNF Cost Settlement	0	(679)	1,287	608	The State began their reconciliation.
AB915	(17,000)	859	1,136	(15,005)	AB915/Medi-Cal Hospital OP cost settlement. DHCS began reconciling older years during FY23.
All Other Supplemental Programs	0	911	3,947	4,857	Hospital Fee, NDPH & P4P programs
Subtotal	**$ (25,493)**	**$ 50,318**	**$150,986**	**$ 175,811**	
Old Waiver (FY11, DSH/SNCP)	(4,796)	0	0	(4,796)	FY11 DY5 & DY6 is pending reconciliation. All other years have been finalized.
Physician SPA (FY08-12)	(25,000)	0	0	(25,000)	FY13 final settled.
FQHC (FY12-18)	(40,000)	0	0	(40,000)	Negotiating settlement for Highland FQ clinics is pending for HGH K-6 clinic.
Subtotal	**$ (69,797)**	**$ -**	**$ -**	**$ (69,797)**	
Grand Total	**$ (95,290)**	**$ 50,318**	**$150,986**	**$ 106,014**	

The information presented in the table provides subsidiary information for Supplemental Program receivables and payables on the Balance Sheet. The net receivable balance for Supplemental Programs is $106.0 million, which was a decrease of $25.4 million over last month. Key items are noted below.

- Payment received for EPP CY2023 ($8.7 million).
- Payment received for QIP CY2023 ($13.8 million).
- Payment received for GME FY2024 Final Settlement ($7.4 million).
- Payment received for GME FY2025 Q4 ($5.4 million).
- Payment received for AB915 FY202 ($9.9 million).
- Minor cost report adjustments and monthly accruals ($19.8 million).

Estimates are necessary to record supplemental income because the ultimate amount that may be collected under the program is uncertain, dependent on costs for services that were ultimately provided, quality metrics achieved, Medi-Cal enrollment, and our ability to identify and claim related costs. The timing of receipts and payments is critical because these cashflows affect the NNB under our Line of Credit with the County. Nearly half of AHS annual revenue comes from supplemental funding. AHS has liability under the old Medi-Cal Waiver, Physician SPA and Highland FQHC. The total estimated amount due is $69.8 million which is consistent with the prior month.

Net County Receivable and Payable

Due To/From County of Alameda

	May-25	Apr-25	FY 2024
Due from County of Alameda	$ 30,516	$ 36,030	$ 32,869
Capital designation receivable	-	-	7,000
Due from County of Alameda	**30,516**	**36,030**	**39,869**
Due to County of Alameda	(1,790)	(4,241)	(1,446)
County IGT funding	-	(6,667)	-
Capital cost payable	(6,120)	(6,120)	(13,623)
Due to County of Alameda	**(7,910)**	**(17,028)**	**(15,069)**
Net due from/(to) County	**$ 22,606**	**$ 19,002**	**$ 24,800**

The net County receivable and payable due under arrangements with the County are reflected as part of the Due to and Due From accounts reported on the Balance Sheet as follows:

- The County receivable includes the HPAC contract, John George Pavilion (JGP) services agreement and grants.
- The Capital Designation receivable reflects reimbursement expected from the County ($7 million per year) to help fund the Sapphire project. An annual invoice is sent to the County after AHS transfers the funds, and certain contractual requirements are met at the end of the fiscal year. The FY2024 payment was received in December 2024.
- Inter-government transfers (IGT) are ongoing to draw down federal supplemental funding and then paid back to the County.

- The Capital Cost Transfer reflects a payable based on the balance remaining on open cost report settlements associated with County owned buildings ($6.1 million). AHS transfers cost reimbursement estimates to the County each year and AHS has the contractual ability to benefit from these funds to help maintain and invest in County owned facilities. In May 2024, the County accessed $1.2 million to pay for an emergency transformer on the Fairmont campus. AHS is working with the County to develop a workflow to allow AHS to capture costs for future cost reimbursement.

Net Position

The Net Position or Fund Balance of AHS as of May 31, 2025, is negative $75.5 million, which deteriorated $7.2 million over last month reflecting the net loss for the month.

Net Negative Balance

The Net Negative Balance (NNB) or Line of Credit with the County is $52.4 million receivable on May 31, 2025 and remains compliant with the terms of the Permanent Agreement. The Working Capital Loan is reported on the Balance Sheet as a long-term liability labeled "Liquidity Facility – County of Alameda." To calculate the NNB, the Liquidity Facility ($25.3 million receivable) increased by the County Restricted Cash Fund ($27.1 million) which is included in Cash.

Contingencies

John George Pavilion (JGP)

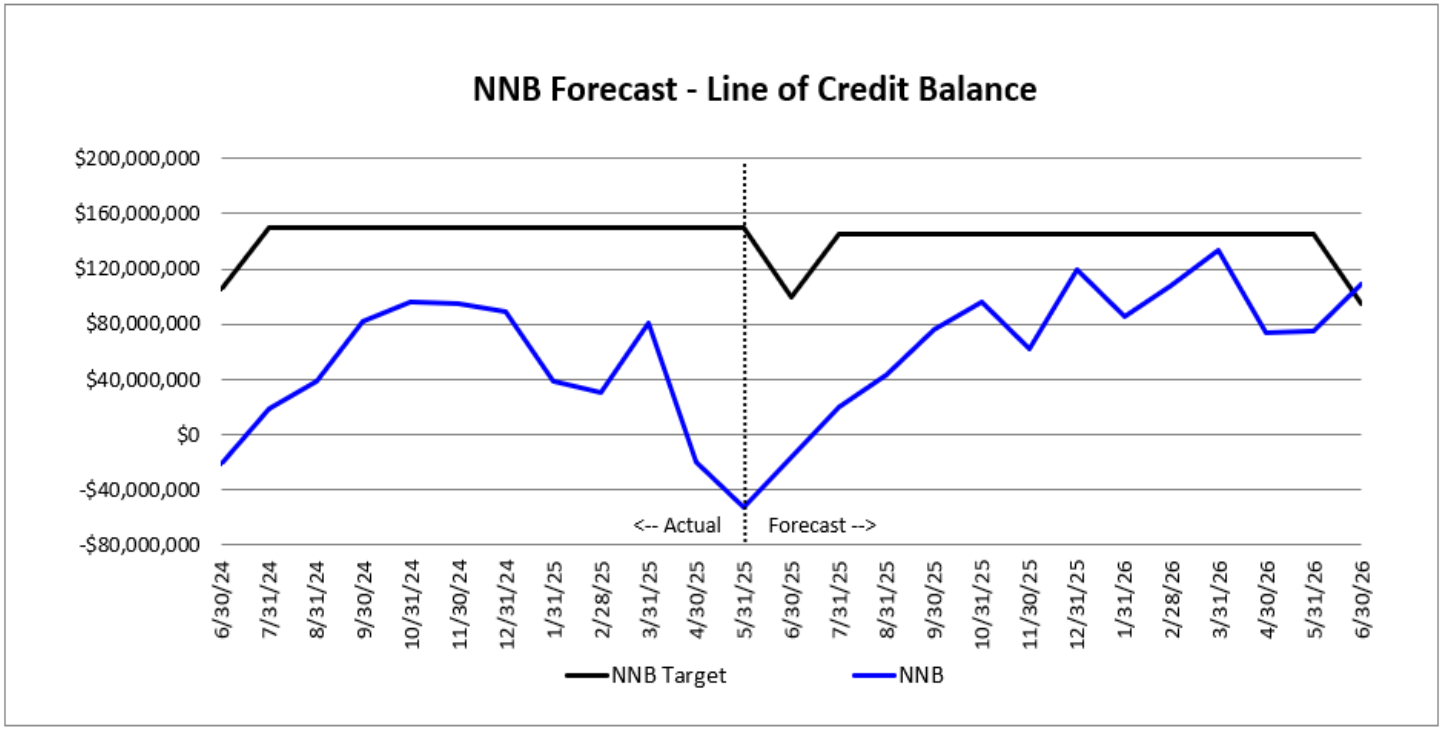
Consistent with FY2024 reporting, AHS is accruing revenue for FY2025 assuming payment of $72.1 million under the County contract based on the FY23 contract maximum and our understanding that the change from Short Doyle cost reimbursement to fee for service payments under Cal Aim was not going to reduce funding for behavioral health services. The amendment for the FY2025 contract was signed in May 2025 increasing the contract maximum from $49.2 million to $74.2 million. The FY24 2nd contract amendment was also signed in May 2025 increasing the contract maximum from $61.2 million to $73.6 million. AHS has submitted invoices to the County to capture the contract increases and avoid further adjustment.

The transition to Cal Aim has been difficult. The published FY2024 Alameda County inpatient rates under Cal Aim developed by the State were low because they were developed using older cost data and did not reflect current reality. Alameda County was not the only County negatively impacted by the published CalAIM rates either due to inflation or other issues. Alameda County and other Counties worked with the State and submitted a State Plan Amendment (SPA) giving the State more flexibility to calculate rates using the best available information. This SPA, number 23-0045, was approved by CMS in May 2024, with an effective date of December 12, 2023. The new rates resulting from this approved SPA were eventually posted, with FY 2024 rates increased to $4,716/day and FY 2025 rates to $4,866/day, both significantly higher versus the previous $2,642. Unfortunately, because the rates only apply for inpatient days starting December 12, 2023, that leaves about 5.5 months of days to be reimbursed at a lower rate. The County paid AHS based on the interim contracted rate of $3,092.10, which covered a portion of the shortfall starting July 1, 2023.

Also complicating matters, the County implemented new billing software, SmartCare, which has delayed billing. JGP technical services have been input into SmartCare to be billed and paid for by the State although AHS has not received any information from the County on denials or payments they have received. AHS and the County partnered to determine appropriate billing of professional fees, which under this new system are payable separate from technical services for the first time. There is a twelve-month timely filing requirement which began impacting claims after July 1, 2024. The County has indicated it will ensure claims are paid even if the timely filing deadline means they cannot be federally matched. AHS has submitted professional claims to the County; however, no information has been provided to us on the status of these claims.

Highland Federally Qualified Healthcare Center (FQHC) Settlement
The State reached out to AHS inquiring about a new application that AHS submitted to establish the dental clinic located at Highland as a new FQHC. The State wanted to understand the new application request which started a conversation that ultimately resulted in the State verbally agreeing AHS could resume billing previous service locations on the Highland campus as FQHC. AHS began billing as an FQHC for these service locations on March 1, 2022. AHS and the State started negotiations on a retroactive settlement going back to the FY2012 filing made by AHS to establish an FQHC rate. Once the negotiations progress to a point where a new estimate can be determined, AHS will adjust the current liability on the balance sheet. AHS currently has a pending recoupment of $40.0 million. AHS is being paid at the historical Highland FQ rate for the additional service locations until the new rate is finalized.

Line of Credit (Net Negative Balance) Forecast
The Line of Credit Balance or the Net Negative Balance (NNB) held with the County is forecasted in the line graph below through June 30, 2026 for planning purposes. AHS is currently forecasting that the NNB will be compliant with the terms of the agreement with the County which limits the NNB to $100.0 million on June 30, 2025. The current graph reflects that the NNB will exceed the $95.0 million on June 30, 2026; however, AHS expects to receive CY2024 SNF DP-NF which will cover the shortfall and bring AHS into compliance. The forecast updates as actual activity is reflected in the cashflow model.



The forecasted NNB on June 30, 2025 improved from higher patient receipts than expected in May 2025. As a reminder, AHS received the first year of SNF DP-NF funding for CY2023 ($19.2 million) which is reflected in the NNB as these funds were swept to the County Treasurer. CY2024 and CY2025 funding are not included in the projection at this time. The intent was to preserve SNF DP-NF funds for future investments or to establish reserve fund since these funds are not expected to continue beyond the three-year period. The cash projection

reflects the funds will be needed to stay below the NNB ceiling in FY2026. Also, the current projection assumes that the St. Rose Hospital will not have a balance on the line of credit and AHS operations are consistent with the approved budget.

Material items impacting the NNB are summarized in the table below. The top portion of the table provides expected cash flow from sizable items included in NNB forecast. Forecasted items have changed as follows.

- Behavior Health (JGP/Alameda County) was changed from $4.1 million to $8.2 million reflecting the delay in payment.
- AB85 Realignment repayment was updated from $40.0 million to $41.7 million.
- St. Rose Hospital accessed $11.0 million of the $15.0 million Line of Credit on May 31st and repayment was received in June 2025 using the IGT funds.
- St. Rose Hospital is projecting to access the line of credit in October 2025, which was not included in the AHS forecast. AHS has also not included a donation to help fund the local share required to maximize the FY26 IGT.
- St. Rose Hospital budget planning is underway for FY2027.

The bottom portion of the table below reflects prior year recoupments which are not included in the forecast (blue line). Beginning with the final open Waiver recoupment for FY2011 for which the timing of the settlement remains unknown. The Federal Qualified Health Center (FQHC) recoupment is a conservative settlement estimate based on the difference between reimbursement rates for services provided at Highland campus locations that were considered qualified and subsequently denied by the State. AHS is in current discussions with the State and once an agreement is reached with the State the FQHC liability will be adjusted Lastly, Physician SPA reconciliations are delayed because the State is having difficulty obtaining claim data.

Material Items Included in NNB Forecast
(in thousands)

	Jun-25	Jul-25	Aug-25	Sep-25	FY26 Q2	FY26 Q3	FY26 Q4
GPP (quarterly)	$ -	$ -	$ 25,700	$ -	$ 25,700	$ 25,700	$ 25,700
EPP (semi-annual)	-	-	-	-	21,000	-	21,000
QIP	-	-	-	-	34,364	-	34,364
Medi-Cal Rate Range	-	-	-	-	-	42,700	-
BHCS (JGP/Alameda County) - fy25	8,200	7,100	7,100	7,000	-	-	-
BHCS (JGP/Alameda County) - fy26	-	-	-	6,084	18,251	18,251	18,251
HPAC	-	-	-	-	21,600	10,800	10,800
AB85 Realignment	-	-	-	-	(41,670)	-	-
St. Rose Hospital LOC	11,000	-	-	-	-	-	-
	$ 19,200	$ 7,100	$ 32,800	$ 13,084	$ 79,245	$ 97,451	$ 110,115

Prior Year Reimbursement Settlements

Waiver recoupment (fy11)	$ (4,796)	TBD
Medi-Cal FQHC recoupment (fy08 - fy13)	(40,000)	TBD
Physician SPA (fy08 - fy13)	(25,000)	TBD
	$ (69,796)	

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Revenues and Expenses
For the Period Ended May 31, 2025
(In Thousands)

	May 2025				Year-To-Date				FY 2024		
	Actual	Budget	Variance	% Variance	Actual	Budget	Variance	% Variance	YTD	Variance	% Variance
Operating revenue											
Net patient service revenue	$ 80,706	$ 76,529	$ 4,177	5.5%	$ 855,039	$ 809,049	$ 45,990	5.7%	$ 769,064	$ 85,975	11.2%
Capitation revenue	4,626	4,136	490	11.8%	50,790	45,500	5,290	11.6%	45,760	5,030	11.0%
Other government programs	36,303	40,060	(3,757)	(9.4)%	491,811	440,660	51,151	11.6%	441,105	50,706	11.5%
Other operating revenue	6,443	4,520	1,923	42.5%	57,518	49,718	7,800	15.7%	52,160	5,358	10.3%
Total operating revenue	**128,078**	**125,245**	**2,833**	**2.3%**	**1,455,158**	**1,344,927**	**110,231**	**8.2%**	**1,308,089**	**147,069**	**11.2%**
Operating expense											
Labor costs	99,388	90,794	(8,594)	(9.5)%	1,056,888	975,390	(81,498)	(8.4)%	958,790	(98,098)	(10.2)%
Physician contract services	3,377	3,358	(19)	(0.6)%	38,797	36,940	(1,857)	(5.0)%	43,618	4,821	11.1%
Purchased services	9,843	8,414	(1,429)	(17.0)%	96,154	91,789	(4,365)	(4.8)%	94,818	(1,336)	(1.4)%
Materials and supplies	13,595	12,682	(913)	(7.2)%	141,799	132,466	(9,333)	(7.0)%	126,741	(15,058)	(11.9)%
Facilities	3,755	3,451	(304)	(8.8)%	35,750	37,524	1,774	4.7%	34,350	(1,400)	(4.1)%
Depreciation and amortization	2,254	1,993	(261)	(13.1)%	34,564	31,699	(2,865)	(9.0)%	35,797	1,233	3.4%
General and administrative	2,851	2,566	(285)	(11.1)%	42,955	28,229	(14,726)	(52.2)%	25,539	(17,416)	(68.2)%
Total operating expense	**135,063**	**123,258**	**(11,805)**	**(9.6)%**	**1,446,907**	**1,334,037**	**(112,870)**	**(8.5)%**	**1,319,653**	**(127,254)**	**(9.6)%**
Operating income (loss)	**(6,985)**	**1,987**	**(8,972)**	**(451.5)%**	**8,251**	**10,890**	**(2,639)**	**(24.2)%**	**(11,564)**	**19,815**	**171.4%**
Non-operating activity											
Interest income (expense)	(252)	(93)	(159)	(171.0)%	(3,908)	(907)	(3,001)	(330.9)%	(2,299)	(1,609)	(70.0)%
Other nonoperating revenue	11	13	(2)	(15.4)%	(263)	140	(403)	(287.9)%	143	(406)	(284.0)%
Total non-operating activity	**(241)**	**(80)**	**(161)**	**(201.3)%**	**(4,171)**	**(767)**	**(3,404)**	**(443.8)%**	**(2,156)**	**(2,015)**	**(93.5)%**
Net income (loss)	**$ (7,226)**	**$ 1,907**	**$ (9,133)**	**(478.9)%**	**$ 4,080**	**$ 10,123**	**$ (6,043)**	**(59.7)%**	**$ (13,720)**	**$ 17,800**	**129.7%**
EBIDA adjustments											
Interest income (expense)	252	93	159		3,908	907	3,001		2,299	1,609	
Depreciation and amortization	2,254	1,993	261		34,564	31,699	2,865		35,797	(1,233)	
Total EBIDA adjustments	2,506	2,086	420		38,472	32,606	5,866		38,096	376	
EBIDA	**$ (4,720)**	**$ 3,993**	**$ (8,713)**		**$ 42,552**	**$ 42,729**	**$ (177)**		**$ 24,376**	**$ 18,176**	

ALAMEDA HEALTH SYSTEM (consolidated)
Balance Sheet
As of May 31, 2025
(In Thousands)

	Current Month	Prior Month	FYE 2024
ASSETS			
Cash & cash equivalents	$ 12,971	$ 11,376	$ 5,630
Patient account receivables, net	100,085	99,861	106,096
Due from third-party payors	294,867	301,221	313,969
Due from County of Alameda	30,516	36,030	39,869
Due from State of California	25,132	30,378	24,264
Inventories	11,893	11,948	11,987
Other current assets	22,760	21,664	17,622
TOTAL CURRENT ASSETS	**498,224**	**512,478**	**519,437**
Restricted cash equivalents	27,133	27,133	26,328
Right-to-use lease assets, net	32,228	32,851	39,085
Right-of-use subscription assets, net	3,931	4,102	869
Capital assets - nondepreciable	9,021	9,021	9,021
Capital assets - depreciable, net	127,034	126,932	136,930
TOTAL NONCURRENT ASSETS	**199,347**	**200,039**	**212,233**
DEFERRED OUTFLOWS OF RESOURCES	**167,665**	**167,665**	**167,665**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$ 865,236**	**$ 880,182**	**$ 899,335**
LIABILITIES & NET ASSETS			
Accounts payable and accrued expenses	$ 68,487	$ 57,899	$ 85,488
Accrued compensation	49,667	44,920	56,267
Due to third-party payors	188,853	169,821	168,636
Due to County of Alameda	7,910	17,028	15,069
Other Payables	39,483	53,191	32,642
TOTAL CURRENT LIABILITIES	**354,400**	**342,859**	**358,102**
Liquidity facility - County of Alameda	(25,267)	(6,476)	5,101
Net pension obligation	425,359	425,359	426,007
Post employment benefit asset	38,374	38,374	38,374
Accrued compensated absences, net of current portion	23,293	23,293	23,293
Self-insurance liabilities, net of current portion	39,820	39,820	37,258
Lease obligations, net of current portion	30,875	31,410	36,469
Subscription obligations, net of current portion	1,429	1,364	167
Other long-term liabilities	76	76	2,783
TOTAL LONG TERM LIABILITIES	**533,959**	**553,220**	**569,452**
DEFERRED INFLOWS OF RESOURCES	**52,403**	**52,403**	**52,403**
Fund balance - capital contribution	86,466	86,466	85,451
Fund balance - prior years	(166,072)	(166,072)	(169,139)
Current year income/(loss)	4,080	11,306	3,066
FUND BALANCE	**(75,526)**	**(68,300)**	**(80,622)**
TOTAL LIABILITIES, DEFERRED INFLOWS, & FUND BALANCE	**$ 865,236**	**$ 880,182**	**$ 899,335**

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Cash Flows
For the Period Ended May 31, 2025
(in thousands)

	Current Month	Year-to Date	FYE 2024
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating income (loss)	$ (6,985)	$ 8,251	$ 4,809
Depreciation and amortization	2,254	34,564	41,048
Net changes in operating assets and liabilities:			
Patient account receivables, net	(224)	6,011	(11,664)
Due from/to third-party payors	25,386	39,319	(72,070)
Due from/to County	(3,604)	2,194	(3,778)
Due from State	5,246	(868)	2,648
Inventory	55	94	(318)
Other current assets	(1,096)	(5,138)	242
Accounts payable and accrued expenses	10,589	(17,000)	11,238
Accrued compensation	4,747	(6,600)	16,540
Other current payables	(13,709)	6,841	2,572
Net pension liability	-	(648)	(87,151)
Other postemployment benefits obligations	-	-	4,703
Other long-term liabilities	-	2,562	8,608
Deferred outflows/inflows	-	-	72,675
Net cash provided by (used in) operating activities	**22,659**	**69,582**	**(9,898)**
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES			
Change in liquidity facility	(18,791)	(30,368)	38,104
Interest payments on working capital loan	356	4,045	2,655
Receipts of rental income	11	(263)	155
Net cash provided by (used in) noncapital financing activities	**(18,424)**	**(26,586)**	**40,914**
CASH FLOWS FROM CAPITAL AND FINANCING ACTIVITIES			
Purchase and construction of capital assets	(1,561)	(15,832)	(20,601)
Proceeds from disposals of capital assets	0	0	0
Repayment of other long-term liabilities	0	(2,707)	(3,977)
Payments of lease liabilies	(535)	(5,594)	(6,148)
Interest payments on lease liabilities	96	1,137	997
Payments of subscription obligations	64	(3,779)	(870)
Interest payments on subscription obligations	9	117	43
Capital contributions and transfers	-	1,015	385
Net cash provided by (used in) capital and financing activities	**(1,927)**	**(25,643)**	**(30,171)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest and investment income	(713)	(9,207)	(5,593)
Net cash provided by (used in) investing activities	**(713)**	**(9,207)**	**(5,593)**
CHANGES IN CASH AND CASH EQUIVALENTS	**1,595**	**8,146**	**(4,748)**
CASH AND CASH EQUIVALENTS, beginning of period	38,509	31,958	36,706
CASH AND CASH EQUIVALENTS, end of period	**$ 40,104**	**$ 40,104**	**$ 31,958**

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: May

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: AHS ALL CAMPUS											
Total Adjusted Patient Days	31,278	30,623	655	2.1%	335,017	322,222	12,795	4.0%	320,907	14,110	4.4%
Total Adjusted Discharges	2,586	2,789	(203)	-7.3%	28,630	29,994	(1,364)	-4.5%	29,148	(518)	-1.8%
GENERAL ACUTE											
GA Patient Days	6,387	6,556	(169)	-2.6%	70,916	74,562	(3,646)	-4.9%	73,419	(2,503)	-3.4%
GA Discharges	1,172	1,326	(154)	-11.6%	13,394	15,054	(1,660)	-11.0%	14,406	(1,012)	-7.0%
Average Daily Census	206	211.5	(5.5)	-2.6%	211.7	222.6	(10.9)	-4.9%	218.5	(7)	-3.1%
Average Length of Stay	5.4	4.9	0.5	10.2%	5.3	5	0.3	6.9%	5.1	0	3.9%
Adjusted Patient Days	11,991	11,864	127	1.1%	130,538	127,132	3,406	2.7%	126,839	3,699	2.9%
Adjusted Discharges	2,200	2,400	(200)	-8.3%	24,655	25,668	(1,013)	-3.9%	24,888	(233)	-0.9%
GA CMI MTD	1.610	1.615	(0.006)	-0.4%	1.636	1.596	0.04	2.5%	1.565	0	4.6%
Emergency Visits	9,546	9,570	(24)	-0.3%	100,655	96,265	4,390	4.6%	95,974	4,681	4.9%
Left Without Being Seen (LWBS)	464	735	271	58.4%	6,604	7,407	803	12.2%	7,041	437	6.6%
Trauma Cases	353	296	57	19.3%	3,383	3,189	194	6.1%	3,103	280	9.0%
Observation Equivalent Days	715	254	461	181.2%	7,107	3,005	4,102	136.5%	2,448	4,659	190.3%
IP Surgeries	307	299	8	2.7%	3,331	3,795	(464)	-12.2%	3,609	(278)	-7.7%
OP Surgeries	386	505	(119)	-23.5%	4,555	4,785	(230)	-4.8%	4,709	(154)	-3.3%
Total Surgeries	693	804	(111)	-13.8%	7,886	8,580	(694)	-8.1%	8,318	(432)	-5.2%
Deliveries	114	132	(18)	-13.6%	1,430	1,365	65	4.7%	1,420	10	0.7%
PSYCH											
Psych Patient Days	2,101	1,973	128	6.5%	21,761	22,231	(470)	-2.1%	21,938	(177)	-0.8%
Psych Discharges	229	217	12	5.5%	2,290	2,443	(153)	-6.3%	2,425	(135)	-5.6%
Average Daily Census	67.8	63.6	4	6.4%	65	66.4	(1.4)	-2.1%	65.3	(0)	-0.5%
Average Length of Stay	9.2	9.1	(0.1)	-1.1%	9.5	9.1	(0.4)	-4.4%	9	(1)	-5.0%
Adjusted Patient Days	2,472	2,373	99	4.2%	25,974	26,409	(435)	-1.6%	26,004	(30)	-0.1%
Adjusted Discharges	269	261	8	3.1%	2,731	2,902	(171)	-5.9%	2,875	(144)	-5.0%
PES Equivalent Days	819	568	251	44.2%	7,648	7,489	159	2.1%	7,366	281	3.8%
REHAB											
Rehab Patient Days	676	731	(55)	-7.5%	7,708	7,898	(190)	-2.4%	7,332	376	5.1%
Rehab Discharges	56	53	3	5.7%	575	568	7	1.2%	536	39	7.3%
Average Daily Census	21.8	23.6	(1.8)	-7.5%	23	23.6	(0.6)	-2.4%	21.8	1	5.4%
Average Length of Stay	12.1	13.9	(1.8)	-13.2%	13.4	13.9	(0.5)	-3.6%	13.7	(0)	-2.0%
Adjusted Patient Days	676	731	(55)	-7.5%	7,708	7,898	(190)	-2.4%	7,332	376	5.1%
Adjusted Discharges	56	53	3	6.5%	575	568	7	1.2%	536	39	7.3%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: May

SNF with Sub-Acute											
SNF Patient Days	8,577	8,546	31	0.4%	92,150	92,349	(199)	-0.2%	91,610	540	0.6%
SNF Discharges	10	26	(16)	-61.5%	195	279	(84)	-30.0%	281	(86)	-30.6%
Average Daily Census	276.7	275.7	1	0.4%	275.1	275.7	(0.6)	-0.2%	272.6	2	0.9%
Average Length of Stay	857.7	331.4	526	158.8%	472.6	331.4	141.2	42.6%	326	147	45.0%
Adjusted Patient Days	8,848	8,836	12	0.1%	94,983	95,446	(463)	-0.5%	94,562	421	0.4%
Adjusted Discharges	10	27	(17)	-63.0%	201	288	(87)	-30.2%	290	(89)	-30.7%
Bed Holds	80	78	2	2.4%	927	1031.56	(105)	-10.1%	945	(18)	-1.9%
CLINICVISITS	34,636	35,756	(1,120)	-3.1%	379,473	360,951	18,522	5.1%	360,280	19,193	5.3%
Clinic Visits	28,644	29,237	(593)	-2.0%	317,213	297,120	20,093	6.8%	296,671	20,542	6.9%
Telehealth Visits	5,992	6,519	(527)	-8.1%	62,260	63,831	(1,571)	-2.5%	63,609	(1,349)	-2.1%
FQHC Visits	29,227	30,585	(1,358)	-4.4%	318,112	307,177	10,935	3.6%	305,138	12,974	4.3%
Clinic Visits	24,204	25,079	(875)	-3.5%	265,817	253,118	12,699	5.0%	251,466	14,351	5.7%
Telehealth Visits	5,023	5,506	(483)	-8.8%	52,295	54,059	(1,764)	-3.3%	53,672	(1,377)	-2.6%
Non-FQHC Visits	5,409	5,171	238	4.6%	61,361	53,774	7,587	14.1%	55,142	6,219	11.3%
Clinic Visits	4,440	4,158	282	6.8%	51,396	44,002	7,394	16.8%	45,205	6,191	13.7%
Telehealth Visits	969	- 1,013	(44)	-4.3%	9,965	9,772	193	2.0%	9,937	28	0.3%
Physician wRVU	135,633	136,477	(844)	-0.6%	1,569,475	1,354,249	215,226	15.9%	1,281,512	287,963	22.5%
PAYOR MIX											
Insurance %	6.3%	7.3%	-1.0%	-14.1%	6.8%	7.3%	-0.5%	-6.9%	6.8%	-0.1%	-0.7%
Medi-Cal %	7.3%	13.0%	-5.7%	-43.8%	8.7%	13.1%	-4.4%	-33.4%	18.0%	-9.3%	-51.5%
Medi-Cal MC %	53.3%	45.9%	7.4%	16.1%	51.8%	45.5%	6.3%	13.8%	42.1%	9.8%	23.2%
Medicare %	22.7%	19.7%	3.0%	15.3%	21.3%	20.0%	1.3%	6.4%	20.6%	0.7%	3.2%
Medicare MC %	6.6%	6.8%	-0.2%	-3.1%	7.1%	6.9%	0.2%	2.5%	6.7%	0.4%	5.3%
Other Govt %	1.5%	4.0%	-2.6%	-63.8%	1.8%	3.8%	-2.1%	-54.4%	2.9%	-1.2%	-40.5%
Self-Pay %	2.5%	3.4%	-0.9%	-27.2%	2.5%	3.3%	-0.8%	-23.3%	2.8%	-0.3%	-10.0%
Total Payor Mix %	100.0%	100.0%	0.0%	0.0%	100.00%	100.00%	0.00%	0.0%	100.0%	0.0%	0.0%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: May

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: HIGHLAND											
Total Adjusted Patient Days	7,819	30,623	249	3.3%	84,571	82,346	2,225	2.7%	82,557	2,014	2.4%
Total Adjusted Discharges	1,260	1,299	-39	-3.0%	28,630	14,125	33	0.2%	14,012	146	1.0%
GENERAL ACUTE											
GA Patient Days	4,420	4,289	131	3.1%	48,225	49,227	-1,002	-2.0%	49,452	-1,227	-2.5%
GA Discharges	712	736	-24	-3.2%	8,073	8,444	-371	-4.4%	8,393	-320	-3.8%
GA OP Factor	1.7733	1.7697	-0.0036	-0.2%	1.7593	1.677	-0.0823	-4.9%	1.6743	-0.085	-5.1%
Average Daily Census	142.6	138.3	4.2	3.1%	144	146.9	-3	-2.0%	147.2	-3.2	-2.2%
Average Length of Stay	6.2	5.8	0.4	6.5%	6	5.8	0.1	2.5%	5.9	0.1	1.4%
Adjusted Patient Days	7,838	7,590	248	3.3%	84,843	82,555	2,288	2.8%	82,797	2,045	2.5%
Adjusted Discharges	1,263	1,302	-39	-3.0%	14,203	14,161	42	0.3%	14,052	151	1.1%
Occupancy %	84%	82%	3%	3.1%	85%	87%	-2%	-2.0%	87%	-2%	-2.2%
TOTAL FTE, HOURS, WRVU											
Paid FTE	1,761	1,650	-111	-6.7%	1,774	1,689	-85	-5.0%	1,710	-64	-3.7%
Productive FTE	1,574	1,443	-131	-9.0%	1,528	1,445	-83	-5.7%	1,486	-41	-2.8%
Paid FTE Per AOB	6.97	6.74	-0.22	-3.3%	7	6.85	-0.15	-2.2%	6.94	-0.06	-0.9%
Worked Hours per APD	35.6	33.7	-1.9	-5.6%	34.5	33.5	-1	-2.9%	34.5	0	0.0%
Worked Hours per AD	221	196	-24	-12.4%	206	195	-11	-5.4%	203	-3	-1.4%
OTHER STATS											
Emergency Visits	4,912	4,783	129	2.7%	50,297	48,341	1,956	4.0%	48,110	2,187	4.5%
Left Without Being Seen (LWBS)	289	576	287	99.4%	4,787	5,824	-1,037	21.7%	5,466	679	14.2%
Trauma Cases	353	296	57	19.4%	3,383	3,189	194	6.1%	3,103	280	9.0%
IP Surgeries	249	223	26	11.5%	2,637	2,740	-103	-3.8%	2,676	-39	-1.5%
OP Surgeries	212	257	-45	-17.4%	2,210	2,621	-411	-15.7%	1,879	331	17.6%
Total Surgeries	461	480	-19	-3.9%	4,847	5,362	-515	-9.6%	4,555	292	6.4%
Deliveries	114	132	-18	-13.5%	1,430	1,365	65	4.7%	1,420	10	0.7%
CLINIC / TELEHEALTH VISITS											
Specialty	753	432	321	74.3%	7,071	4,358	2,713	62.3%	4,585	2,486	54.2%
Behavioral Health	590	821	-231	-28.1%	7,701	8,964	-1,263	-14.1%	9,322	-1,621	-17.4%
Clinic Visits	1,343	1,253	90	7.2%	14,772	13,322	1,450	10.9%	13,907	865	6.2%
Telehealth Specialty	793	847	-54	-6.4%	8,117	8,093	24	0.3%	8,287	-170	-2.1%
Telehealth Behavioral Health	99	106	-7	-6.6%	1,038	1,051	-13	-1.2%	1,099	-61	-5.6%
Telehealth Visits	892	953	-61	-6.4%	9,155	9,144	11	0.1%	9,386	-231	-2.5%
TOTAL CLINIC VISITS	2,235	2,206	29	1.3%	23,927	22,466	1,461	6.5%	23,293	634	2.7%
PAYOR MIX											
Insurance %	6.98%	8.31%	-1.33%	-16.0%	7.60%	8.35%	-0.75%	-9.0%	7.64%	-0.04%	-0.5%
Medi-Cal %	7.11%	13.86%	-6.75%	-48.7%	9.19%	14.00%	-4.81%	-34.3%	21.79%	-12.60%	-57.8%
Medi-Cal MC %	53.35%	45.05%	8.29%	18.4%	51.19%	44.53%	6.66%	15.0%	38.22%	12.97%	33.9%
Medicare %	22.49%	18.02%	4.46%	24.8%	19.99%	18.27%	1.72%	9.4%	19.09%	0.90%	4.7%
Medicare MC %	5.85%	7.13%	-1.28%	-18.0%	7.22%	7.30%	-0.08%	-1.1%	7.08%	0.14%	2.0%
Other Govt %	1.61%	4.47%	-2.86%	-64.0%	2.07%	4.27%	-2.20%	-51.6%	3.30%	-1.23%	-37.3%
Self-Pay %	2.63%	3.16%	-0.54%	-17.0%	2.74%	3.27%	-0.53%	-16.3%	2.89%	-0.15%	-5.2%
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%
CAMPUS CMI MTD & YTD											
CMI Highland MTD	1.733	1.723	0.01	0.6%	1.723	1.68	0.044	2.6%	1.652	0.072	4.3%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: May

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: ALAMEDA											
Total Adjusted Patient Days	9,307	30,623	214	2.3%	100,712	94,984	5,728	6.0%	98,465	2,248	2.3%
Total Adjusted Discharges	338	384	-46	-12.0%	28,630	4,076	-205	-5.0%	4,138	-267	-6.4%
GENERAL ACUTE											
GA Patient Days	959	1,142	-183	-16.0%	11,310	12,587	-1,277	-10.1%	12,353	-1,043	-8.4%
GA Discharges	219	260	-41	-15.6%	2,492	2,861	-369	-12.9%	2,740	-248	-9.1%
GA OP Factor	1.8381	1.6823	-0.1559	-9.3%	1.8007	1.5824	-0.2182	-13.8%	1.6909	-0.1098	-6.5%
Average Daily Census	30.9	36.8	-5.9	-16.0%	33.8	37.6	-3.8	-10.1%	36.8	-3	-8.2%
Average Length of Stay	4.4	4.4	0	-0.5%	4.5	4.4	0.1	3.1%	4.5	0	0.7%
Adjusted Patient Days	1,763	1,921	-158	-8.2%	20,365	19,918	448	2.2%	20,887	-522	-2.5%
Adjusted Discharges	403	437	-34	-7.8%	4,487	4,527	-40	-0.9%	4,633	-146	-3.1%
Occupancy %	47%	56%	-9%	-16.0%	51%	57%	-6%	-10.1%	56%	-5%	-8.2%
Paid FTE	410	398	-12	-3.0%	413	404	-9	-2.3%	410	-3	-0.8%
Productive FTE	363	348	-15	-4.3%	359	348	-11	-3.1%	357	-1	-0.4%
Paid FTE Per AOB	7.21	6.42	-0.79	-12.2%	6.79	6.79	0	0.0%	6.59	-0.2	-3.1%
Worked Hours per APD	36.5	32.1	-4.4	-13.6%	33.7	33.4	-0.3	-0.9%	32.9	-0.9	-2.7%
Worked Hours per AD	160	141	-19	-13.1%	153	147	-6	-4.1%	148	-5	-3.3%
Emergency Visits	1,695	1,695	0	0.0%	18,330	17,560	770	4.4%	17,383	947	5.4%
Left Without Being Seen (LWBS)	56	46	-10	-17.9%	595	476	-119	-20.0%	471	-124	-20.8%
IP Surgeries	15	18	-3	-15.1%	159	245	-86	-35.2%	250	-91	-36.4%
OP Surgeries	6	0	6	0.0%	456	0	456	0.0%	1,547	-1,091	-70.5%
Total Surgeries	21	18	3	18.9%	615	245	370	150.7%	1,797	-1,182	-65.8%
SNF with Sub-Acute											
SNF Patient Days	5,261	5,290	-29	-0.6%	56,465	57,171	-706	-1.2%	56,038	427	0.8%
SNF Discharges	7	12	-5	-42.9%	113	133	-20	-14.7%	134	-21	-15.7%
SNF OP Factor	1.0051	1.0059	0.0008	0.1%	1.005	1.0041	-0.0009	-0.1%	1.0046	-0.0004	0.0%
Average Daily Census	169.7	170.7	-1	-0.6%	168.6	170.7	-2.1	-1.2%	166.8	1.8	1.1%
Average Length of Stay	751.6	431.5	320	74.2%	499.7	431.5	68.2	15.8%	418.2	81.5	19.5%
Adjusted Patient Days	5,288	5,322	-34	-0.6%	56,746	57,406	-660	-1.1%	56,294	452	0.8%
Adjusted Discharges	7	12	-5	-42.9%	114	133	-19	-14.6%	135	-21	-15.6%
Occupancy %	94%	94%	0%	0.0%	93%	94%	0%	0.0%	92%	0%	0.0%
Bed Holds	43	51	-8	-15.3%	529	549	-20	-3.6%	531	-2	-0.4%
Paid FTE	257	209	-49	-23.4%	217	212	-6	-2.6%	185	-33	-17.6%
Productive FTE	238	182	-55	-30.4%	193	182	-11	-5.9%	161	-32	-19.9%
Paid FTE per AOB	1.51	1.22	-0.29	-24.2%	1.28	1.24	-0.05	-3.8%	1.1	-0.18	-16.4%
Worked Hours per APD	8	6.1	-1.9	-31.2%	6.5	6.1	-0.4	-7.1%	5.5	-1	-18.6%
Worked Hours per AD	5985	2618	-3367	-128.6%	3255	2624	-631	-24.0%	2297	-958	-41.7%

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TOTAL FTE, HOURS, WRVU METRICS												
Total Paid FTE	668	591	-77	-13.0%	630	604	-27	-4.4%	594	-36	-6.0%	
Total Productive FTE	601	514	-86	-16.8%	552	519	-33	-6.4%	519	-33	-6.4%	
Total Paid FTE per AOB	2.22	2.01	-0.21	-10.4%	2.1	2.13	0.03	1.5%	2.03	-0.07	-3.4%	
Worked Hours Per APD	11.4	10	-1.4	-14.1%	10.5	10.5	0	-0.4%	10.1	-0.4	-3.8%	
Worked Hours Per AD	315	237	-78	-32.7%	273	244	-29	-12.1%	241	-32	-13.4%	
CLINIC / TELEHEALTH VISITS												
Specialty	1,334	1,175	159	13.5%	14,374	11,746	2,628	22.4%	11,955	2,419	20.2%	
Clinic Visits	1,334	1,175	159	13.5%	14,374	11,746	2,628	22.4%	11,955	2,419	20.2%	
Telehealth Specialty	16	17	-1	-5.9%	177	157	20	12.7%	165	12	7.3%	
Telehealth Visits	16	17	-1	-5.9%	177	157	20	12.7%	165	12	7.3%	
TOTAL CLINIC VISITS	1,350	1,192	158	13.3%	14,551	11,903	2,648	22.2%	12,120	2,431	20.1%	
PAYOR MIX												
Insurance %	8.49%	7.72%	0.77%	10.0%	7.45%	7.55%	-0.11%	-1.4%	7.01%	0.43%	6.2%	
Medi-Cal %	6.28%	16.20%	-9.92%	-61.2%	5.72%	15.95%	-10.24%	-64.2%	14.98%	-9.26%	-61.8%	
Medi-Cal MC %	50.86%	40.55%	10.31%	25.4%	50.40%	40.28%	10.11%	25.1%	41.57%	8.83%	21.2%	
Medicare %	22.39%	24.26%	-1.88%	-7.7%	24.43%	24.95%	-0.52%	-2.1%	25.18%	-0.75%	-3.0%	
Medicare MC %	9.19%	7.76%	1.43%	18.4%	9.31%	7.88%	1.43%	18.1%	8.24%	1.07%	13.0%	
Other Govt %	1.52%	1.42%	0.10%	6.8%	1.33%	1.37%	-0.04%	-2.9%	1.60%	-0.28%	-17.4%	
Self-Pay %	1.27%	2.09%	-0.81%	-38.9%	1.37%	2.01%	-0.64%	-31.9%	1.41%	-0.04%	-3.0%	
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%	
CAMPUS CMI MTD & YTD												
CMI Alameda MTD	1.405	1.431	-0.026	-1.8%	1.461	1.43	0.031	2.1%	1.401	0.06	4.3%	

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: May

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: SAN LEANDRO											
Total Adjusted Patient Days	3,589	30,623	138	4.0%	37,962	36,100	1,863	5.2%	34,090	3,872	11.4%
Total Adjusted Discharges	633	713	-80	-11.3%	28,630	7,549	-780	-10.3%	6,854	-84	-1.2%
GENERAL ACUTE											
GA Patient Days	1,008	1,126	-118	-10.5%	11,381	12,748	-1,367	-10.7%	11,614	-233	-2.0%
GA Discharges	241	331	-90	-27.2%	2,829	3,749	-920	-24.5%	3,273	-444	-13.6%
GA OP Factor	2.4567	2.0968	-0.3599	-17.2%	2.2737	1.9471	-0.3266	-16.8%	2.0137	-0.26	-12.9%
Average Daily Census	32.5	36.3	-3.8	-10.5%	34	38.1	-4.1	-10.7%	34.6	-0.6	-1.7%
Average Length of Stay	4.2	3.4	0.8	23.0%	4	3.4	0.6	18.3%	3.5	0.5	13.4%
Adjusted Patient Days	2,476	2,361	116	4.9%	25,877	24,822	1,055	4.2%	23,387	2,490	10.6%
Adjusted Discharges	592	694	-102	-14.7%	6,432	7,301	-868	-11.9%	6,591	-158	-2.4%
Occupancy %	52%	58%	-6%	-10.5%	54%	60%	-6%	-10.7%	55%	-1%	-1.7%
Paid FTE	414	404	-9	-2.3%	408	397	-10	-2.6%	390	-17	-4.4%
Productive FTE	361	346	-16	-4.5%	350	334	-17	-5.0%	338	-12	-3.5%
Paid FTE Per AOB	5.18	5.31	0.13	2.5%	5.28	5.36	0.08	1.5%	5.61	0.33	6.0%
Worked Hours per APD	25.9	25.9	0.1	0.3%	25.9	25.7	-0.2	-0.8%	27.8	1.9	6.7%
Worked Hours per AD	108	88	-20	-22.6%	104	87	-17	-19.2%	99	-6	-5.8%
Emergency Visits	2,939	3,092	-153	-5.0%	32,028	30,364	1,664	5.5%	30,481	1,547	5.1%
Left Without Being Seen (LWBS)	119	113	-6	-5.3%	1,222	1,107	-115	-9.4%	1,104	-118	-9.7%
IP Surgeries	43	58	-15	-26.0%	535	810	-275	-33.9%	683	-148	-21.7%
OP Surgeries	168	248	-80	-32.2%	1,889	2,164	-275	-12.7%	1,283	606	47.2%
Total Surgeries	211	306	-95	-31.0%	2,424	2,973	-549	-18.5%	1,966	458	23.3%
REHAB											
Rehab Patient Days	676	731	-55	-7.5%	7,708	7,898	-190	-2.4%	7,332	376	5.1%
Rehab Discharges	56	53	3	6.5%	575	568	7	1.2%	536	39	7.3%
Rehab OP Factor	1	1	0	0.0%	1	1	0	0.0%	1	0	0.0%
Average Daily Census	21.8	23.6	-1.8	-7.5%	23	23.6	-0.6	-2.4%	21.8	1.2	5.4%
Average Length of Stay	12.1	13.9	-1.8	-13.2%	13.4	13.9	-0.5	-3.6%	13.7	-0.3	-2.0%
Adjusted Patient Days	676	731	-55	-7.5%	7,708	7,898	-190	-2.4%	7,332	376	5.1%
Adjusted Discharges	56	53	3	6.5%	575	568	7	1.2%	536	39	7.3%
Occupancy %	78%	84%	0%	0.0%	82%	84%	0%	0.0%	78%	0%	0.0%
Bed Holds	-1	1	-2	-173.6%	-1	15	-16	-106.8%	7	-8	-114.3%
Paid FTE	67	73	6	8.3%	70	72	2	2.1%	68	-2	-2.9%
Productive FTE	59	64	5	8.1%	60	61	1	1.4%	57	-3	-5.4%
Paid FTE per AOB	3.09	3.11	0.03	0.8%	3.06	3.05	-0.01	-0.3%	3.13	0.08	2.4%
Worked Hours per APD	15.5	15.6	0.1	0.6%	15	14.9	-0.1	-1.0%	15	0	0.1%
Worked Hours per AD	187	216	30	13.7%	201	207	5	2.6%	206	4	2.1%
TOTAL FTE, HOURS, WRVU METRICS											
Total Paid FTE	482	464	-18	-3.9%	479	459	-20	-4.3%	460	-19	-4.1%
Total Productive FTE	421	396	-25	-6.4%	412	385	-27	-7.0%	397	-15	-3.8%
Total Paid FTE per AOB	4.16	4.17	0	0.1%	4.23	4.26	0.03	0.8%	4.53	0.31	6.8%
Worked Hours Per APD	20.8	20.3	-0.5	-2.3%	20.8	20.4	-0.4	-1.7%	22.3	1.6	7.1%
Worked Hours Per AD	118	98	-20	-19.9%	116	98	-19	-19.3%	111	-5	-4.8%
PAYOR MIX											
Insurance %	4.50%	6.32%	-1.83%	-28.9%	5.83%	6.25%	-0.42%	-6.7%	6.47%	-0.64%	-9.9%
Medi-Cal %	7.05%	9.79%	-2.74%	-28.0%	7.65%	9.83%	-2.18%	-22.1%	15.89%	-8.24%	-51.8%
Medi-Cal MC %	46.46%	44.36%	2.09%	4.7%	48.49%	43.96%	4.53%	10.3%	38.54%	9.94%	25.8%
Medicare %	27.39%	22.93%	4.46%	19.5%	25.27%	23.35%	1.92%	8.2%	24.60%	0.67%	2.7%
Medicare MC %	10.50%	9.00%	1.49%	16.6%	8.70%	9.14%	-0.44%	-4.8%	8.78%	-0.07%	-0.8%
Other Govt %	0.84%	4.06%	-3.22%	-79.2%	1.27%	3.90%	-2.63%	-67.4%	2.65%	-1.38%	-52.0%
Self-Pay %	3.27%	3.53%	-0.26%	-7.5%	2.78%	3.57%	-0.78%	-22.0%	3.06%	-0.28%	-9.2%
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%
CAMPUS CMI MTD & YTD											
CMI San Leandro MTD	1.369	1.436	-0.067	-4.6%	1.489	1.453	0.036	2.5%	1.433	0.056	3.9%

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: JOHN GEORGE											
Total Adjusted Patient Days	2,472	2,372	100	4.2%	25,974	26,409	-435	-1.6%	26,004	-30	-0.1%
Total Adjusted Discharges	269	261	8	3.1%	2,731	2,902	-171	-5.9%	2,875	27	0.9%
PSYCH											
Psych Patient Days	2,101	1,973	128	6.5%	21,761	22,231	-470	-2.1%	21,938	-177	-0.8%
Psych Discharges	229	217	12	5.6%	2,290	2,443	-153	-6.3%	2,425	-135	-5.6%
Average Daily Census	67.8	63.6	4.1	6.5%	65	66.4	-1.4	-2.1%	65.3	-0.3	-0.5%
Average Length of Stay	9.2	9.1	-0.1	-0.8%	9.5	9.1	-0.4	-4.4%	9	-0.5	-5.0%
PES Equivalent Days	819	568	251	44.2%	7,648	7,489	159	2.1%	7,366	281	3.8%
PES Visits	806	825	-19	-2.3%	8,611	8,345	266	3.2%	8,722	-111	-1.3%
PES Hours	19,657	16,947	2,710	16.0%	183,540	175,421	8,119	4.6%	176,786	6,754	3.8%
PES Hours per Visit	24	21	-4	-18.7%	21	21	0	-1.4%	20	-1	-5.2%
TOTAL FTE, HOURS, WRVU METRICS											
Total Paid FTE	387	356	-31	-8.8%	387	374	-13	-3.4%	378	-8	-2.2%
Total Productive FTE	345	306	-39	-12.6%	335	316	19	-5.8%	327	-7	-2.2%
Total Paid FTE per AOB	4.13	4.1	-0.03	-0.7%	3.95	4.38	0.43	9.9%	4.33	0.39	8.9%
Worked Hours Per APD	21	20.1	-0.9	-4.3%	19.5	21.2	1.7	7.8%	21.4	1.9	8.9%
Worked Hours Per AD	192	183	-9	-5.1%	185	193	7	3.7%	194	8	4.3%
Physician wRVU	8,689	11,869	-3,179	-26.8%	192,965	124,931	68,034	54.5%	93,602	99,362	106.2%
PAYOR MIX											
Insurance %	1.96%	5.65%	-3.69%	-65.2%	5.13%	5.73%	-0.60%	-10.4%	5.39%	-0.26%	-4.8%
Medi-Cal %	12.24%	12.45%	-0.21%	-1.7%	13.26%	12.74%	0.51%	4.0%	16.27%	-3.02%	-18.5%
Medi-Cal MC %	54.48%	47.98%	6.50%	13.5%	51.09%	48.80%	2.28%	4.7%	48.60%	2.49%	5.1%
Medicare %	24.19%	20.34%	3.85%	18.9%	22.49%	20.92%	1.57%	7.5%	20.79%	1.70%	8.2%
Medicare MC %	3.80%	2.59%	1.21%	46.6%	3.30%	2.64%	0.66%	25.1%	2.23%	1.06%	47.7%
Other Govt %	1.55%	2.36%	-0.81%	-34.5%	1.63%	2.37%	-0.74%	-31.1%	1.71%	-0.08%	-4.4%
Self-Pay %	1.77%	8.62%	-6.85%	-79.4%	3.10%	6.79%	-3.69%	-54.3%	5.00%	-1.90%	-38.0%
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%
CAMPUS CMI MTD & YTD											
CMI Behavioral Health MTD	1.348	1.243	0.105	8.5%	1.354	1.212	0.142	11.7%	1.282	0.072	5.6%

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: FAIRMONT											
Total Adjusted Patient Days	4,320	30,623	26	0.6%	47,810	46,586	1,225	2.6%	45,589	2,221	4.9%
Total Adjusted Discharges	4	18	-14	-78.1%	28630	194	-84	-43.3%	188	-79	-41.7%
SNF with Sub-Acute											
SNF Patient Days	3,316	3,255	61	1.9%	35,685	35,178	507	1.4%	35,572	113	0.3%
SNF Discharges	3	14	-11	-77.8%	82	146	-64	-43.9%	147	-65	-44.2%
Average Daily Census	107	105	2	1.9%	106.5	105	1.5	1.4%	105.9	0.7	0.6%
Average Length of Stay	1,105.30	240.6	864.7	359.4%	435.2	240.6	194.6	80.9%	242	193.2	79.8%
Occupancy %	98%	96%	0%	0.0%	98%	96%	0%	0.0%	97%	0%	0.0%
Bed Holds	38	26	12	46.2%	399	468	-69	-14.7%	407	-8	-2.0%
TOTAL FTE, HOURS, WRVU METRICS											
Total Paid FTE	284	281	-4	-1.3%	295	287	-8	-2.7%	290	-5	-1.7%
Total Productive FTE	249	248	-1	-0.2%	255	249	-6	-2.6%	250	-6	-2.2%
Total Paid FTE per AOB	2.04	2.03	-0.01	-0.7%	2.06	2.06	0	-0.1%	2.14	0.07	3.3%
Worked Hours Per APD	10.2	10.2	0	0.4%	10.2	10.2	0	0.1%	10.5	0.3	2.8%
Worked Hours Per AD	11281	2465	-8816	-357.7%	4448	2461	-1987	-80.7%	2545	-1904	-74.8%
CLINIC / TELEHEALTH VISITS											
Behavioral Health	1,749	1,720	29	1.7%	22,117	18,848	3,269	17.3%	19,251	2,866	14.9%
Rehab	14	10	4	40.0%	133	86	47	54.7%	92	41	44.6%
Clinic Visits	1,763	1,730	33	1.9%	22,250	18,934	3,316	17.5%	19,343	2,907	15.0%
Telehealth Behavioral Health	61	43	18	41.9%	633	471	162	34.4%	386	247	64.0%
Telehealth Visits	61	43	18	41.9%	633	471	162	34.4%	386	247	64.0%
TOTAL CLINIC VISITS	1,824	1,773	51	2.9%	22,883	19,405	3,478	17.9%	19,729	3,154	16.0%
PAYOR MIX											
Insurance %	2.56%	0.86%	1.70%	196.5%	1.18%	0.88%	0.30%	34.5%	0.65%	0.53%	80.5%
Medi-Cal %	4.04%	7.51%	-3.47%	-46.2%	6.42%	7.41%	-0.99%	-13.4%	8.58%	-2.16%	-25.2%
Medi-Cal MC %	76.04%	70.46%	5.58%	7.9%	71.31%	70.33%	0.98%	1.4%	71.01%	0.29%	0.4%
Medicare %	14.06%	17.53%	-3.47%	-19.8%	18.15%	17.66%	0.49%	2.8%	16.16%	1.99%	12.3%
Medicare MC %	2.10%	2.30%	-0.19%	-8.4%	2.43%	2.32%	0.11%	4.6%	2.10%	0.32%	15.3%
Other Govt %	0.22%	1.19%	-0.97%	-81.3%	0.22%	1.23%	-1.00%	-81.7%	0.88%	-0.66%	-74.5%
Self-Pay %	0.98%	0.16%	0.82%	515.0%	0.29%	0.17%	0.12%	69.7%	0.60%	-0.31%	-52.0%
Total Payor Mix %	100.00%	100.00%	0.00%	0.0%	100.00%	100.00%	0.00%	0.0%	100.00%	0.00%	0.0%

G2. Public Affairs and Community Engagement Report

ALAMEDA HEALTH SYSTEM

TO: Board of Trustees

FROM: Alice Kinner, Vice President, Public Affairs & Community Engagement

DATE: June 27, 2025

SUBJECT: Public Affairs and Community Engagement Report

Public Affairs and Community Engagement (PACE) provides collaborative and integrated strategic communications and meaningful engagement with stakeholders that supports, promotes, and amplifies AHS's mission and vision while reinforcing its brand identity. PACE has four main functional areas: Government and Legislative Affairs, Community Engagement, Communications, and Media. This report provides an overview of key activities.

Government and Legislative Affairs

The primary responsibility of Government and Legislative Affairs is to develop and maintain relationships with elected officials at local, state, and federal levels, to track and analyze legislation's impact on AHS, and facilitate the participation of AHS's interested parties in legislative and policy development.

The California State Legislature will begin its summer recess on July 18 and is scheduled to reconvene on August 18. Appendix A includes a list of state bills AHS is currently tracking. Governor Newsom and the Legislature have reached an agreement on the FY 2025-26 state budget. While this budget allows the state to meet its immediate obligations, it is generally considered a placeholder. Additional budget adjustments are anticipated later this year, depending on changes at the federal level.

At the federal level, Congress is actively negotiating the Budget Reconciliation Bill. The Senate released its version on June 16, proposing an additional $200 billion in Medicaid spending reductions on top of the nearly $800 billion included in the House-approved bill from May. The situation remains fluid. Senate leaders have indicated they aim to hold a floor vote soon and meet their self-imposed July 4 deadline.

Community Engagement

The community engagement team supports and participates in activities throughout the year that align with organizational priorities and strategies. Engagement efforts help develop and maintain relationships with key community-based organizations, local business groups, and elected officials, in addition to enhancing the health and well-being of the communities we serve. Outreach and engagement initiatives support AHS’s mission and strategic goals.

Below is a recap of activities for June 2025 and a preview of activities for July 2025.

*Contact Louise Nakada, LNakada@alamedahealthsystem.org for more information.

Date	Location	Event	Description
May 30, 2025 11:00 a.m. – 5:00 p.m.	Alameda Hospital, Conference Room A, Alameda	American Red Cross Community Blood Drive	In partnership with the American Red Cross, AHS/Alameda Hospital will host a community blood drive to help save lives and alleviate the blood supply shortage.
June 7, 2025 11:00 a.m. – 6:00 p.m.	Downtown San Leandro, San Leandro	San Leandro Cherry Festival	AHS / San Leandro Hospital participated in this annual community event that featured community resources, entertainment, food, and local vendors. Health screenings, wellness tips, and information about AHS programs and services were provided.
June 11, 2025 11:00 a.m. – 1:00 p.m.	Palo Vista Gardens, Oakland	Oakland Housing Authority Palo Vista Health Fair	AHS participated in this community event hosted by the Oakland Housing Authority. Information about AHS programs and services was provided.
June 18, 2025 12:00 p.m. – 1:30 p.m.	Berkeley Hope Center, Berkeley	Summer Solstice Celebration of Strength and Resilience of People Experiencing Homelessness	The AHS Co-applicant Board and the AHS Foundation, along with partners across Alameda County, honored Resilience and Determination Heroes at this annual event celebrating those who experience homelessness.
June 21, 2025 1:00 p.m. – 4:00 p.m.	Dunsmuir Hellman Historic Estate, Oakland	Mental Health Association of Alameda County's Rock the Estate	AHS sponsored this event that benefits individuals experiencing serious mental health conditions and their family members. John George Psychiatric Hospital leaders were in attendance.
June 24, 2025 10:00 a.m. – 1:00 p.m.	San Leandro Senior Center, San Leandro	San Leandro Senior Fair	AHS participated in this annual senior resource fair that focused on senior services, housing, health and wellness, and financial planning. Health education, and AHS service information was provided.
June 26, 2025 5:00 p.m. – 8:00 p.m.	Almanac Brewing Co., Alameda	Alameda Chamber Innovation Island Excellence Awards	AHS / AH leaders attended this community awards event that celebrated Alameda businesses and organizations.
June 28, 2025 8:30 a.m.	Lake Merritt, Oakland	Let's Walk with CEO James Jackson	AHS family and friends joined CEO James Jackson for a three-mile walk around Lake Merritt. This event offered an opportunity to connect with colleagues.

June 28, 2025 4:00 p.m. – 9:30 p.m.	St. Rose Hospital Parking Lot, Hayward	Hayward Night Market	AHS / St. Rose Hospital participated in this annual festival held in the St. Rose Hospital parking lot. Hosted by Organize Hayward, thousands of community members attended this celebration that featured entertainment, food, local vendors, and community resources.
July 3 – 6, 2025	Fremont High School, Oakland	Eritrean Sports Tournament	The AHS Health Outcomes and Outreach Team will provide information about AHS' cancer screening and prevention initiative – Screening For Life.
July 4, 2025 10:00 a.m.	City of Alameda	Alameda 4th of July Parade	AHS / AH employees and their families are invited to participate in this annual community celebration. The parade contingent will include a cable car, walkers, and District Board members in partnership with the City of Alameda Health Care District.
July 19, 2025 9:00 a.m. – 10:00 a.m.	Alameda Hospital, Leonardville, Alameda	Alameda Recreation and Parks: Alameda Walks	AHS / AH will host this walk, led by the City of Alameda Recreation and Parks Department. The walk begins with an overview of Alameda Hospital and Alameda Health System and will explore the local neighborhood and famous architects of the city.
July 19, 2025 10:00 a.m. – 2:00 p.m.	Oakland Arena and Coliseum, Oakland	Alameda County Safe Kids Day Health and Wellness Fair	AHS is sponsoring the helmet decorating station at this community event that focuses on safety, health, and community resources. Health and wellness tips and information about AHS programs and services will be provided.
July 23, 2025	San Leandro Hospital, Education Room	San Leandro Hospital Community Blood Drive	In partnership with the American Red Cross, AHS/San Leandro Hospital will host a community blood drive to help save lives and alleviate the blood supply shortage.
July 24, 2025 5:30 p.m.	San Leandro Marina, San Leandro	Let's Walk with CEO James Jackson at the San Leandro Marina	AHS family and friends are invited to join CEO James Jackson for a two-mile walk at the San Leandro Marina.
July 26, 2025 9:00 a.m. – 11:00 a.m.	Wilma Chan Highland Hospital Campus, Oakland	Wilma Chan Highland Hospital Campus (WCHHC) Neighborhood Clean-up	In partnership with the City of Oakland's Adopt-a-spot program, AHS staff will volunteer to pick up trash surrounding the WCHHC to help support the neighborhood residents.

COMMUNICATIONS

The PACE Communications Team develops and implements communication strategies and plans for key organizational initiatives. Updates are provided as of June 25, 2025.

Unique Stories

In June 2025, PACE wrote 27 unique stories to spotlight AHS programs and departments. These stories were shared via the AHS intranet, the internet, CEO Chronicles and social media.

CEO Chronicles Newsletter

The CEO Chronicles is a monthly newsletter sent to nearly 6,000 Alameda Health System (AHS) employees, 612 St. Rose Hospital staff, and 645 community stakeholders, including elected officials, community partners, and local businesses. PACE drives the strategy, planning and content development for each newsletter.

When compared to industry standards, as published by Constant Contact Email Content Management System (CMS), the AHS newsletter typically performs at or above industry benchmarks.

The CEO Chronicles is sent to three separate distribution lists, internally and externally.

The June 2025 newsletter's open rate was 48% for AHS staff distribution, 43% for St. Rose Hospital distribution, and the open rate for external distribution was 54%. The benchmark for open rate (i.e., the percentage of newsletter emails that are opened) is 27%.

The June 2025 CEO Chronicles CEO video featured St. Rose Hospital and the upcoming subacute unit. The Real People, Real Care Spotlight video featured Allison Vonk, a respiratory therapist at San Leandro Hospital.

The newsletter included two patient stories. One featured Jacqueline, a cancer survivor who received care at Highland and Loretta Madellin, who averted leg amputation due to the care she received at our Creedon Advanced Wound Care. In addition, we had a Father's Day slideshow tribute, news coverage about our $77 million award for Behavioral Health care services, a calendar of events and our AHS Index that focused on the transgender health equity crisis.

The CEO Chronicles video was the most viewed and the cancer patient story was the second most viewed for both the AHS staff and St. Rose distributions. For external distribution, the Creedon Advanced Wound Care patient story and the lung cancer patient story were the top two.

Leadership Desktop Chat

PACE supports employee and physician engagement by producing Leadership Desktop Chats every Wednesday. This includes coordinating and preparing talking points, determining the run of show, booking guest speakers and special presentations, coordinating follow-up to employee questions, tracking and posting frequently asked questions, and posting Chat videos and FAQs on the intranet for those who were unable to attend.

The webinar is hosted by the Vice President of PACE. Regular panelists include our Chief Executive Officer, Chief Operating Officer, Interim Chief Human Resources Officer, Interim Chief Medical Officer, Chief Nursing Officer, Vice President of Support Services and the Interim Chief Information Officer. Finance attends monthly to provide updates.

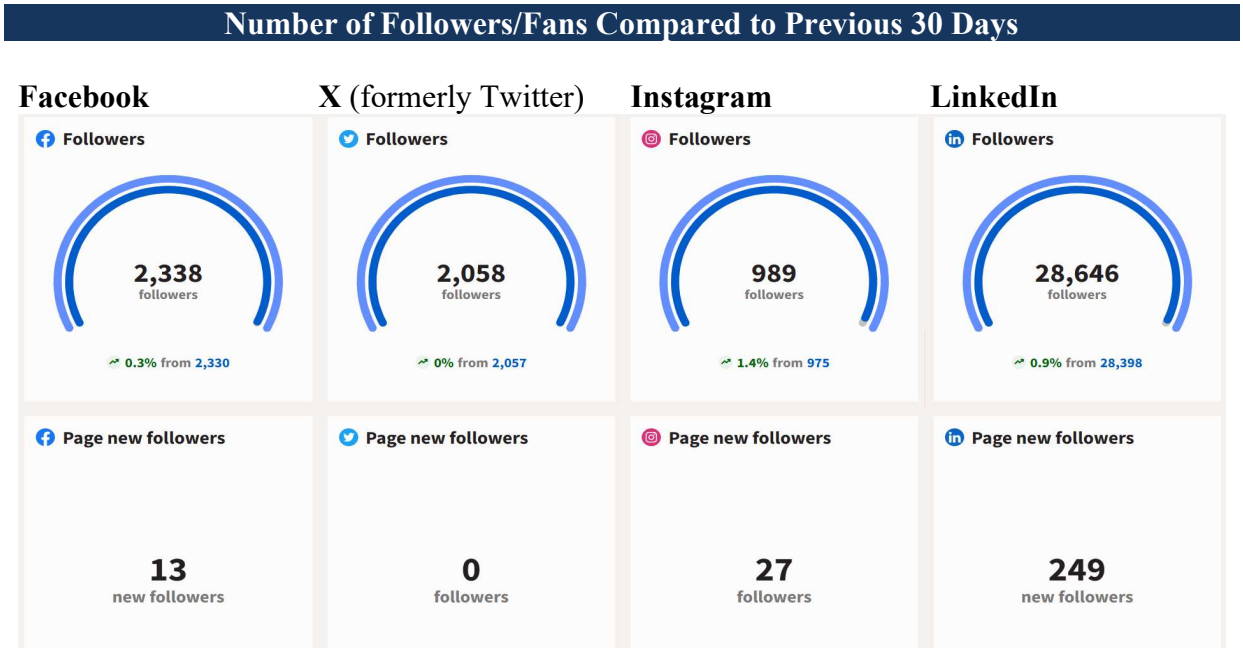
Attendees hear a report from the CEO and have an opportunity to ask questions of leadership. Guest panelists are invited to provide information about key AHS initiatives.

In June 2025, staff received presentations on the preferred patient name and pronouns project, supply chain refresh, the new learning management system, and the new benefits platform. The June 18 Chat was cancelled due to the holiday.

For June 2025, the Chat averaged 499 total participants every Wednesday. Total participants include all panelists and attendees.

Social Media Report

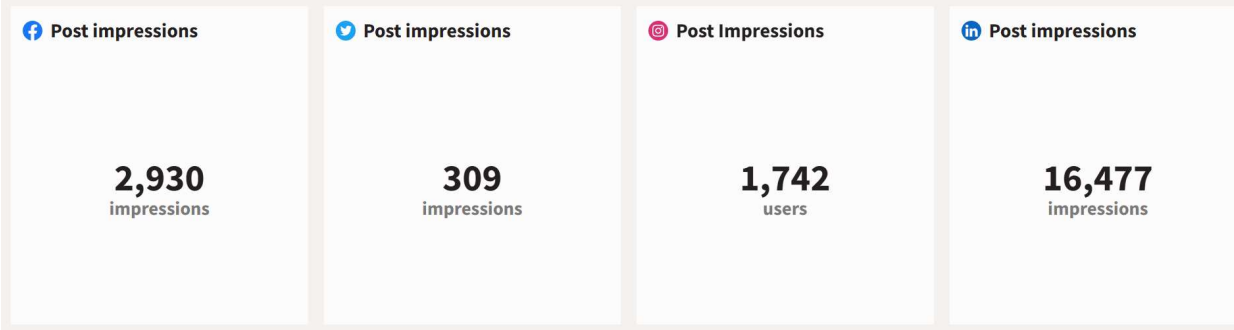
Date Range of Report: June 1 to June 25, 2025



Engagement Report Last 30 Days

Post engagement is the number of interactions (reactions, comments, shares and more) our posts received. Post impressions is the number of times content we published during the time frame was displayed on a person's screen. Content includes statuses, photos, links, videos and more.

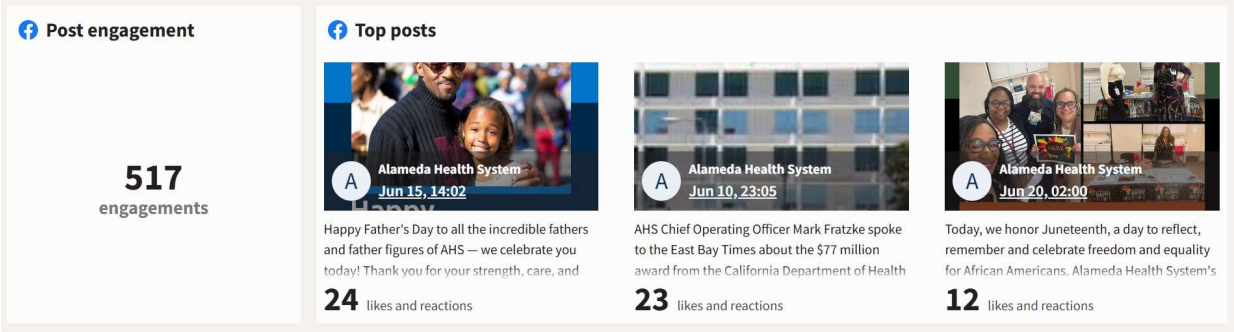
Facebook **X** (formerly Twitter) **Instagram** **LinkedIn**



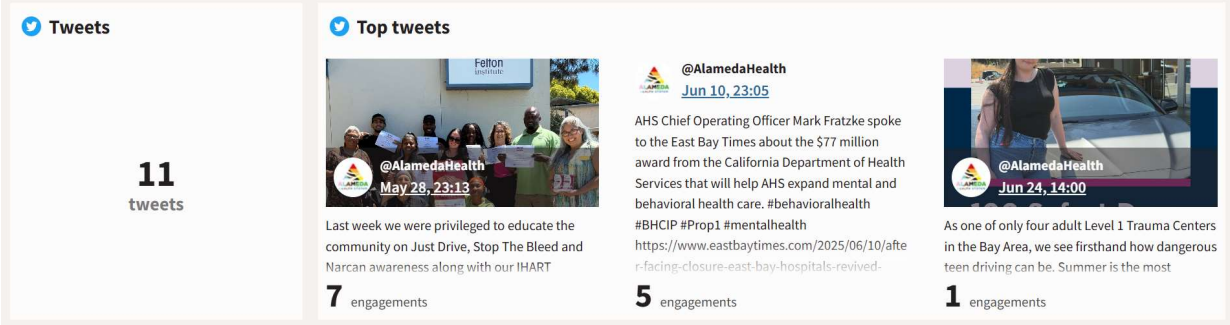
Social media engagement is the measure of interactions - comments, likes, shares, posts, etc. that our audience has with the content AHS posts.

Top 3 Social Media Posts Based on Engagement On All Social Media Platforms June 1 to June 25, 2025

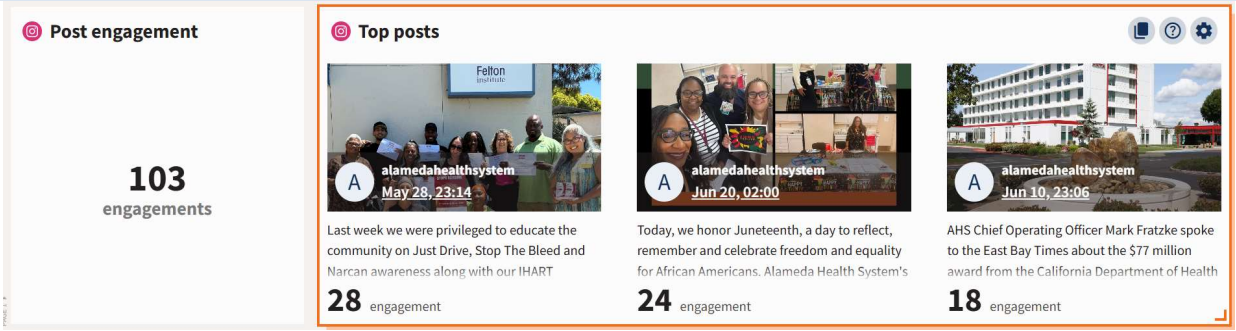
Facebook



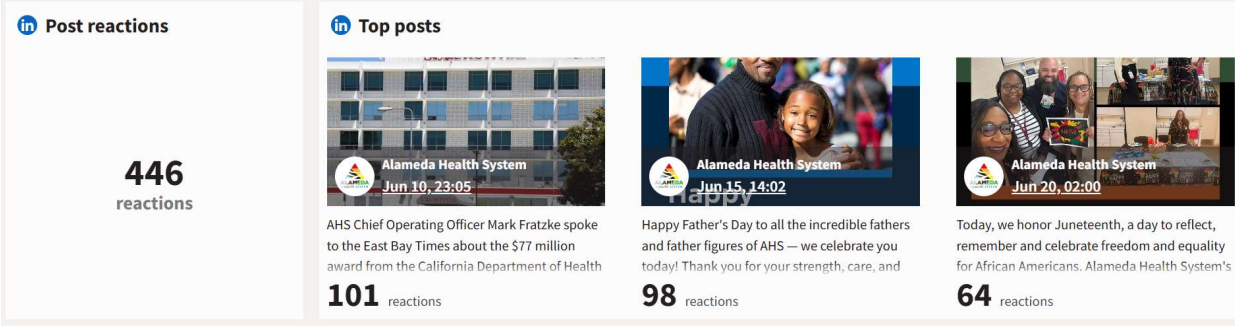
X (formerly Twitter)



Instagram



LinkedIn



Media and Communications

Media and Communications is responsible for press coverage, media relations, and public relations that champion Alameda Health System (AHS) and our critical role in the community. We amplify stories that inform the public, elevate the profiles of AHS leadership, publicize the heroic acts our staff perform every day, and establish AHS as the community health pillar within Alameda County.

Audience & Reach

PACE uses Critical Mention, an all-in-one platform for real-time media monitoring across Television, Radio, Social Media, and Online News. Critical Mention calculates our audience and publicity values using data from industry-leading media data providers such as LexisNexis, Nielsen

and Podchaser. The performance metrics below are a measure of media mentions, audience size, and publicity value associated in the United States.

Mentions are the number of instances in which Alameda Health System, Alameda Hospital, Highland Hospital, John George Psychiatric Hospital, San Leandro Hospital, or The Wilma Chan Highland Hospital Campus were mentioned across all media. The audience estimate represents the number of people who potentially viewed the AHS mentions. The publicity value estimate represents the cost to advertise for a specific time, program, and/or platform used multiplied by the audience number.

Time Period	Mentions	Audience	Publicity Value
June 1 – 27, 2025	107	75,223,612	$1,348,618

Media Highlights –June 1 – 27, 2025

AHS receives $77 million in behavioral health funding

The news of AHS's BHCIP funding to build and expand behavioral health facilities was reported across the local media landscape including The East Bay Times, San Jose Mercury News, Contra Costa Times, The Fresno Bee, and KTVU.

AHS expands stroke care with Wilma Chan Highland Hospital Campus' new certification

AHS patients experiencing symptoms of a stroke will now receive faster and more integrated care, thanks to the Wilma Chan Highland Hospital Campus' recent certification as a stroke center. This designation joins the long-standing certification at Alameda Hospital, expanding AHS' ability to deliver lifesaving care across Alameda County.

Appendix A – AHS Activities on Key State Bills – 6/27/2025

Bill No.	Author	Title	Summary	Status	AHS Activities & Potential Impact
AB 40	Bonta	Emergency services and care	would add "reproductive health services, including abortion," to the definition of "emergency services and care" under the Health and Safety Code. Per the state's laws governing the provision of emergency services, health facilities must provide "emergency services and care" to determine if an emergency medical condition or active labor exists.	Sen. Appropriations	AHS is monitoring this bill
AB 339	Ortega	Local public employee organizations: notice requirement	would require public entities, including public hospitals and health systems, to give recognized employee organizations a minimum of 120 days' written notice before issuing requests for proposals, requests for quotes, or renewing or extending existing contracts that affect job classifications represented by these organizations.	Sen. Labor, Public Employment and Retirement	AHS is monitoring this bill
AB 447	González	ED patient prescriptions: dispensing unused portions upon discharge	would allow physicians or authorized prescribers to dispense an unused portion of a non-controlled medication to an emergency department (ED) patient upon discharge if all of the following conditions are met: the drug is not a controlled substance, it was previously ordered and administered to the patient during their ED visit, it was administered from single patient use multidose packaging and can be self-administered by the patient, and dispensing the remaining portion is necessary to continue the patient's treatment.	Sen. Health	AHS is monitoring this bill
AB 1460	Rogers	Prescription Drug pricing	would prohibit prescription drug manufacturers from discriminating against qualifying nonhospital 340B community clinics by imposing conditions or restrictions on their ability to purchase or receive federally discounted drugs based on the type of pharmacy they use, including contract pharmacies, to dispense the medication to eligible patients.	Sen. Health	AHS is monitoring this bill
SB 81	Arreguín	Health facilities: information sharing	would prohibit health facilities from collaborating with, providing access to, or providing information about patients to immigration authorities.	Asm. Privacy and Consumer Protection	AHS collaborated closely with CAPH on this bill to ensure its feasibility for implementation and alignment with current hospital practices.

Bill No.	Author	Title	Summary	Status	AHS Activities & Potential Impact
SB 596	Menjivar	Health facilities: administrative penalties	would increase hospitals' nurse staffing compliance requirements by mandating that they document the use and exhaustion of their on-call nurse list before qualifying for an exemption from staffing violation penalties. The bill defines an on-call list as at least 10% of the hospital's registered nurse staff and requires that all nurses on the list maintain verified competencies specific to their assigned unit.	Asm. Health	AHS is monitoring this bill
SB 632	Arreguín	Workers' compensation: hospital employees	would create a series of workers' compensation rebuttable presumptions for hospital employees for a variety of infectious and respiratory diseases, including COVID-19 and severe acute respiratory syndrome, and extend the presumptions after the employee's termination.	Asm. Insurance	AHS is monitoring this bill

Bills that are not moving forward this year

Bill No.	Author	Title	Summary	Status	AHS Activities & Potential Impact
AB 315	Bonta	Medi-Cal: Home and Community-Based Alternatives Waiver	would require the Department of Health Care Services to expand capacity in the Medi-Cal Home and Community-Based Alternatives (HCBA) waiver and submit a study to the Legislature on rates and rate-setting methodologies for HCBA waiver services by March 1, 2026.	Held in Asm. Appropriations	AHS monitored this bill
AB 1386	Bains	Health facilities: perinatal services	would require perinatal services to be considered a basic service at general acute care hospitals, as well as establish a process for hospitals that do not provide this service to submit a compliance plan to the California Department of Public Health (CDPH) for approval or denial. The plan must include information on the hospital's transfer agreements, financial limitations, efforts to establish perinatal care, and other requirements as determined by CDPH.	Held in Asm. Appropriations	AHS monitored this bill