



BOARD OF TRUSTEES SPECIAL MEETING

WEDNESDAY, JANUARY 7, 2026

6:00pm or immediately following the Finance Committee meeting

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

Teleconference Location: 4501 Pleasanton Avenue, Pleasanton, CA 94566

ZOOM Meeting Link:¹

<https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=87501543123>

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MEMBERS

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Nicholas Moss, MD	Nely Obligacion
Rachel Richman	David Sayen
Sblend A. Sblendorio	

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.

BOARD OF TRUSTEES SPECIAL 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.

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

ACTION/DISCUSSION

- A. **[ACTION: FY 25 Financial Statements Approval](#)**
Kim Miranda, Chief Financial Officer
Ann Metzger, Vice President of Finance

- B. **[ACTION: Staff Requests Board Authorization for the allocation of a not-to-exceed amount of \\$10, 507,500 million to support an Intergovernmental Transfer for the benefit of St. Rose Hospital](#)**
Kim Miranda, Chief Financial Officer

CLOSED SESSION

- 1. **Conference with Labor Negotiators**
[Government Code Section 54957.6]
AHS Designated Representatives: Jet Chapman, CHRO
Employee Organization: SEIU 1021, SEIU-UHW, BTC, ACMEA

- 2. **Conference with Legal Counsel – Anticipated Litigation**
(Paragraph (2) of subdivision (d) of Gov. Code § 54956.9)
1 Case
Ahmad Azizi, General Counsel

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.

ACTION: FY 25 Financial Statements Approval

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Reports of Independent Auditors and Financial Statements
with Required Supplementary Information
and Supplementary Information

**Alameda Health System, A Public Hospital Authority
(A Component Unit of County of Alameda, California)**

June 30, 2025

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Management's Discussion and Analysis

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**Alameda Health System, A Public Hospital Authority
Management's Discussion and Analysis (Unaudited)
As of and for the Years Ended June 30, 2025 and 2024**

Insert Management's Discussion and Analysis

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Report of Independent Auditors

This report is a draft of the financial statements for the Health System as of and for the years ended June 30, 2025.

The independent auditor does **not** provide any opinion on these statements. For this reason, no opinions or drafts thereof have been included.

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Financial Statements

Alameda Health System, A Public Hospital Authority
Statement of Net (Deficit) Position
June 30, 2025

	Enterprise Fund Financial Statements			Government-Wide Financials	
	Major Funds			Business-type Activities	
	Alameda Health System	St. Rose	Total Enterprise Funds	Primary Government	Alameda Health System Foundation
ASSETS					
CURRENT ASSETS					
Cash and cash equivalents	\$ 14,556	\$ 4,799	\$ 19,355	\$ 19,355	\$ 4,058
Patient accounts receivable, net	101,401	10,787	112,188	112,188	-
Due from third-party payors	350,869	8,601	359,470	359,470	-
Contributions receivable, net	-	-	-	-	1,857
Due from County of Alameda	61,678	-	61,678	61,678	-
Due from State of California, net	12,955	-	12,955	12,955	-
Inventory	12,267	1,109	13,376	13,376	9
Other current assets	20,089	2,306	22,395	22,395	1,920
Total current assets	573,815	27,602	601,417	601,417	7,844
NONCURRENT ASSETS					
Restricted cash equivalents	27,781	-	27,781	27,781	-
Investments	-	4,243	4,243	4,243	14,854
Investments restricted for capital assets	-	854	854	854	-
Investments held by trustee	-	1,050	1,050	1,050	-
Contributions receivable, net of current portion	-	-	-	-	1,477
Other assets, net of current portion	-	3,204	3,204	3,204	-
Right-to-use lease assets, net	31,604	1,167	32,771	32,771	-
Right-of-use subscription assets, net	8,190	696	8,886	8,886	-
Capital assets:					
Nondepreciable	33,738	10,187	43,925	43,925	261
Depreciable	104,958	26,262	131,220	131,220	-
Capital assets, net	138,696	36,449	175,145	175,145	261
Total assets	780,086	75,265	855,351	855,351	24,436
DEFERRED OUTFLOWS OF RESOURCES					
Deferred outflows of resources - pension	74,934	-	74,934	74,934	-
Deferred outflows of resources - other postemployment benefits	30,636	-	30,636	30,636	-
Total deferred outflows of resources	105,570	-	105,570	105,570	-
Total assets and deferred outflows of resources	\$ 885,656	\$ 75,265	\$ 960,921	\$ 960,921	\$ 24,436

See accompanying notes.

Alameda Health System, A Public Hospital Authority
Statement of Net (Deficit) Position
June 30, 2025

	Enterprise Fund Financial Statements			Government-Wide Financials	
	Major Funds		Total Enterprise Funds	Business-type Activities	Alameda Health System Foundation
	Alameda Health System	St. Rose		Primary Government	
	(amounts in thousands)				
LIABILITIES					
CURRENT LIABILITIES					
Bank line of credit	\$ -	\$ 10,000	\$ 10,000	\$ 10,000	\$ -
Accounts payable and accrued expenses	77,247	9,857	87,104	87,104	962
Accrued compensation	65,654	2,018	67,672	67,672	-
Due to third-party payors	179,634	764	180,398	180,398	-
Due to County of Alameda	12,033	-	12,033	12,033	-
Accrued compensated absences, current portion	33,501	2,168	35,669	35,669	-
Self-insurance liability, current portion	12,282	832	13,114	13,114	-
Lease obligations, current maturities	6,730	179	6,909	6,909	-
Subscription obligations, current maturities	3,278	221	3,499	3,499	-
Notes payable, current maturities	-	4,092	4,092	4,092	-
Other liabilities, current maturities	-	280	280	280	-
Total current liabilities	390,359	30,411	420,770	420,770	962
NONCURRENT LIABILITIES					
Liquidity facility - County of Alameda	832	-	832	832	-
Accrued compensated absences, net of current portion	26,667	1,320	27,987	27,987	-
Net pension liability	370,400	-	370,400	370,400	-
Other postemployment benefit obligation	43,255	-	43,255	43,255	-
Self-insurance liability, net of current portion	41,231	1,932	43,163	43,163	-
Lease obligations, net of current maturities	29,739	1,044	30,783	30,783	-
Subscription obligations, net of current maturities	3,771	453	4,224	4,224	-
Notes payable, net of current maturities	-	31,881	31,881	31,881	-
Other liabilities, net of current maturities	-	259	259	259	-
Total noncurrent liabilities	515,895	36,889	552,784	552,784	-
Total liabilities	906,254	67,300	973,554	973,554	962
DEFERRED INFLOWS OF RESOURCES					
Deferred inflows of resources - lease income	-	3,454	3,454	3,454	-
Deferred inflows of resources - pension	21,433	-	21,433	21,433	-
Deferred inflows of resources - other postemployment benefits	19,768	-	19,768	19,768	-
Total deferred inflows of resources	41,201	3,454	44,655	44,655	-
NET POSITION (DEFICIT)					
Net investment in capital assets	138,696	18,126	156,822	156,822	261
Restricted for capital assets	27,781	1,050	28,831	28,831	-
Restricted for health programs	-	-	-	-	20,180
Unrestricted net (deficit) position	(228,276)	(14,665)	(242,941)	(242,941)	3,033
Total net (deficit) position	(61,799)	4,511	(57,288)	(57,288)	23,474
Total liabilities, deferred inflows of resources, and net (deficit) position	\$ 885,656	\$ 75,265	\$ 960,921	\$ 960,921	\$ 24,436

See accompanying notes.

Alameda Health System, A Public Hospital Authority
Statement of Revenues, Expenses, and Changes in Net (Deficit) Position
Year Ended June 30, 2025

	Enterprise Fund Financials			Government-Wide Financials	
	Major Funds			Business-type Activities	
	Alameda Health System	St. Rose	Total Enterprise Funds <small>(amounts in thousands)</small>	Primary Government	Alameda Health System Foundation
OPERATING REVENUES					
Patient service revenues, net	\$ 942,426	\$ 77,225	\$ 1,019,651	\$ 1,019,651	\$ -
Capitation revenues	105,726	-	105,726	105,726	-
Other government programs	507,972	39,414	547,386	547,386	-
Other operating revenues	63,966	4,553	68,519	68,519	-
Total operating revenues	1,620,090	121,192	1,741,282	1,741,282	-
OPERATING EXPENSES					
Salaries and benefits	1,159,373	84,396	1,243,769	1,243,769	-
Physician contract services	39,278	7,904	47,182	47,182	-
Purchased services	105,279	9,982	115,261	115,261	-
Materials and supplies	154,414	10,481	164,895	164,895	-
Facilities	41,248	4,644	45,892	45,892	-
Depreciation and amortization	37,542	4,366	41,908	41,908	5
General and administrative	53,334	3,978	57,312	57,312	4,102
Fundraising	-	-	-	-	1,182
Grant-related program expenses	14,511	-	14,511	14,511	4,211
Total operating expenses	1,604,979	125,751	1,730,730	1,730,730	9,500
Operating profit (loss)	15,111	(4,559)	10,552	10,552	(9,500)
NONOPERATING REVENUES (EXPENSES)					
Contribution revenue	-	340	340	340	11,693
COVID-19 revenue	5,830	-	5,830	5,830	-
Interest and investment income	2,238	1,181	3,419	3,419	902
Interest expense	(5,136)	(1,979)	(7,115)	(7,115)	-
Other nonoperating (expenses) revenue	(253)	401	148	148	-
Total nonoperating revenues (expenses), net	2,679	(57)	2,622	2,622	12,595
Income before other revenues, expenses, gains, losses, and transfers	17,790	(4,616)	13,174	13,174	3,095
CAPITAL CONTRIBUTIONS	1,015	-	1,015	1,015	-
CAPITAL TRANSFERS - AHS AND FOUNDATION	18	-	18	18	(18)
INCREASE (DECREASE) IN NET (DEFICIT) POSITION	18,823	(4,616)	14,207	14,207	3,077
NET (DEFICIT) POSITION, beginning of year	(80,622)	-	(80,622)	(80,622)	20,397
Change in reporting entity	-	9,127	9,127	9,127	-
NET (DEFICIT) POSITION, end of year	\$ (61,799)	\$ 4,511	\$ (57,288)	\$ (57,288)	\$ 23,474

See accompanying notes.

Alameda Health System, A Public Hospital Authority
Statement of Cash Flows
Year Ended June 30, 2025

	Enterprise Fund Financial Statements			Government-Wide Financials	
	Major Funds		Total Enterprise Funds	Business-type Activities	
	Alameda Health System	St. Rose		Primary Government	Alameda Health System Foundation
	(amounts in thousands)				
CASH FLOWS FROM OPERATING ACTIVITIES					
Cash received for operations	\$ 1,585,916	\$ 117,763	\$ 1,703,679	\$ 1,703,679	\$ -
Cash paid to suppliers and contractors	(403,364)	(37,267)	(440,631)	(440,631)	(6,052)
Cash paid to employees for services and benefits	(1,138,736)	(83,750)	(1,222,486)	(1,222,486)	(3,196)
Net cash provided by (used in) operating activities	<u>43,816</u>	<u>(3,254)</u>	<u>40,562</u>	<u>40,562</u>	<u>(9,248)</u>
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES					
Draws on Liquidity facility - County of Alameda	1,924,121	-	1,924,121	1,924,121	-
Principal repayment of Liquidity Facility - County of Alameda	(1,928,390)	-	(1,928,390)	(1,928,390)	-
Interest payments on Liquidity Facility - County of Alameda	(3,604)	-	(3,604)	(3,604)	-
Proceeds from grants for COVID-19 pandemic	5,830	-	5,830	5,830	-
Contributions received	-	340	340	340	13,952
Other nonoperating expenses	(253)	-	(253)	(253)	-
Other nonoperating income	-	401	401	401	-
Other interest payments	(170)	-	(170)	(170)	-
Net cash (used in) provided by noncapital financing activities	<u>(2,466)</u>	<u>741</u>	<u>(1,725)</u>	<u>(1,725)</u>	<u>13,952</u>
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES					
Purchase and construction of capital assets	(19,936)	(7,386)	(27,322)	(27,322)	4
Payments of other long-term liabilities	(2,783)	(2,650)	(5,433)	(5,433)	-
Proceeds from other long-term liabilities	-	(338)	(338)	(338)	-
Payments of lease obligations	(6,149)	(171)	(6,320)	(6,320)	-
Interest payments on lease obligations	(1,232)	(66)	(1,298)	(1,298)	-
Payments of subscription obligations	(4,012)	(268)	(4,280)	(4,280)	-
Interest payments on subscription obligations	(131)	(20)	(151)	(151)	-
Payments of notes payable	-	(2,966)	(2,966)	(2,966)	-
Interest payments on notes payable	-	(1,893)	(1,893)	(1,893)	-
Proceeds from issuance of notes payable	-	17,650	17,650	17,650	-
Capital contributions	1,015	-	1,015	1,015	-
Grants to Alameda Health System for purchase of property and equipment	18	-	18	18	-
Net cash (used in) provided by capital and related financing activities	<u>(33,210)</u>	<u>1,892</u>	<u>(31,318)</u>	<u>(31,318)</u>	<u>4</u>
CASH FLOWS FROM INVESTING ACTIVITIES					
Purchase of investments	-	-	-	-	(24,920)
Proceeds from sales of investments	-	-	-	-	8,296
Interest and investment income	2,239	606	2,845	2,845	8,460
Net cash provided by (used in) investing activities	<u>2,239</u>	<u>606</u>	<u>2,845</u>	<u>2,845</u>	<u>(8,164)</u>
CHANGES IN CASH, CASH EQUIVALENTS, AND RESTRICTED CASH EQUIVALENTS					
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH EQUIVALENTS, beginning of year	<u>31,958</u>	<u>4,814</u>	<u>36,772</u>	<u>36,772</u>	<u>7,514</u>
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH EQUIVALENTS, end of year	<u>\$ 42,337</u>	<u>\$ 4,799</u>	<u>\$ 47,136</u>	<u>\$ 47,136</u>	<u>\$ 4,058</u>

See accompanying notes.

Alameda Health System, A Public Hospital Authority
Statements of Cash Flows
Year Ended June 30, 2025

	Enterprise Fund Financial Statements			Government-Wide Financials	
	Major Funds			Business-type Activities	
	Alameda Health System	St. Rose	Total Enterprise Funds	Primary Government	Alameda Health System Foundation
	(amounts in thousands)				
CASH, CASH EQUIVALENTS, AND RESTRICTED CASH EQUIVALENTS					
Unrestricted	\$ 14,556	\$ 4,799	\$ 19,355	\$ 19,355	\$ 4,058
Restricted cash equivalents	27,781	-	27,781	27,781	-
Cash, cash equivalents, and restricted cash equivalents	<u>\$ 42,337</u>	<u>\$ 4,799</u>	<u>\$ 47,136</u>	<u>\$ 47,136</u>	<u>\$ 4,058</u>
RECONCILIATION OF OPERATING PROFIT (LOSS) TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES					
Operating profit (loss)	\$ 15,111	\$ (4,559)	\$ 10,552	\$ 10,552	\$ (9,517)
Adjustments to reconcile operating profit (loss) to net cash provided by (used in) operating activities:					
Depreciation and amortization	37,542	4,366	41,908	41,908	5
Bad debt provision	40,209	2,032	42,241	42,241	-
Changes in operating assets and liabilities:					
Patient accounts receivable, net	(35,514)	(1,593)	(37,107)	(37,107)	-
Due from third-party payors	(27,862)	749	(27,113)	(27,113)	-
Due from County of Alameda	(21,823)	-	(21,823)	(21,823)	-
Due from State of California	2,271	-	2,271	2,271	-
Inventory	(280)	96	(184)	(184)	-
Other current assets	(2,453)	(3,578)	(6,031)	(6,031)	(60)
Deferred outflows of resources	62,095	-	62,095	62,095	-
Accounts payable and accrued expenses	5,560	(247)	5,313	5,313	-
Accrued compensation	9,387	429	9,816	9,816	324
Due to third-party payors	10,998	(4,493)	6,505	6,505	-
Due to County of Alameda	(3,036)	-	(3,036)	(3,036)	-
Accrued compensated absences	11,084	217	11,301	11,301	-
Self-insurance liability	5,239	(527)	4,712	4,712	-
Net pension obligation	(55,607)	-	(55,607)	(55,607)	-
Other long-term liabilities	(2,783)	400	(2,383)	(2,383)	-
Other postemployment benefits obligation	4,881	-	4,881	4,881	-
Deferred inflows of resources	(11,203)	3,454	(7,749)	(7,749)	-
Net cash provided by (used in) operating activities	<u>\$ 43,816</u>	<u>\$ (3,254)</u>	<u>\$ 40,562</u>	<u>\$ 40,562</u>	<u>\$ (9,248)</u>
SUPPLEMENTAL DISCLOSURES OF NONCASH TRANSACTIONS					
Right-of-use subscription obligations	\$ 10,191	\$ -	\$ 10,191	\$ 10,191	\$ -
Change in reporting entity	\$ -	\$ 9,127	\$ -	\$ -	\$ -

See accompanying notes.

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

Note 1 – Organization and Reporting Entity

Alameda Health System (the Health System) represents the business-type activities presented as part of the government-wide financials. The primary government activity consists of two major funds, Alameda Health and Hayward Sisters Hospital dba St. Rose Hospital (St. Rose), and the discretely presented Alameda Health System Foundation (Foundation). The Alameda Health major fund is comprised of Alameda Hospital, Fairmont Hospital, Wilma Chan Highland Hospital, John George Psychiatric Hospital, and community ambulatory care clinics (collectively AHS) and Alameda Health Medical Group (AHMG) component units. The St. Rose major fund is comprised of St. Rose Hospital (SRH), St. Rose Medical Building Inc. (St. Rose MOB), and St. Rose Foundation (St. Rose Foundation) component units. The government-wide financial statements are reflected in the County of Alameda (County) annual comprehensive financial report as a discretely presented component unit. Information for the individual companies is discussed below.

The Health System is a Public Hospital Authority created originally under the name of Alameda County Medical Center (Medical Center) on July 1, 1998, pursuant to California Health and Safety Code Section 101850 with a fiscal year ending June 30th. The governance, management, administration, and control of health care facilities were transferred from the County to the Medical Center in 1998. The Medical Center started doing business as the Health System on January 1, 2013.

The Health System is governed by a nine-member Board of Trustees (Trustees), eight members of which are appointed by a majority vote of the Board of Supervisors of the County. Trustees are appointed for three-year terms and can be reappointed for up to three consecutive complete terms. The remaining position on the Board of Trustees is filled by a representative of the Medical Staff of the Health System, which is also appointed by the Board of Supervisors.

Under the terms of the transfer arrangement (Master Contract) between the County and the Health System, certain operating assets, liabilities, and the net (deficit) position of health care operations were transferred from the County to the Health System. The Health System leases land, hospital facilities, and other equipment from the County for one dollar annually. Leased facilities include Fairmont Hospital, Wilma Chan Highland Hospital, John George Psychiatric Hospital, and community ambulatory care clinics. The County has the authority to terminate any or all of the transfer agreements with or without cause.

The Health System through Alameda Health provides a continuum of acute and long-term care to residents of the County. In addition to offering general acute care, skilled nursing, and rehabilitative care, the Health System provides an adult day health center and a trauma center. Alameda Health is currently staffed for 272 acute, 69 acute psychiatric, and 325 sub-acute skilled nursing and acute rehabilitation beds.

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

AHMG is a blended component unit of the Health System and is included in these financial statements as a condensed combined unit with AHS. AHMG was established as a governmentally financed public benefit corporation under the California Corporations Code with a fiscal year ending June 30. AHMG is a wholly controlled subsidiary of the AHS. AHMG's mission is to serve the public purposes of Section 1400.2 of California's Welfare and Institutions Code. The Articles of Incorporation and Bylaws of AHMG provide that AHS is the sole Corporate Member of AHMG, which includes substantial reserved power over AHMG, including the power to appoint or remove AHMG Board members and approve any changes to AHMG's Bylaws. Separate financial statements of AHMG can be obtained from AHMG, 55 Harrison Street, Suite 600, Oakland, California 94607.

SRH is the sole corporate member of St. Rose MOB and St. Rose Foundation, collectively are included as a condensed combined unit of the Health System and is included in these financial statements. SRH operates as an independent, nonprofit, community hospital with 177 beds providing access to care in Alameda County. SRH is organized as an exempt entity under Section 501(c)(3) of the Internal Revenue Code with fiscal year ending on September 30. On October 31, 2024, a Membership Issuance Agreement was signed to establish the AHS as the sole statutory member of SRH with an effective date of November 1, 2024. AHS is not responsible for expenses, losses or liabilities of St. Rose and has no rights to profits or assets of St. Rose. Separate financial statements of St. Rose can be obtained from St. Rose Hospital, 27200 Calaroga Avenue, Hayward, California 94545.

Foundation is a discretely presented component unit of the Health System and is included in these financial statements. The Foundation's mission is to raise funds and generate community support for the Health System. The Articles of Incorporation and Bylaws of the Foundation provide that the Health System approve the Foundation's Board members and that upon dissolution, the Foundation's remaining assets will be distributed to the Health System. The Foundation is organized as an exempt entity under Section 501(c)(3) of the Internal Revenue Code with a fiscal year ending June 30. Stand-alone audited financial statements of the Foundation can be obtained from the Foundation, 55 Harrison Street, Suite 600, Oakland, California 94607.

Note 2 – Summary of Significant Accounting Policies

Basis of accounting – The financial statements provide information about the Health System's major funds, the Alameda Health and St. Rose, and the discretely presented component unit, the Foundation. Basis of accounting refers to when revenues and expenses are recognized in the accounts and reported in the financial statements and relates to the timing of measurements made, regardless of the measurement focus applied. The financial statements are reported using the economic resources measurement focus and accrual basis of accounting, wherein revenues are recognized when earned and expenses are recognized when incurred, regardless of the timing of cash flows.

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Notes to Financial Statements

The Enterprise Fund, a proprietary fund, distinguishes operating revenues and expenses from nonoperating items. Operating revenues are defined as transactions deemed by management to be ongoing or central to the provision of healthcare services. Operating revenues are derived from direct patient care, monthly premium payments received for patients enrolled in managed care, and other programs, as well as revenues from the sale of other goods and services. Revenues derived from interest income and income from rents are classified as nonoperating in the accompanying statements of revenues, expenses, and changes in net (deficit) position. Consistent with the treatment in the accompanying statements of cash flows, all expenses, with the exception of interest expense, are treated as operating expenses in the accompanying statements of revenues, expenses, and changes in net (deficit) position.

Change in reporting entity – On October 31, 2024, upon recognizing the Health System as the sole corporate member of St. Rose, the Health System's management determined that St. Rose as of and for the year ended September 30, 2024, Alameda Health as of and for the year ended June 30, 2025, would be reported as major funds of the Health System. The beginning net position of St. Rose at October 1, 2023 of \$9.1 million is reported as a change in reporting entity on the statements of revenue, expenses, and changes in net (deficit) position.

Proprietary fund accounting – The Health System utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and financial statements are prepared using the economic resources measurement focus.

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Fair value of financial instruments – Unless otherwise indicated, the fair values of all reported assets and liabilities, which represent financial instruments, approximate their carrying values. The Health System's policy is to recognize transfers in and transfers out of Levels 1, 2, and 3, as of the end of the reporting period.

Cash and cash equivalents – For purposes of the statements of cash flows, The Health System considers cash held in bank accounts and short-term investments with original maturities of three months or less to be cash and cash equivalents. This includes cash deposited with the County as part of the Alameda County Investment Pool.

Restricted cash equivalents – Restricted cash equivalents include cash held on behalf of patients and cash held that is restricted for certain programs or capital improvements.

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

Patient accounts receivable, net – The Alameda Health and St. Rose provide care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. A provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible. Additionally, third-party contractual adjustments are accrued on an estimated basis in the period the related services are rendered. Patient accounts receivable are reported net of allowances for contractual adjustments and bad debts and amounted to \$101.4 million for the Alameda Health at June 30, 2025, and \$10.8 million for St. Rose at September 30, 2024.

Inventory – Inventory balances consist of operating supplies and pharmaceuticals and are recorded at cost and adjusted by periodic counts.

Right-to-use lease assets, net – The Health System has recorded right-to-use lease assets in accordance with Governmental Accounting Standards Board (GASB) Statement No. 87, *Leases* (GASB 87). The right-to-use lease assets are initially measured at an amount equal to the initial measurement of the related lease obligation plus any lease payments made prior to the lease term, less lease incentives, and plus ancillary charges necessary to place the lease into service. The right-to-use lease assets are amortized on a straight-line basis over the life of the related lease.

Lease receivables – St. Rose MOB has recorded lease receivables in accordance with GASB 87, which are recorded in other current and noncurrent assets. A lease receivable is initially measured based on the present value of future lease payments to be received when the lease contract commences. A corresponding deferred cash inflow is measured at the initial value of the lease receivable to reflect the rent income related to future periods.

Right-of-use subscription assets, net – The Health System has recorded right-of-use subscription assets related to its subscription-based information technology arrangements (SBITAs), in accordance with GASB Statement No. 96, *Subscription-Based Information Technology Arrangements* (GASB 96). The right-of-use subscription assets are initially measured at an amount equal to the initial measurement of the related subscription obligation plus any payments made prior to the subscription term and capitalizable implementation costs less any incentives received from the SBITA vendor. The right-of-use subscription assets are amortized on a straight-line basis over the life of the related subscription arrangement.

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Notes to Financial Statements

Capital assets, net – The Alameda Health defines capital assets, net as assets with an individual cost of \$10,000 or greater and an estimated useful life in excess of one year. St. Rose defines capital assets, net, as assets with an individual cost of \$5,000 or greater and an estimated useful life of one year or greater. Capital assets, net are stated at cost when purchased or constructed, or for donated property, at the asset's estimated fair value at the time the donated property is received. Depreciation is provided using the straight-line method over the assets' estimated useful lives. Useful lives by asset classification are as follows:

Capital Asset Class	Estimated Useful Lives (in Years)
Equipment and software	3 – 20
Land improvements	5 – 20
Building improvements	5 – 40

The Health System evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset. Management evaluates prominent events or changes in circumstances to determine whether an impairment loss should be recognized. Based on this evaluation, there were no impairment losses during the year ended June 30, 2025, for the Alameda Health and the Foundation, and there were no impairment losses during the year ended September 30, 2024 for St. Rose.

Investments – Investments in marketable securities are reported at fair value and are based on quoted market prices. Net appreciation or depreciation in investments, including realized gains or losses and unrealized appreciation or depreciation on those investments, as well as all dividends, interest, and other investment income, is reported in the statements of revenues, expenses, and changes in net (deficit) position.

Fair value measurements – Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. The Health System determines the fair values of its assets and liabilities based on a fair value hierarchy that includes three levels of inputs:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that the Health System has the ability to access at the measurement date. An active market is a market in which transactions occur with sufficient frequency and volume to provide pricing information on an ongoing basis.

Level 2 – Inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly.

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Level 3 – Inputs are unobservable inputs for the asset or liability. Unobservable inputs reflect the Health System’s own assumptions about the assumptions market participants would use in pricing the asset or liability (including assumptions about risk). Unobservable inputs are developed based on the best information available in the circumstances and may include the Health System’s own data. The valuation levels are not necessarily an indication of the risk or liquidity associated with the investments. All assets and liabilities of the Health System are Level 1.

Compensated absences – Accumulated unpaid vacation is recorded as a liability when future payments for such compensated absences have been earned by employees. Benefits for which an employer is liable and are directly associated with payments to be made for compensated absences or termination obligations are also accrued with the related liability. Employees earn either vacation time or paid time off depending on the employees’ bargaining unit and accrual rates, which vary based on length of employment.

Risk management – The Health System is exposed to various risks of loss from torts; medical malpractice; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee illnesses; natural disasters; and employee health, employee dental, and employee accidental benefits. Commercial insurance coverage is purchased for claims arising from such matters.

Alameda Health is self-insured for general liability, medical malpractice, workers’ compensation, and unemployment claims. The self-insurance programs are administered through a third-party administrator, and estimated losses are accounted for on an accrual basis.

St. Rose has commercial insurance policies for general liability, medical malpractice claims, and workers’ compensation. General liability and medical malpractice is a claims-made basis with a \$100,000 deductible and a liability limit of \$20.0 million per occurrence. Workers’ compensation is a claims-made basis with liability limit of \$1.0 million per claim. The programs are administered through a third-party administrator, and estimated losses are accounted for on an accrual basis.

Lease obligations – The Health System recognizes lease contracts or equivalents that have a term exceeding one year and meet the definition of an other-than-short-term lease. The Health System uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the Health System’s incremental borrowing rate at the start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

Subscription obligations – The Health System recognizes subscription obligations for SBITA contracts that have a term exceeding one year. The Health System uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the Health System’s incremental borrowing rate at start of the arrangement for a similar arrangement type and term length to the contract. Short-term SBITA payments are expensed when incurred.

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Notes to Financial Statements

Net (deficit) position – Net (deficit) position is classified in three components:

Net investment in capital assets – Represents the difference between the net book value of capital assets and the outstanding balances of debt that are attributable to the acquisition, construction, or improvement of those capital assets.

Restricted – Represents the portion of net (deficit) position that is externally restricted for capital projects, restricted grant funds, and other uses.

Unrestricted – Represents the portion of net (deficit) position that does not meet the definition of net investment in capital assets and restricted net position (deficit).

When both restricted and unrestricted net (deficit) position are equally available, restricted resources are depleted first before unrestricted resources are used.

The Foundation's restricted net position of \$20.2 million at June 30, 2025, represents assets restricted by donors for specific purposes.

Patient service revenues, net – Patient service revenues, net is reported at the estimated net realizable amounts from patients, third-party payors, including the State of California (the State), and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Charity care – The Health System provides care without charge or at amounts less than its established rates to patients who meet certain criteria under its charity care policy. Accumulated costs for services provided to those patients are recorded as unreimbursed charges for services that are fully discounted. The cost associated with providing services to these patients that are not reimbursed is considered charity care cost (see Note 13).

Capitation revenues – Alameda Health has entered into capitation arrangements with the County to provide medical services to eligible participants. Under these agreements, Alameda Health receives monthly capitation payments based on the number of health program participants, regardless of services actually performed by Alameda Health. Alameda Health is in turn responsible for certain covered medical services for these capitated patients.

Novel coronavirus (COVID-19) – On March 13, 2020, the President of the United States (U.S.) declared a public health emergency related to the COVID-19 pandemic. On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law, which provided financial relief to hospitals, among other provisions. The U.S. Department of Health and Human Services declared the public health emergency to end on May 11, 2023.

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Notes to Financial Statements

The COVID-19 pandemic marked the first time the Disaster Relief Fund (DRF) was used to respond to a nationwide public health emergency. The Federal Emergency Management Agency (FEMA), which manages the DRF, used the fund to provide pandemic assistance for COVID-19 related costs not funded by other sources. The disaster incident period is January 20, 2020, through May 11, 2023. For the year ended June 30, 2025, Alameda Health recognized \$5.8 million of FEMA grant awards, which is included within COVID-19 revenue in the statements of revenues, expenses, and changes in net (deficit) position.

Net pension obligation and related balances

Alameda County Employees' Retirement Association (ACERA) Plan – The ACERA plan is a cost-sharing multiple-employer plan and, accordingly, only Alameda Health's proportionate share of the net pension obligation and related balances are reported in the accompanying financial statements. For purposes of measuring the net pension obligation, deferred outflows and inflows of resources related to pensions and pension expense for the ACERA plan, information about the fiduciary net position, and additions to/deductions from the fiduciary net position have been determined on the same basis as they are reported by the ACERA plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when currently due and payable in accordance with the benefit terms. ACERA audited financial statements are publicly available reports that can be obtained at ACERA's website (www.acera.org). Reported results pertain to liability and asset information within the following defined timeframes:

Valuation Date – December 31, 2024

Measurement Date – December 31, 2024

Measurement Period – January 1, 2024, to December 31, 2024

Alameda Health System Defined Benefit (AHS DB Plan) – For purposes of measuring the net pension obligation, deferred outflows and inflows of resources related to pensions and pension expense for the AHS DB Plan, information about the fiduciary net position, and additions to/deductions from the fiduciary net position have been determined by Alameda Health and its actuary. For this purpose, benefit payments (including refunds of employee contributions) are recognized when currently due and payable in accordance with the benefit terms. The AHS DB Plan does not have separately issued financial statements.

Reported results included in Alameda Health's financial statements pertain to information within the following defined timeframes:

Valuation Date – January 1, 2025

Measurement Date – June 30, 2025

Measurement Period – July 1, 2024, to June 30, 2025

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

Deferred inflows and outflows of resources – In addition to assets, the statements of net (deficit) position report a separate section for deferred outflows of resources. This separate financial statement element represents a consumption of net deficit or position that applies to a future period(s) and therefore will not be recognized as an outflow of resources (expense/expenditure) until that time. In addition to liabilities, the statements of net (deficit) position report a separate section for deferred inflows of resources. This separate financial statement element represents an acquisition of net (deficit) position that applies to a future period(s) and therefore will not be recognized as an inflow of resources (revenue/contra expense) until that time.

Alameda Health has deferred outflows and inflows of resources related to the net pension asset or obligation and other postemployment benefits asset or obligation. Actuarial gains and losses, changes in actuarial assumptions, and projected compared to actual investment earnings identified during the measurement period are deferred and amortized as a component of pension expense in future periods. Gains and losses arise due to unexpected differences in participant demographics (e.g., salary increases, termination rates, retirement rates). In addition, contributions made after the measurement date are reported as deferred outflows of resources until the next measurement period. See Note 14 for further discussion on these deferrals related to the net pension asset or obligation and Note 16 for further discussion on these deferrals related to the other postemployment benefits assets or obligations.

St. Rose has deferred inflows related to future lease income contracts from St. Rose MOB.

New accounting pronouncements – In June 2022, the GASB issued Statement No. 101, *Compensated Absences* (GASB 101). GASB 101 establishes standards of accounting and financial reporting for compensated absences and associated salary-related payments, including certain defined contribution pensions and defined contribution other postemployment benefits. GASB 101 is effective for reporting periods beginning after December 15, 2023. The Health System's management has determined the impact of this standard was not material to the financial statements.

In December 2023, the GASB issued Statement No. 102, *Certain Risk Disclosures* (GASB 102). The objective of GASB 102 is to provide users of government financial statements with essential information about risks related to a government's vulnerabilities due to certain concentrations or constraints. GASB 102 requires a government to assess whether a concentration or constraint makes the primary government reporting unit or other reporting units that report a liability for revenue debt vulnerable to the risk of a substantial impact. Additionally, GASB 102 requires a government to assess whether an event or events associated with a concentration or constraint that could cause the substantial impact to have occurred, to have begun to occur, or are more likely than not to begin to occur within 12 months of the date the financial statements are issued. GASB 102 is effective for fiscal years beginning after June 15, 2024. The Health System's management has determined the impact of this standard was not material to the financial statements.

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Notes to Financial Statements

In April 2024, the GASB issued Statement No. 103, *Financial Reporting Model Improvements* (GASB 103). The objective of GASB 103 is to improve key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a government's accountability. The financial statement improvements resulting from GASB 103 include changes to management's discussion and analysis, presentation of major discretely presented component units, reporting extraordinary and special items as unusual or infrequent items, changes to the proprietary statement of revenues, expenses, and changes in fund net position, definitions of operating and nonoperating revenues and expenses, and the presentation of budgetary comparison information. GASB 103 is effective for fiscal years beginning after June 15, 2025. The Health System's management is currently assessing the impact of GASB 103 on the financial statements.

In September 2024, the GASB issued statement No. 104, *Disclosure of Certain Capital Assets* (GASB 104). The objective of this Statement is to provide users of the financial statements with essential information about certain type of capital assets. This Statement requires certain types of capital assets to be disclosed separately in the capital assets note disclosures required by Statement 34. Lease assets recognized in accordance with Statement No. 87, *Leases*, and intangible right-to-use assets recognized in accordance with Statement No. 94, *Public-Private and Public-Public Partnerships and Availability Payment Arrangements*, should be disclosed separately by major class of underlying asset in the capital assets note disclosures. Subscription assets recognized in accordance with Statement No. 96, *Subscription-Based Information Technology Arrangements*, also should be separately disclosed. In addition, this Statement requires intangibles assets other than those three types to be disclosed separately by major class and additional disclosures for capital assets held for sale. GASB 104 is effective for fiscal years beginning after June 15, 2025. The Health System's management does not anticipate GASB 104 will have a material impact on the financial statements.

In December 2025, the GASB issued statement No. 105, *Subscription-Based Information Technology Arrangements*. The objective of this Statement is to provide users of the financial statements with information about subscription-based information technology arrangements. GASB 105 is effective for fiscal years beginning after June 15, 2026. The Health System's management is currently assessing the impact of GASB 105 on the financial statements.

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Notes to Financial Statements

Note 3 – Cash, Cash Equivalents, and Restricted Cash Equivalents

The composition of cash, cash equivalents, and restricted cash equivalents was as follows:

	Health System June 30, 2025	St. Rose September 30, 2024
(amounts in thousands)		
Cash and cash equivalents:		
Cash on hand	\$ 33	\$ 2
Deposits with bank	<u>14,523</u>	<u>4,797</u>
Total cash and cash equivalents	14,556	4,799
Restricted cash equivalents:		
Cash with Alameda County Investment Pool	<u>27,781</u>	<u>-</u>
Total cash, cash equivalents, and restricted cash equivalents	<u>\$ 42,337</u>	<u>\$ 4,799</u>
Health System	\$ 42,337	\$ -
St. Rose	<u>-</u>	<u>4,799</u>
Total cash, cash equivalents, and restricted cash equivalents	<u>\$ 42,337</u>	<u>\$ 4,799</u>

Deposits - custodial credit risk – Custodial credit risk for deposits is the risk that in the event of a bank failure, the Health System’s deposits may not be returned to it. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty to a transaction, an organization will not be able to recover the value of its investment that is in the possession of another party. The Health System does not have a policy for custodial credit risk on deposits or investments. Under the California Government Code, a financial institution is required to secure deposits made by state or local governmental units in excess of federally insured amounts by pledging securities held in the form of an undivided collateral pool. The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies. The collateral is held by the pledging financial institution’s trust department and is considered held in the Health System’ name.

Alameda Health – Alameda Health had cash on deposit in banks of \$20.9 million at June 30, 2025, that was covered by depository insurance or collateralized by the pledging financial institution. The carrying value at June 30, 2025 was \$8.1 million.

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Notes to Financial Statements

Alameda Health maintains its unrestricted cash and restricted cash in the Alameda County Investment Pool (the Pool). Income earned or losses arising from pooled investments are allocated quarterly based on Pool participants' average cash balances. Alameda Health considers its pooled deposits held with the County to be demand deposits and, therefore, cash and cash equivalents for financial reporting purposes. Alameda Health's deposits in the Pool were \$27.8 million at June 30, 2025. As of June 30, 2025, the total amount invested by all public agencies in the Pool was \$10.5 billion with a weighted-average maturity of 833 days. The Pool is unrated. The County's Treasury Oversight Committee has responsibility for the Pool. The Pool consists of U.S. government and agency securities, commercial paper, mutual funds, and the Local Agency Investment Fund as authorized by State statutes and the County's investment policy. For further information regarding the County's Pool (such as interest rate, credit, and concentration of credit risks), contact the County Treasury, Alameda County, 1221 Oak Street, Oakland, California 94612.

St. Rose – St. Rose had cash on deposit in banks of \$6.4 million of which \$4.8 million at September 30, 2024 was not covered by federal depository insurance.

Foundation – The Foundation had cash on deposit in banks of \$4.3 million of which \$3.8 million at June 30, 2025 was not covered by federal depository insurance.

Note 4 – Accounts Receivable and Concentration of Credit Risk

Alameda Health and St. Rose grant credit without collateral to patients, most of whom are local residents and are insured under third-party payor agreements. The mix of net receivables from patients and third-party payors was as follows:

	Health System June 30, 2025	St. Rose September 30, 2024
Medicare	29.4%	48.8%
Medi-Cal	50.0%	24.6%
Commercial	17.9%	24.6%
Self pay	0.3%	0.4%
Other government	2.4%	1.6%
	100.0%	100.0%

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

Note 5 – Due from/Due to Third-Party Payors

Due from third-party payors consisted of the following components:

	Health System June 30, 2025	St. Rose September 30, 2024
	(amounts in thousands)	
Medi-Cal settlement reserves (Section 1115 Waiver)	\$ 27,565	\$ -
Global Payment Program (GPP)	21,152	-
Voluntary Rate Range Program (VRRP)	69,800	-
Quality Incentive Program (QIP)	106,747	-
Enhanced Payment Program (EPP)	108,318	-
Graduate Medical Expenditures (GME)	8,237	-
Medi-Cal cost report settlement	5,406	-
Hospital Quality Assurance Fee (HQUAF)	3,644	8,601
	<u>\$ 350,869</u>	<u>\$ 8,601</u>
Total due from third-party payors	<u>\$ 350,869</u>	<u>\$ 8,601</u>

Due to third-party payors consisted of the following components:

	Health System June 30, 2025	St. Rose September 30, 2024
	(amounts in thousands)	
Federally Qualified Health Center (FQHC)	\$ 63,328	\$ -
Assembly Bill (AB) 85 realignment	82,915	-
Medicare audit payable	6,233	764
Physician SPA	27,158	-
	<u>\$ 179,634</u>	<u>\$ 764</u>
Total due to third-party payors	<u>\$ 179,634</u>	<u>\$ 764</u>

Note 6 – Due from State of California, Net

Due from State of California, net consisted of the following components:

	Health System June 30, 2025	St. Rose September 30, 2024
	(amounts in thousands)	
AB 915 supplemental reimbursement	\$ (14,647)	\$ -
Sales tax	25,635	-
Other State supplemental programs	1,967	-
	<u>\$ 12,955</u>	<u>\$ -</u>
Total due from State of California	<u>\$ 12,955</u>	<u>\$ -</u>

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Notes to Financial Statements

Note 7 – Capital Assets, Net

Changes in capital assets, net of Alameda Health for the year ended June 30, 2025, were as follows:

	Balance July 1, 2024	Additions	Retirements	Transfers	Balance June 30, 2025
	(amounts in thousands)				
Capital assets, nondepreciable:					
Assets not placed in service	\$ 26,251	\$ 14,719	\$ -	\$ (16,253)	\$ 24,717
Land	9,021	-	-	-	9,021
Total capital assets, nondepreciable	<u>35,272</u>	<u>14,719</u>	<u>-</u>	<u>(16,253)</u>	<u>33,738</u>
Capital assets, depreciable:					
Land improvements	228	63	-	25	316
Building and leasehold improvements	83,170	268	(1,695)	93	81,836
Equipment	225,173	4,886	(3,541)	16,135	242,653
Total capital assets, depreciable	<u>308,571</u>	<u>5,217</u>	<u>(5,236)</u>	<u>16,253</u>	<u>324,805</u>
Less accumulated depreciation for:					
Land improvements	(213)	(21)	-	-	(234)
Building and leasehold improvements	(27,798)	(3,941)	1,695	-	(30,044)
Equipment	(169,881)	(23,229)	3,541	-	(189,569)
Total accumulated depreciation	<u>(197,892)</u>	<u>(27,191)</u>	<u>5,236</u>	<u>-</u>	<u>(219,847)</u>
Total capital assets, depreciable, net	<u>110,679</u>	<u>(21,974)</u>	<u>-</u>	<u>16,253</u>	<u>104,958</u>
Capital assets, net	<u>\$ 145,951</u>	<u>\$ (7,255)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 138,696</u>

Changes in capital assets, net of the St. Rose for the year ended September 30, 2025, were as follows:

	Balance October 1, 2023	Additions	Retirements	Transfers	Balance September 30, 2024
	(amounts in thousands)				
Capital assets, nondepreciable:					
Assets not placed in service	\$ 2,169	\$ 5,588	\$ -	\$ (313)	\$ 7,444
Land	2,743	-	-	-	2,743
Total capital assets, nondepreciable	<u>4,912</u>	<u>5,588</u>	<u>-</u>	<u>(313)</u>	<u>10,187</u>
Capital assets, depreciable:					
Land improvements	2,532	-	-	-	2,532
Building and leasehold improvements	66,033	74	-	313	66,420
Equipment	39,998	1,726	-	-	41,724
Total capital assets, depreciable	<u>108,563</u>	<u>1,800</u>	<u>-</u>	<u>313</u>	<u>110,676</u>
Less accumulated depreciation for:					
Land improvements	(1,825)	(100)	-	-	(1,925)
Building and leasehold improvements	(42,807)	(2,596)	-	-	(45,403)
Equipment	(35,855)	(1,231)	-	-	(37,086)
Total accumulated depreciation	<u>(80,487)</u>	<u>(3,927)</u>	<u>-</u>	<u>-</u>	<u>(84,414)</u>
Total capital assets, depreciable, net	<u>28,076</u>	<u>(2,127)</u>	<u>-</u>	<u>313</u>	<u>26,262</u>
Capital assets, net	<u>\$ 32,988</u>	<u>\$ 3,461</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 36,449</u>

Capital assets, net for the Foundation were immaterial to the financial statements as a whole for the year ended June 30, 2025.

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

Note 8 – Related-Party Transactions

Liquidity Facility - County of Alameda – Alameda Health receives certain services from the County under the terms of the Master Contract. Alameda Health uses the County's Consolidated Treasury function (the Liquidity Facility) for weekly cash-flow funding to meet payroll, vendor, and other obligations that are offset by Alameda Health's cash receipts that are swept daily to the County. The Liquidity Facility is a payable when the cash provided to Alameda Health exceeds deposits held at the County and a receivable when deposits with the County exceed the cash provided to Alameda Health. When the Liquidity Facility is a payable balance, Alameda Health incurs interest expense on the outstanding payable balance.

On August 10, 2004, the County Board of Supervisors passed a resolution to limit the Liquidity Facility to a maximum payable balance of \$200.0 million. This maximum payable balance was defined as the Liquidity Facility receivable (payable) plus restricted cash amounts held at the County (the Net Negative Balance or NNB). The resolution also established a schedule for the repayment of the Liquidity Facility payable through fiscal year 2019, requiring a payment of \$15.0 million in fiscal year 2014 and \$20.0 million per year for the remaining years of the loan through fiscal year 2019.

During fiscal year 2015, Alameda Health and the County signed an interim agreement, effective from October 28, 2014, through February 27, 2015, and subsequently extended through December 31, 2015. The interim agreement developed a longer-term agreement on repayment of Alameda Health's Liquidity Facility payable to the County. Under this agreement, Alameda Health's maximum NNB could not exceed \$195.0 million.

During fiscal year 2016, Alameda Health completed a replacement Agreement on the Repayment of Debt to the Consolidated Treasury of the County of Alameda (the Debt Restructure Agreement), which enacted a declining maximum NNB to the County as of June 30 of each year. The Debt Restructure Agreement schedules further reductions to the maximum NNB, ultimately reducing it to \$50.0 million. Other than on June 30 of each year, the Debt Restructure Agreement provides Alameda Health an additional \$50.0 million of liquidity beyond the June 30 maximum NNB (the Flexible NNB) in recognition of the variability of the timing of cash receipts for supplemental government programs.

Throughout the year ended June 30, 2025, Alameda Health remained below the Flexible NNB of \$150.0 million. At June 30, 2025, Alameda Health had a Liquidity Facility payable of \$0.8 million, a NNB (receivable) of (\$26.9 million), and was below the Debt Restructure Agreement's maximum NNB of \$100.0.

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Liquidity Facility key measures of Alameda Health were as follows:

		June 30, 2025
		(amounts in thousands)
Total interest paid on County liquidity facility	\$	3,604
Liquidity Facility (payable)	\$	832
Net Negative Balance - Liquidity Facility net of restricted cash held by County	\$	(26,949)
Net Negative Balance - Maximum allowed by the Debt Restructure Agreement	\$	100,000

The Liquidity Facility bore an interest rate of 4.1% at June 30, 2025.

As of and for the year ended June 30, 2025, management has determined Alameda Health was in compliance with the Debt Restructure Agreement, including the requirement regarding the availability of monthly financial reporting.

Medical service reimbursements - County of Alameda – Alameda Health is reimbursed by the County at a negotiated annual amount for care of the County’s medically indigent patients and amounts under other supplemental programs. The County reimbursed Alameda Health \$91.5 million during fiscal year 2025 for these services, which is included in capitation revenue. Alameda Health has no receivables from the County related to these services at June 30, 2025.

Alameda Health is reimbursed by the County at negotiated rates for behavioral health services of the County’s medically indigent patients. The County reimbursed Alameda Health \$86.6 million during fiscal year 2025 for these services, which is included in patient service revenues, net. Alameda Health has recorded receivables of \$46.3 million from the County related to these services, which is included in due from County of Alameda on the statements of net (deficit) position at June 30, 2025.

In addition to providing behavioral health services to the County’s medically indigent patients, Alameda Health is also required to submit reports to the County for uncompensated behavioral health services. The County reimbursed Alameda Health \$4.8 million for these services, which is included in other government programs revenue (see Note 12), during fiscal year 2025.

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Notes to Financial Statements

Other - County of Alameda – Other County departments provide Alameda Health with certain services, such as sheriffs, motor pool, laboratory testing, telecommunications, building repairs, and maintenance. Alameda Health also leases several buildings from the County, the majority of which are covered under a \$1 million annual medical facilities lease that expires in 2028. Charges for County provided services to Alameda Health for the year ended June 30, 2025 were \$5.4 million and the related outstanding payable as of June 30, 2025 was \$1.0 million.

Capital Designation Fund - County of Alameda – The Capital Designation Fund was created as part of the Debt Restructure Agreement dated March 29, 2016, with the County Board of Supervisors. Alameda Health agreed to deposit \$7.0 million by June 30 of each fiscal year starting in 2019 and ending 2035, into a Capital Designation Fund. At the August 8, 2018, County Board of Supervisors' meeting, the Board approved Alameda Health to access up to \$7.0 million per year for ten years to reimburse for EPIC implementation expenditures. To access these funds, Alameda Health is required to achieve the following conditions:

- Alameda Health is in compliance with the terms of the Debt Restructure Agreement at June 30 of each fiscal year;
- Alameda Health has deposited \$7.0 million into the Capital Designation Fund established by the County by June 30 of each fiscal year;
- Alameda Health has achieved project benchmarks established by the County;
- Alameda Health has presented quarterly updates on its finances and the Electronic Health Records (EHR) project to the Board of Supervisors or Health Committee;
- Alameda Health signed an agreement on June 30, 2018, with the County that any reimbursement for depreciation and interest claimed on County-owned assets operated by Alameda Health, including but not limited to the Acute Care Tower, will be deposited with the County Auditor in a Capital Fund designated for maintenance and investment in the County's facilities; and
- Alameda Health obtains annual County Board of Supervisors approval for disbursement of funds up to \$7.0 million upon certification by the County Administrator and County Auditor-Controllers that Alameda Health is in compliance with the terms of the conditions cited above.

Payment was issued to the County for \$7.0 million during the fiscal year ended June 30, 2025. Alameda Health has a receivable due from the County of \$7.0 million at June 30, 2025, included in the Due from County of Alameda on the statements of net (deficit) position.

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Capital cost transfer - County of Alameda – On July 26, 2018, Alameda Health entered into the Capital Cost Transfer Agreement with the County (the Capital Cost Transfer Agreement). Per the Capital Cost Transfer Agreement, Alameda Health agrees to remit to the County all State and federal reimbursement associated with depreciation and interest claimed on the County-owned facilities operated by Alameda Health. This funding will be used to maintain the County’s investment in Alameda Health’s assets since Alameda Health is approved to use the Capital Designation funds to fund the EHR project. The funding is transferred to the County upon completion of the final P-14 audits for each fiscal year. The County will access these funds for capital improvement on properties occupied by Alameda Health. Alameda Health has a payable of \$10.9 million at June 30, 2025, included in the Due to County of Alameda on the statements of net (deficit) position.

Management service agreement – St. Rose – Alameda Health receives certain service fees from St. Rose under the terms of the management service agreement dated November 1, 2024, for the period of November 1, 2024 through October 31, 2039. Services provided by Alameda Health included providing a Chief Administrative Officer, other executive leadership support as needed, and access to a line of credit up to \$15.0 million. Interest is incurred upon accessing the line of credit or late payment of management fees invoice.

Alameda Health recognized management service revenue for the fiscal year ended June 30, 2025, of \$2.2 million as other operating revenue. St. Rose recognizes expense for these services under purchased services. The management fee revenue was not eliminated as the revenue was earned after November 1, 2024, which was after the St. Rose year ended September 30, 2024.

Alameda Health provided funding under the line of credit of \$11.0 million that was repaid by St. Rose in May 2025. Alameda Health earned nonoperating interest revenue of \$0.1 million during the year ended June 30, 2025, which St. Rose recognizes as interest expense during the year ended September 30, 2025. The nonoperating interest revenue was not eliminated as the revenue was earned after November 1, 2024, which was after the St. Rose year ended September 30, 2024.

Note 9 – Long-Term Obligations, Net

Long-term obligations, net activity, summarized for Alameda Health during the year ended June 30, 2025, were as follows:

	Balance June 30, 2024	Additional Obligations and Net Increases	Retirements and Net Decreases	Balance June 30, 2025	Amounts Due Within One Year
	(amounts in thousands)				
Liquidity facility - County of Alameda	\$ 5,101	\$ 57	\$ (4,326)	\$ 832	\$ -
Accrued compensated absences	49,084	11,084	-	60,168	33,501
Net pension obligation	426,007	90	(55,697)	370,400	-
Other postemployment benefit obligation	38,374	4,881	-	43,255	-
Self-insurance liabilities (See Note 18)	48,273	5,240	-	53,513	12,282
Lease obligations (See Note 19)	42,618	-	(6,149)	36,469	6,730
Subscription obligations (See Note 20)	870	6,401	(222)	7,049	3,278
	<u>\$ 610,327</u>	<u>\$ 27,753</u>	<u>\$ (66,394)</u>	<u>\$ 571,686</u>	<u>\$ 55,791</u>
Total noncurrent liabilities					

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Notes to Financial Statements

Long-term obligations, net activity, summarized for St. Rose during the year ended September 30, 2024, were as follows:

	Balance October 1, 2023	Additional Obligations and Net Increases	Retirements and Net Decreases	Balance September 30, 2024	Amounts Due Within One Year
	(amounts in thousands)				
Accrued compensated absences	\$ 3,271	\$ 217	\$ -	\$ 3,488	\$ 2,168
Self-insurance liabilities (See Note 18)	2,678	86	-	2,764	832
Lease obligations (See Note 19)	1,394	-	(171)	1,223	179
Subscription obligations (See Note 20)	942	-	(268)	674	221
Notes payable (See Note 21)	21,289	14,684	-	35,973	4,092
Other liabilities	3,127	462	(3,050)	539	280
Total noncurrent liabilities	\$ 32,701	\$ 15,449	\$ (3,489)	\$ 44,661	\$ 7,772

Note 10 – Patient Service Revenues, Net

Patient service revenues, net are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated adjustments (contractual allowances) under reimbursement agreements with third-party payors and the uncollectible portion of patient service revenues.

Alameda Health and St. Rose have agreements with third-party payors that provide for payments to Alameda Health and St. Rose at amounts different from its established rates. These payment arrangements include:

Medicare – Acute care services and substantially all outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic, acuity, and other factors. Alameda Health and St. Rose are reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by Alameda Health and St. Rose and audits thereof by the Medicare administrative contractor.

The Medicare administrative contractor has audited Alameda Health’s cost reports through June 30, 2019. Alameda Health recognized in the statements of revenues, expenses, and changes in net (deficit) position an increase of \$5.7 million in 2025 in net patient services revenue, pertaining to adjustments and settlements of cost reports.

The Medicare administrative contractor has audited St. Rose’s cost reports through September 30, 2021. Adjustments and settlements relating to the closing of cost reports were considered minor.

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Medi-Cal – Inpatient acute services rendered to Medi-Cal fee-for-services (FFS) program beneficiaries are paid at cost for Wilma Chan Highland Hospital, Fairmont Hospital, San Leandro Hospital, and Alameda Hospital. Alameda Health is paid at an interim per diem rate with final settlements determined after submission of annual cost reports and audits thereof by the California Department of Health Care Services (DHCS). Because Alameda Health is responsible for the nonfederal share of this cost-based reimbursement, which is around 30.0% of the total, net inpatient reimbursement always leaves a shortfall with costs, being calculated as a percentage below costs. Laws and regulations governing Medicare and Medi-Cal programs are complex and subject to interpretation and change. The programs’ administrative procedures preclude final determination of amounts due for services to program patients until after the cost reports are audited or otherwise reviewed by and settled with the respective administrative agencies. All Medi-Cal cost reports through 2022 have completed the audit stage but only cost reports through 2017 have settled the FFS inpatient patient reimbursement to the final audited cost report. Medi-Cal cost reports for 2025 will be filed by January 5, 2026, and are subject to audit and possible adjustment. Alameda Health recognized in the statements of revenues, expenses, and changes in net (deficit) position a decrease of \$22.4 million in 2025 in net patient services revenue pertaining to adjustments and settlements of cost reports.

Outpatient Medi-Cal services in Federally Qualified Health Clinics (FQHC) settings (Highland, Eastmont, Hayward, and Newark Wellness Centers) are reimbursed under an all-inclusive Prospective Payment System (PPS) rate per visit. All other outpatient services, as well as professionally billed and skilled nursing services, are reimbursed at statewide Medi-Cal rates, then supplemented based on the remaining uncompensated costs (per the Medi-Cal cost reports mentioned above) and the rates paid. For these services as with inpatient, Alameda Health contributes nonfederal share, meaning net overall reimbursement cannot exceed cost.

St. Rose’s inpatient services rendered to California Medi-Cal program beneficiaries are based on a prospectively established contracted per diem rate. Outpatient services are reimbursed on a fee-for-service basis from predetermined fee schedules. Open settlements at September 30, 2024, were considered minor.

Other – Alameda Health has also entered into payment agreements with certain Medicare and Medi-Cal managed care plans as well as commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to Alameda Health under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Patient service revenues, net, for the fiscal years ended were as follows:

	Health System June 30, 2025	St. Rose September 30, 2024
	(amounts in thousands)	
Gross patient service revenues	\$ 4,811,202	\$ 448,087
Contractual allowances	(3,828,567)	(368,830)
Bad debt provision	(40,209)	(2,032)
Net patient service revenues	\$ 942,426	\$ 77,225

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The mix of gross patient service revenues by payor for the fiscal years ended were as follows:

	Health System June 30, 2025	St. Rose September 30, 2024
Medi-Cal	60.4%	45.8%
Medicare	28.6%	41.2%
Commercial insurance	6.7%	9.4%
Other government	1.7%	1.4%
Self pay	2.6%	2.2%
	100.0%	100.0%

Note 11 – Capitation Revenue

Health Program for Alameda County (HPAC) – The HPAC provides health care coverage for the County’s indigent population. The indigent population is not qualified for full-scope Medi-Cal coverage and reports a gross monthly income at or below the 200.0% Federal Poverty Level. Alameda Health contracts with the County and other primary care community-based organizations to provide health care services.

Following the Affordable Care Act, HPAC continues to provide coverage for the remaining uninsured population of Alameda County. For the year ended June 30, 2025, Alameda Health recognized \$91.5 million. Included in capitation revenue was \$50.1 million in 2025 of Assembly Bill (AB 85) Realignment revenue (discussed in Note 12) that was passed on from the State to the County.

In addition to the direct cost of charity care (see Note 13), Alameda Health recognizes the unreimbursed costs of care provided to medically indigent patients covered by HPAC as contractual allowances. There were no HPAC unreimbursed costs in 2025 for Alameda Health.

Alameda Alliance for Health – Alameda Health entered into a capitation agreement with Alameda Alliance for Health in April 2018 to provide primary care services for its Medi-Cal members. As a result, Alameda Health recognized \$14.3 million in capitation revenue for the year ended June 30, 2025.

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Notes to Financial Statements

Note 12 – Other Government Program Revenue and Other Operating Revenue

Government program revenue for the fiscal years ended were as follows:

	Health System June 30, 2025	St. Rose September 30, 2024
	(amounts in thousands)	
Components of the Medi-Cal waiver:		
Section 1115 waiver including GPP and CalAIM	\$ 141,920	\$ -
AB 85 Realignment	(42,093)	-
Quality Incentive Program (QIP)	82,504	-
Enhanced Payment Program (EPP)	68,131	-
Voluntary Rate Range Program (VRRP)	42,592	-
Graduate Medical Education (GME)	18,191	-
AB 915 CPE	6,535	-
DP-NF Passthrough (DP-NF PT)	19,281	-
Hospital Quality Assurance Fee (HQAF)	7,129	11,302
Private Hospital Supplemental Fund (PHSF)	-	21,244
Sales tax revenue	146,177	-
Parcel tax revenue	4,049	-
Behavioral Health Services	4,809	-
Other program revenue	8,747	6,868
	<u>\$ 507,972</u>	<u>\$ 39,414</u>
Other government program revenue	<u>\$ 507,972</u>	<u>\$ 39,414</u>

State of California Medi-Cal Programs (Section 1115 Waiver) – Centers for Medicare & Medicaid Services (CMS) authorized California to invest savings generated through California’s Medi-Cal Hospital/Uninsured Care Demonstration Project (Demonstration) to achieve critical objectives, such as improved quality of care and better care coordination through safety net providers. The Demonstration, as described above, is a system initiated in 2005 for paying selected hospitals for hospital care provided to Medi-Cal and uninsured patients. The Demonstration lasted 5 years until 2010 and was renewed in modified form in 2010 to last through June 30, 2015, in that form.

Alameda Health has been informed by the California Association of Public Hospitals and The Health Systems (CAPH) that CMS has instructed the DHCS to finalize all years through fiscal year 2015 under the Waiver program. Alameda Health has estimated net liabilities for the period for fiscal year 2011, based on the revised analysis provided by CAPH. As of June 30, 2025, Alameda Health recorded a net receivable of \$27.6 million for this program, as shown in Note 5.

Global Payment Program (GPP) – Effective July 1, 2015, California’s Section 1115 Waiver (Waiver), called Medi-Cal 2020, was approved by CMS. The Waiver has been extended so that the GPP component expires December 31, 2026. Under the Waiver, the GPP establishes a statewide pool of funding for the remaining uninsured by combining DSH and SNCP, where selected Designated Public Hospital systems like Alameda Health can achieve their goal of a “global budget” by meeting a service threshold that incentivizes movement from high-cost, avoidable services to providing higher-value and preventative services. Alameda Health recognized \$141.9 million in revenue for the year ended June 30, 2025 for Section 1115 Waiver programs, including GPP and California Advancing and Innovating Medi-Cal (CalAIM). As of June 30, 2025, Alameda Health recorded a receivable of \$21.2 million for this program, as shown in Note 5.

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AB 85 Realignment – Accountability for providing health care to the uninsured has, historically, shifted back and forth between the counties and State of California. In 1991, responsibility for these services was transferred to the counties and increases to the State sales tax and vehicle license fees provided “realignment” funding to the counties. In 2013, due to passage of the Affordable Care Act and the shift from uninsured to Medi-Cal enrollees, the State determined that the cost of services to the uninsured would decrease, and the funding needed by the counties would need to be proportionately reduced through a realignment redirection. Counties with public health systems negotiated with the State resulting in AB 85 (2013) where realignment redirection varies from year to year depending on the public health system’s costs and revenues for safety net patients. The variation of 1991 Realignment funding up or down is described as AB 85 funding. Due to the complexity of formula calculations, each fiscal year’s AB 85 amount is finalized two years after the end of the subject fiscal year.

Each year before the year begins, the traditional 1991 Realignment funding for Alameda County is calculated, and some, all, or none may be redirected on an interim basis. Anything not redirected by the State is paid to the County, which pays the applicable funding to Alameda Health with the understanding that Alameda Health will be responsible for any repayment calculated on final reconciliation. Total AB 85 Realignment revenues included in other government program revenues was a reduction of \$42.1 million for the year ended June 30, 2025. Alameda Health had a liability of \$82.9 million as of June 30, 2025 for this program, as shown in Note 5.

Medi-Cal Managed Care Supplemental Programs – In order to partially bridge the gap between Medi-Cal base rates and the actual cost of providing care, California’s public health care systems have been financing and receiving supplemental payments for services provided to Medi-Cal managed care enrollees. As Medi-Cal is a state/federal partnership, federal funding must be matched by a “nonfederal share,” which, for supplemental payments, is financed by the public hospitals so as to create no additional cost to the State. Each public health system has provided the nonfederal share to the State, and the State has then provided the total enhanced payment with the federal match back to the public health care systems, via Medi-Cal managed care plans including the Quality Incentive Program (QIP) and the Enhanced Payment Program (EPP).

The QIP is designed as payments tied to meeting quality performance metrics. As a result of participating in the QIP, Alameda Health recognized \$82.5 million in revenue for the year ended June 30, 2025. As of June 30, 2025, Alameda Health recorded a receivable of \$106.7 million for this program, as shown in Note 5.

The EPP supplements managed care payments on a flat rate based on number of days and visits provided to that plan’s enrollees, determined by utilization encounter data reported to the State. The rates per day/visit vary depending on the amount of funding allocated to the EPP and the provider class the public health care system falls within. As a result of participating in the EPP, Alameda Health recognized \$68.1 million in revenue for the year ended June 30, 2025. As of June 30, 2025, Alameda Health recorded a receivable of \$108.3 million for this program, as shown in Note 5.

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Voluntary Rate Range Program – Alameda Health participates in the Voluntary Rate Range Program (VRRP) for Medi-Cal managed care plans covering inpatient and outpatient services. DHCS develops additional amounts or “ranges” over and above the monthly capitation amounts calculated for Medi-Cal Managed Care plans in accordance with rate-setting guidelines established by CMS. The VRRP amounts are accessible by Alameda Health. As a result of participating in the VRRP, Alameda Health recognized \$42.6 million in revenue for the year ended June 30, 2025. As of June 30, 2025, Alameda Health recorded a receivable of \$69.8 million for this program as shown in Note 5.

Graduate Medical Education – Alameda Health participates in the Medi-Cal Graduate Medical Education (GME) program, which provides direct resources for resident stipends, supervisory physician salaries, and administrative costs of Alameda Health’s residency program, as well as indirect costs associated with Alameda Health’s residency program that would otherwise result in higher patient care costs in teaching hospitals relative to nonteaching hospitals. This program was approved by CMS on March 19, 2020, and was effective January 1, 2017, mimicking the Medicare GME program. Alameda Health recognized \$18.2 million in revenue for the year ended June 30, 2025. As of June 30, 2025, Alameda Health recorded a receivable of \$8.2 million for this program as shown in Note 5.

DP-NF Pass-Through (DP-NF PT) – Starting January 2023, skilled nursing facilities (SNF) services, previously mostly paid through FFS in Medi-Cal, transitioned to become almost all a managed care plan responsibility (“carve-in”). The State acknowledged that this would reduce funding to public hospitals with DP-NFs because the days would no longer be subject to supplemental payment SNF State Plan Amendment (SPA), which partially makes up the difference between rates and certified costs, but for FFS days only. The state agreed to lessen or eliminate the impact on public hospitals by creating a “pass-through” supplemental payment which would be calculated based on an estimated replacement amount for each hospital and be paid to managed care plans which would in turn have to pass the amounts through to hospitals. A pass-through is a type of supplemental payment program that, under federal regulation, can only exist for three (3) years and must end after that. So, the DP-NF Pass-Through started in calendar year 2023 and its last year will be calendar year 2025. Alameda Health recognized \$19.3 million in revenue for the year ended June 30, 2025. Alameda Health has no receivable related to this program at June 30, 2025.

Hospital Quality Assurance Fee Program –The Hospital Quality Assurance Fee Program (HQA) which provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. The program was enacted In January 2010 by the State and made permanent by the passage of Proposition 52 in November 2016. Alameda Health recognized \$7.1 million in revenue for the year ended June 30, 2025 and a net receivable of \$3.6 million at June 30, 2025. St. Rose recognized \$11.3 million in revenue for the year ended September 30, 2024, and a net receivable of \$8.6 million at September 30, 2024.

California Private Hospital Supplemental Fund – The California Private Hospital Supplemental Fund (PHSF) was created by the Medi-Cal Hospital/Uninsured Care Demonstration Project Act and is a program established to provide supplemental funding to private hospitals that meet specific criteria. The fund is supported by State general funds and is matched by the federal government. St. Rose recognized \$21.2 million in revenue for the year ended September 30, 2024. St. Rose has no receivable related to this program at September 30, 2024.

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Sales Tax Revenue – The State collects and remits to Alameda Health Measure A – Essential Health Services Tax. Measure A was approved by the voters of the County in 2004. Starting in 2005, funds were provided for emergency medical, hospital inpatient, outpatient, public health, mental health, and abuse services to indigent, low-income, and uninsured residents of the County. Measure A was passed by the voters of the County in June 2014 to extend the Essential Health Services Tax through June 30, 2034. Total tax revenues included in other government program revenues were \$146.2 million for the year ended June 30, 2025. Sales taxes receivable from the State were \$25.6 million as of June 30, 2025 for this program, as shown in Note 6.

Other government programs – Alameda Health receives funding for administration of various Medi-Cal programs, including funding under Medi-Cal Administrative Activities (MAA) to reimburse certain costs of administering the Medi-Cal program. MAA revenues of \$3.9 million were included in other operating revenues for the year ended June 30, 2025. Grant revenues, excluding MAA revenues, were \$10.6 million for the year ended June 30, 2025.

Other operating revenue – Other operating revenue for the fiscal years ended were as follows:

	Health System June 30, 2025	St. Rose September 30, 2024
(amounts in thousands)		
Grant revenue	\$ 14.5	\$ 2.5
Other operating revenue	49.5	2.1
	\$ 64.0	\$ 4.6

Note 13 – Charity Care

Alameda Health provides services to patients who are financially screened and qualified to receive charity care under the guidelines of AB 774. Alameda Health records the amount of unreimbursed costs for services and supplies for patients who qualify for the charity care program and county programs based on the Medi-Cal cost to charge ratio. The estimated cost of charity care for the fiscal years ended were as follows:

	Health System June 30, 2025	St. Rose September 30, 2024
(amounts in thousands)		
Charity care cost	\$ 19,044	\$ 760
Percent of operating expenses	1.2%	0.6%

Note 14 – Retirement Plans

Alameda Health participates in three postemployment plans. The tables below summarize net pension liabilities and related balances as of and for the years ended June 30, 2025 and 2024. Further details describing the ACERA plan follow in the summary table below and the other postemployment medical benefits plan in Note 16.

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The AHS DB Plan is not considered material for additional disclosures, with certain exceptions as indicated.

	Health System - June 30, 2025			Total
	ACERA	OPEB	AHS DB Plan	
	(amounts in thousands)			
Net pension obligation	\$ 370,029	\$ -	\$ 371	\$ 370,400
Other postemployment benefits obligation	\$ -	\$ 43,255	\$ -	\$ 43,255
Deferred outflows of resources	\$ (74,398)	\$ (30,636)	\$ (536)	\$ (105,570)
Deferred inflows of resources	\$ 20,845	\$ 19,768	\$ 588	\$ 41,201
Pension expense	\$ (72,660)	\$ -	\$ (621)	\$ (73,281)
Other postemployment benefits expense	\$ -	\$ 4,655	\$ -	\$ 4,655

Alameda County Employees' Retirement Association (ACERA)

Plan description – Alameda Health participates in the cost-sharing multiple employer-employee benefit plans of ACERA. ACERA began operations on January 1, 1948, and is governed by the California Constitution and State and federal laws, including but not limited to the County Employees Retirement Law of 1937 (1937 Act), beginning at California Government Code Section 31450 et. seq., Public Employees' Pension Reform Act (PEPRA), and the bylaws and policies adopted by the Board of Retirement.

ACERA provides service and disability retirement benefits, annual cost-of-living adjustments (COLA), and death benefits to plan members and their beneficiaries. ACERA also provides other non-health postemployment benefits, such as supplemental COLA and a lump-sum death benefit.

The 1937 Act provides the authority for the establishment of ACERA benefit provisions. In most cases where the law provides options concerning the allowance of credit for service, the offering of benefits, or the modification of benefit levels, the law generally requires approval of the employers' governing board for the option to take effect. Separately, in 1984, the Alameda County Board of Supervisors and the Board of Retirement approved the adoption of Article 5.5 of the 1937 Act. This adoption permitted the establishment of a Supplemental Retirees Benefit Reserve (SRBR) for ACERA.

Article 5.5 of the 1937 Act provides for the systematic funding of the SRBR and stipulates that it be used only for the benefit of retired members and their beneficiaries. The law grants discretionary authority over the use of the SRBR funds to the Board of Retirement. Supplemental benefits currently provided through the SRBR include supplemental COLA, supplemental retired member death benefits, active death equity benefits, and the retiree monthly medical allowance, vision, dental, and Medicare Part B coverage. The payment of supplemental benefits from the SRBR is subject to available funding and must be periodically reauthorized by the Board of Retirement. SRBR benefits are not vested. In 2006, the Board of Retirement approved the allocation of SRBR funds to postemployment medical benefits and other pension benefits. These two programs provide the supplemental benefits described above.

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Notes to Financial Statements

Employers participating in ACERA include County of Alameda (General and Safety), First 5 Alameda County, Housing Authority of the County of Alameda, Alameda The Health System, Livermore Area Recreation and Park District, Superior Court of California—County of Alameda, and Alameda County Office of Education. Alameda Health's employees are classified as general members. All full-time employees of participating employers who are appointed to permanent positions are statutorily required to become members of ACERA, with the exception of The Health System employees of Alameda Hospital and San Leandro Hospital, unless they are subject to an existing memorandum of understanding. Effective October 31, 2013, all newly hired unrepresented employees of any The Health System facility are prohibited from membership.

Any new member who becomes a member on or after January 1, 2013, is placed into Tier 4 and is subject to the provisions of PEPRA, California Government Code 7522 et seq. and AB 197.

General members enrolled in Tiers I, II, or III are eligible to retire at the age of seventy, regardless of service, or at age fifty with five or more years of retirement service credit and a total of ten years of qualifying membership. A non-Tier IV general member with thirty years of service is eligible to retire regardless of age. General members enrolled in Tier IV are eligible to retire at the age of fifty-two and have acquired five years of retirement service credit or at age seventy, regardless of service. The retirement benefits the member will receive are based upon age at retirement, final average compensation, years of retirement service credit, and retirement plan and tier.

ACERA provides an annual cost-of-living benefit to all retirees. The COLA, based upon the consumer price index (CPI) for the San Francisco-Oakland-San Jose Area (with 1982-84 as the base period), is capped at 3.0% for Tiers I and III, and at 2.0% for Tiers II and IV.

Additional information regarding benefit tiers, eligibility requirements, and benefits are described in ACERA Annual Comprehensive Financial Report (ACFR). The ACFR for December 31, 2024, may be obtained by writing to ACERA, 475 14th Street, Suite 1000, Oakland, California 94612.

Contributions – Member and employer contribution rates are based on recommendations made by an independent actuary and adopted by the Board of Retirement. These rates are based on membership type (general and safety) and tier (Tiers I, II, III, and IV). Active members are required by statute to contribute toward pension plan benefits. Participating employers are required by statute to contribute the necessary amounts to fund estimated benefits not otherwise funded by member contributions or expected investment earnings.

Participating agencies contribute to the retirement plan based upon actuarially determined contribution rates adopted by the ACERA Board of Retirement. Employer contribution rates are adopted annually based upon recommendations received from ACERA's actuary after the completion of the annual actuarial valuation. The average employer contribution rate for calendar year 2024 (based on the December 31, 2022, valuation for the second half of 2023/2024 and on the December 31, 2023, valuation for the first half of 2024/2025) was 23.2%.

Members are required to make contributions to ACERA regardless of the retirement plan or tier. The average member contribution rate for calendar year 2024 (based on the December 31, 2022, valuation for the second half of 2023/2024 and on the December 31, 2023, valuation for the first half of 2024/2025) was 10.1% of compensation.

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

Actuarial methods and assumptions used to determine total pension obligation – For the measurement period ended December 31, 2024 (the measurement date), the total pension obligation was determined by rolling forward the December 31, 2023, total pension obligation. The actuarial assumptions used to develop the December 31, 2024, total pension obligation were based on the assumptions adopted annually by the Retirement Board for use in the year ended December 31, 2024. These assumptions were applied to all periods included in the measurement:

	Valuation Date
	December 31, 2024
Actuarial cost method	Entry age normal
Actuarial assumptions:	
Discount rate	7.00%
Inflation	2.50%

	Valuation Date
	December 31, 2024
Salary increases	General: 3.45% to 8.00%; and Safety: 4.00% to 11.40%, vary by service, including inflation.
Investment rate of return	7.00% net of pension plan investment, expenses, including inflation.
Mortality rate table	Pub-2010 General healthy Retiree Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2021.
Postretirement benefit increases	2.75% of Tier I and Tier III retirement income 2.00% of Tier II and Tier IV retirement income Non-OPEB – Payable when the current allowance from the pension plan drops below 85% of the original pension plan benefit indexed with CPI. Benefits are assumed to increase by the difference between inflation and the cost-of-living benefit guaranteed in the pension plan, subject to other limitations.

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

The changes in net pension obligation for the ACERA plan and the AHS DB Plan.

	June 30, 2025
	(amounts in thousands)
Beginning net pension obligation	\$ 426,007
Pension expense	73,281
Employer contributions	(73,668)
New net deferred inflows/outflows	(39,394)
Change in allocation of prior deferred inflows/outflows	810
New net deferred flows due to change in proportion	3,721
Recognition of prior deferred inflows/outflows	(20,161)
Recognition of prior deferred flows due to change in proportion	(196)
Ending net pension obligation	\$ 370,400

The target allocation and projected arithmetic real rates of return for each major asset class, after deducting inflation but before deduction investment expenses, used in the derivation of the long-term expected investment rate of return assumptions are summarized in the following table:

	Target Allocation	Long-Term (Arithmetic) Expected Real Rate of Return
Domestic Large Cap Equity	21.60%	6.00%
Domestic Small Cap Equity	2.40%	6.65%
International Developed Equity	16.30%	7.01%
International Small Cap Equity	2.90%	7.34%
Emerging Market Equity	4.80%	8.80%
Core Plus Fixed Income	10.50%	1.97%
High Yield Bonds	1.50%	4.63%
Global Fixed Income	2.00%	1.17%
Private Equity	11.00%	9.84%
Core Real Estate	6.30%	3.86%
Value Added Real Estate	1.80%	6.70%
Opportunistic Real Estate	0.90%	8.60%
Commodities	0.90%	4.21%
Private Credit	4.00%	6.47%
Absolute Return	8.00%	2.10%
Infrastructure	5.10%	7.30%
Total	100.00%	

Discount rate – The discount rate used to measure the total pension obligation was 7.0% as of December 31, 2024. In order to reflect the provisions of Article 5.5 of the 1937 Act, future allocations of 50.0% excess earnings to the SRBR have been treated as an additional outflow against the plan’s fiduciary net position in the GASB crossover test. It is estimated that the additional outflow would average 0.75% of assets over time, based on the results of the actuary’s stochastic modeling of the 50.0% allocation of future excess earnings to the SRBR.

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

The projection of cash flows used to determine the discount rate assumes that plan member contributions will be made at the current member contribution rates, and that employer contributions will be made at rates equal to the actuarially determined contribution rates plus additional future contributions that would follow from the allocation of excess earnings to the SRBR. Projected employer contributions that are intended to fund the service cost for the future plan members and their beneficiaries, as well as projected contributions from future plan members, are not included. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments for the current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension obligation as of December 31, 2024.

Pension plan fiduciary net position – The net pension obligation was measured as of December 31, 2024. Plan fiduciary net position was valued as of the measurement date while the total pension obligation was determined based upon rolling forward the total pension obligation from actuarial valuations as of December 31, 2023.

The total pension obligation and fiduciary net position include liabilities and assets for non-health postemployment benefits (Non-OPEB). The assets for Non-OPEB are held in the SRBR to pay nonvested supplemental COLA and the retired death benefit. The liability and assets associated with the Other Postemployment Benefits (postemployment health-related benefits) (OPEB) component of the SRBR have been excluded from the total pension obligation and the fiduciary net position reported above.

Detailed information about pension plan fiduciary net position is available in the separately issued ACERA financial report.

Sensitivity of the net pension obligation to changes in the discount rate – The following presents the net pension obligation of ACERA as of December 31, 2024, which is allocated to all employers, calculated using the discount rate of 7.0%, as well as what ACERA's net pension obligation would be if it were calculated using a discount rate that is 1-percentage-point lower (6.0%) or 1-percentage-point higher (8.0%) than the current rate.

	1% Decrease (6.00%)	Discount Rate (7.00%)	1% Increase (8.00%)
	(amounts in thousands)		
ACERA plan net pension obligation	\$ 689,715	\$ 370,029	\$ 106,854

Recognition of gains and losses – Under GASB Statement No. 68, *Accounting and Financial Reporting for Pensions—an amendment of GASB Statement No. 27*, gains and losses related to changes in total pension obligation and fiduciary net position are recognized in pension expense systematically over time.

The first amortized amounts are recognized in pension expense for the year the gain or loss occurs. The remaining amounts are categorized as deferred outflows and deferred inflows of resources related to pensions and are to be recognized in future pension expense.

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

The amortization period differs depending on the source of the gain or loss:

Source of Gain or Loss	Amortization Method
Difference between projected and actual earnings	Five-year straight-line amortization
All other amounts	Straight-line amortization over the average expected remaining service lives of all members that are provided with benefits (active, inactive, and retired) as of the beginning of the measurement period.

The average of the expected service lives of all employees is determined by:

- Calculating each active employee's expected remaining service life as the present value of \$1 per year of future service at zero percent interest.
- Setting the remaining service life to zero for each nonactive or retired member.
- Dividing the sum of the above amounts by the total number of active employees, nonactive, and retired members.

The average of the expected service lives of all employees that are provided with pensions through the ACERA plan is 4.84 years as determined as of December 31, 2023 (the beginning of the measurement period ended December 31, 2024).

Pension deferred outflows and deferred inflows – Alameda Health reports deferred outflows and deferred inflows of resources related to the ACERA plan and AHS DB plan.

The pension deferred outflows and inflows of resources at June 30, 2025, recognized during the measurement period ended December 31, 2024, are as follows:

	Deferred Outflows of Resources	Deferred Inflows of Resources
	(amounts in thousands)	
Pension contributions subsequent to the measurement date	\$ 40,818	\$ -
Difference between expected and actual experience	18,146	5,576
Changes in assumptions	3,485	14,389
Net difference between projected and actual earnings on pension plan investments	785	227
Adjustment due to differences in proportions	11,700	1,241
Total	<u>\$ 74,934</u>	<u>\$ 21,433</u>

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Amounts reported as deferred outflows and deferred inflows of resources related to pensions, other than the employer-specific item, will be recognized in future pension expense as follows:

<u>Measurement Periods Ending December 31,</u>	<u>Deferred Outflows (Inflows) of Resources</u>
	(amounts in thousands)
2026	\$ 55,134
2027	32,562
2028	(25,626)
2029	(8,645)
2030	25
Thereafter	51
	\$ 53,501

ACERA's financial statements and required supplementary information are audited annually by independent auditors. The audit report and the financial statements may be obtained by writing to ACERA, 475 14th Street, Suite 1000, Oakland, California 94612.

Note 15 – Fair Value of Assets

AHS DB Plan – The AHS DB Plan has assets that are held in trust with U.S. Bank. The AHS DB Plan's policy for allocation of invested assets is established and may be amended by the Retirement Committee of the Health System's Board of Trustees through a majority vote. It is the policy to pursue an investment strategy that reduces risk through the prudent diversification of the portfolio across a broad selection of specific asset classes. Assets held in the Retirement Plan are limited to those within the terms of the trust agreement and the participation agreement, and any applicable plan documents and in accordance with California Government Code. The investment policy has a long-term focus. It discourages both major shifts of asset class allocations over a short time span and, except for liquidity purposes, the use of cash equivalents. There is no established net rate of return or asset allocation policy. U.S. Bank did not violate any provisions of the investment policy during the fiscal year ended June 30, 2025. At June 30, 2025, the AHS DB Plan held no investments in any one organization that represented 5.0% or more of its fiduciary net position.

Investments – Investments, investments restricted for capital, and investments held by trustee – Investments in marketable securities are reported at fair value and are based on quoted market prices. Net appreciation or depreciation in investments, including realized gains or losses and unrealized appreciation or depreciation on those investments, as well as all dividends, interest, and other investment income, is reported in the statements of activities as investment return, net. Investment return, net, is reported as an increase in net position, restricted for health programs or restricted for capital assets, depending on donor-imposed restrictions on the use of the income.

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Notes to Financial Statements

Beneficial interests in perpetual trusts utilize significant unobservable inputs in estimating fair value due to their unique features, including no active market for selling the beneficial interests. Discounted present value calculations of future cash flows are used to approximate fair values of St. Rose's beneficial interest in the perpetual trust. Because the underlying assets of the perpetual trust are Level 1 investments for which quoted market values were available at September 30, 2024, St. Rose determined that its 50 percent share in the trust could be calculated by multiplying the trust's total fair value by St. Rose's share in the trust, which closely approximated the discounted present value of the trust assets.

Investments are measured at fair value on a recurring basis. Recurring fair value measurements are those that GASB require or permit in the statement of net position at the end of each reporting period. Fair value measurements are categorized based on the valuation inputs used to measure an asset's fair value: Level 1 inputs are quoted prices in active markets for identical assets; Level 2 inputs are significant other observable inputs; Level 3 inputs are significant unobservable inputs. The mutual funds are priced using a net asset value (NAV). Mutual funds may include several different underlying investments, including equities, bonds, real estate, and global securities. The NAV price is derived from the value of these investments, accrued income, anticipated cash flows (maturities), management fees, and other fund expenses. Certain investments within the fund may be deemed unobservable and not considered to be in an active market.

The following table presents the fair value measurements of financial instruments recognized in the accompanying fiduciary statements of net position measured at fair value on a recurring basis and the level within the GASB Statement No. 72, *Fair Value Measurement and Application*, fair value hierarchy in which they fall as of June 30, 2025.

The fair value of asset of the AHS DB Plan were as follows:

	Fair Value Measurement as of June 30, 2025			
	Level 1	Level 2	Level 3	Total
	(amounts in thousands)			
Mutual funds - equity	\$ 3,183	\$ -	\$ -	\$ 3,183
Mutual funds - fixed income	1,795	-	-	1,795
Cash and cash equivalents	92	-	-	92
Total	<u>\$ 5,070</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 5,070</u>

Alameda Health System, A Public Hospital Authority
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The fair value of St. Rose investments, investments restricted for capital, and investments held by trustee were as follows:

	Fair Value Measurement as of September 30, 2024			
	Level 1	Level 2	Level 3	Total
	(amounts in thousands)			
Investments				
Mutual funds - equity	\$ 185	\$ -	\$ -	\$ 185
Equity securities	473	-	-	473
Cash and cash equivalents	3,585	-	-	3,585
Total investments	4,243	-	-	4,243
Investments restricted for capital				
Mutual funds - equity	234	-	-	234
Equity securities	603	-	-	603
Cash and cash equivalents	17	-	-	17
Total investments restricted for capital	854	-	-	854
Investments held by trustee				
Beneficial interest in a trust	-	-	1,050	1,050
Total investments held by trustee	-	-	1,050	1,050
	<u>\$ 5,097</u>	<u>\$ -</u>	<u>\$ 1,050</u>	<u>\$ 6,147</u>

The fair value of Foundation Investments were as follows:

	Fair Value Measurement as of June 30, 2025			
	Level 1	Level 2	Level 3	Total
	(amounts in thousands)			
Investments				
Exchange-traded funds	\$ 245	\$ -	\$ -	\$ 245
Mutual funds - fixed income	11,148	-	-	11,148
Mutual funds - equity	2,566	-	-	2,566
Other assets	683	-	-	683
Cash and cash equivalents	212	-	-	212
Total investments	<u>\$ 14,854</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 14,854</u>

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

Note 16 – Other Postemployment Benefits Medical Plan

Plan description – Alameda Health participates in an OPEB plan, wherein cost-sharing multiple employer medical benefits are administered by ACERA for retired members and their eligible dependents. The OPEB plan is not a benefit entitlement program and benefits are subject to modification and/or deletion by the ACERA Board of Retirement. Annually, based on the recommendation of the Board of Retirement, the Board of Supervisors designates a portion of the County and the Health System’s contribution to retirement towards medical premiums of retirees.

Alameda Health arranges health insurance coverage for employees, negotiating coverage levels, and premium rates annually with several carriers. Employees who meet certain eligibility conditions and make the required contributions may continue coverage in those same health plans after retirement until they become Medicare eligible. Currently, Alameda Health uses a single blended rate for budgeting and setting premium and contribution rates for both active employees and non-Medicare eligible retirees. Alameda Health funds the premiums for employees while ACERA funds the premiums for retirees. ACERA establishes the amount of the Monthly Medical Allowance (MMA). The MMA has been set at \$662 in 2025 for retirees who are not purchasing insurance through the Medicare exchange.

For those purchasing individual insurance through the Medicare exchange, the MMA will be \$507 per month in 2025 and subject to the following subsidy schedule:

<u>Completed Years of Service</u>	<u>Percentage Subsidized</u>
10-14	50%
15-19	75%
20+	100%

Funding policy – Retired employees from Alameda Health receive an MMA toward the cost of their health insurance from the SRBR. The SRBR is a funded trust that receives fifty percent of the investment earnings that are in excess of the target investment return of the ACERA pension fund. Alameda Health does not make postemployment medical benefit payments directly to retirees and does not have the ability to fund these benefits. However, Alameda Health’s pension contribution would be lower if not for the excess interest transfer to the SRBR.

Reporting and measurement dates of the plan and Alameda Health – The reporting date for the employer (Alameda Health) under GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* (GASB 75), is June 30, 2025. The reporting date and measurement date for the plan under GASB Statement No. 74, *Financial Reporting for Postemployment Benefit Plans Other Than Pensions Plans*, is December 31, 2024. Consistent with the provisions of GASB 75, the assets and liabilities of the plan, as measured as of December 31, 2024, are not adjusted or rolled forward to the June 30, 2025 reporting date of Alameda Health.

Determination of proportionate share – Other results, such as the total deferred inflows and outflows, would also be allocated based on the determination of Alameda Health’s proportionate share of the OPEB obligation, calculated at 18.4%. The determination is based on the total employer contributions from January 1 through December 31, 2023, as provided by ACERA. Alameda Health’s share of the total OPEB liability is the ratio of Alameda Health’s total contributions to the total contributions for all participating employers.

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The net obligation, service cost, interest on the total obligation, current-period benefit changes, expenses portion of current-period difference between actual and expected experience in the total obligation, expenses portion of current-period changes of assumptions or other inputs, member contributions, projected earnings on plan investments, expensed portion of current-period differences between actual and projected earnings on plan investments, administrative expense, recognition of beginning of year deferred outflows of resources as expense, and recognition of beginning of year deferred inflows of resources as expense, are allocated based on Alameda Health's proportionate share of the obligation.

Components of postemployment medical benefits expense as calculated under the requirements of GASB 75 for Alameda Health, were as follows:

	June 30, 2025
	(amounts in thousands)
Service cost	\$ 7,060
Interest	16,946
Changes in proportion	116
Differences between expected and actual experience	(826)
Changes of assumptions	372
Projected earnings on plan investments	(13,677)
Differences between actual and projected earnings on investments	(795)
Administrative expense	370
Other	-
Beginning of year deferred outflows	26,454
Beginning of year deferred inflows	(31,197)
Net amortization of deferred amounts	(168)
Total postemployment medical benefits expense	\$ 4,655

Components of deferred inflows and outflows of resources as calculated under the requirements of GASB 75 for Alameda Health are as follows:

	June 30, 2025	
	Deferred Outflows of Resources - OPEB	Deferred Inflows of Resources - OPEB
	(amounts in thousands)	
Changes in proportion	\$ 1,361	\$ 525
Difference between expected and actual experience	4,735	13,046
Net difference between projected and actual earnings on OPEB plan investments	24,540	-
Changes in assumptions	-	6,197
Total	\$ 30,636	\$ 19,768

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

Amounts reported as deferred outflows and inflows of resources for postemployment medical benefits that will be recognized in postemployment medical benefits expense for Alameda Health for the year ending, are as follows:

Measurement Periods Ending December 31,	Deferred Outflows (Inflows) of Resources - OPEB (amounts in thousands)
2026	\$ 2,387
2027	17,796
2028	(6,039)
2029	(2,592)
2030	(589)
Thereafter	(95)
	\$ 10,868

The ACERA total net OPEB obligation, and the ACERA OPEB plan's fiduciary net position (deficit) was as follows:

	June 30, 2025 (amounts in thousands)
ACERA - OPEB obligation	\$ 1,330,606
ACERA - fiduciary net position (deficit)	1,101,639
ACERA net OPEB obligation	\$ 228,967
ACERA plan's fiduciary net position (deficit) as a percentage of the total OPEB obligation	82.8%

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Notes to Financial Statements

The summarized actuarial assumptions and methods used to determine the OPEB liabilities and OPEB plan fiduciary net position, was as follows:

	Valuation Date
	December 31, 2024
Actuarial cost method	Entry age cost method
Asset valuation method	Not applicable
Actuarial assumptions:	
Projected salary increases	2.50% per year due to inflation, plus 0.50% "across the board", plus merit and promotional increases based years of service
Mortality	Pub-2010 General Employee Headcount-Weighted Above-Median Mortality Tables, projected generationally with the two-dimensional mortality improvement scale MP-2021
Discount rate	7.0%
Health care cost trend rates:	
Non-Medicare medical plan	7.75% graded to ultimate 4.50% over 13 years
Medicare medical plan	7.50% graded to ultimate 4.50% over 12 years
Dental	6.00% in 2025, then 5.00% graded to ultimate 4.00% over 3 years
Vision	3.00%
Medicare Part B	6.20% until 2033, then 5.75% graded to ultimate 4.50% over 6 years

Sensitivity of postemployment medical benefits obligation due to change in discount rates:

	1% Decrease	Current Discount Rate	1% Increase
	6.0%	7.0%	8.0%
	(in thousands)		
ACERA plan net OPEB obligation	\$ 77,937	\$ 43,255	\$ 14,643

Sensitivity of postemployment medical benefits obligation due to change in health care cost trend:

	1% Decrease	Current Trend Rate	1% Increase
	(in thousands)		
ACERA plan net OPEB obligation	\$ 12,098	\$ 43,255	\$ 81,765

ACERA's financial statements and required supplementary information are audited annually by independent auditors. The audit report and financial statements may be obtained by writing to ACERA, 475 14th Street, Suite 1000, Oakland, California 94612.

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Note 17 – Defined Contribution Retirement Savings Plans

Deferred Compensation Plan - 403(b) Retirement Savings Plan – Alameda Health provides a retirement savings plan as allowed under the Internal Revenue Code Section 403(b). The plan allows employees to defer compensation earned. Individual accounts are maintained for each participant. The plan is administered by Prudential Financial and is governed by Alameda Health's Board of Trustees.

Contributions to the deferred compensation plan are funded through participant contributions. Participants can elect to reduce their compensation by a specific percentage of their qualified compensation and make pre-tax or post-tax deferrals. Elective deferrals in any calendar year cannot exceed the statutory limit for that year and eligible total compensation may be limited. Alameda Health does not make matching contributions to the plan. Total employee deferrals into the plan were \$16.7 million for fiscal year 2025.

Deferred Compensation Plan - Governmental 457(b) Plan – Alameda Health provides a nonqualified deferred compensation plan as allowed under the Internal Revenue Code Section 457(b). The plan allows eligible employees to defer a portion of their salary to the plan on a pre-tax basis. Individual accounts are maintained for each participant. The deferred compensation is not available to employees until termination, retirement, death, or an unforeseeable emergency.

Contributions to the deferred compensation plan are funded through participant contributions. Participants can elect to reduce their compensation by a specific dollar amount and make pre-tax deferrals. Elective deferrals in any calendar year cannot exceed the statutory limit for that year and eligible total compensation may be limited. Alameda Health does not make any matching contributions to the plan. Total employee deferrals into the plan were \$17.0 million for fiscal year 2025.

Deferred Compensation Plan – 403(b) Savings Plan – St. Rose sponsors a 403(b) plan for certain union represented and non-union employees. Eligible employees may participate without regard to age or years of service. St. Rose may also make discretionary contributions to the Plan. During the year ended September 30, 2024, St. Rose made discretionary contributions based on matching 50% of an eligible employee's contributions up to a maximum of 3% of the employee's gross compensation. Total matching contributions made by St. Rose during the year ended September 30, 2024 was \$0.8 million.

Note 18 – Insurance and Self-Insurance Plans

Alameda Health – Alameda Health is exposed to various risks of loss related to torts; medical malpractice; theft of, damage to, and destruction of assets; errors and omissions; injuries to employees; natural disasters; unemployment; and health benefits to employees and retirees.

Alameda Health is self-insured for workers' compensation liability and partially self-insured for hospital professional liability. Excess workers' compensation coverage is provided by the California State Association of Counties' Excess Insurance Authority (CSAC), a joint powers authority, the purpose of which is to develop and fund programs of excess insurance and provide the joint purchase of coverage from independent third parties for its member entities. CSAC is governed by a Board of Directors consisting of representatives of its member entities.

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Alameda Health purchased occurrence coverage for general, automobile, directors', and officers' liability and claims-made coverage for hospital professional liability from BETA Healthcare Group (Beta), a joint powers authority that operates insurance programs for certain California hospitals.

Alameda Health paid an annual premium of \$14.9 million to Beta and PRISM, formerly CSAC, for the year ended June 30, 2025. Alameda Health pays administrative fees to a third-party administrator (TPA) to process claims and reimburses the TPA for distributions. Claims have not exceeded Alameda Health's policy limits in the past three years.

Selected insurance coverage of Alameda Health for fiscal year 2025 are as follows:

	Policy Limit	Self-Insurance Retention
	(amounts in thousands)	
Hospital liability (medical malpractice)	\$ 40,000	\$ 500
Fiduciary liability	\$ 15,000	\$ 25
Automobile insurance	\$ 20,000	\$ -
Director and officer	\$ 10,000	\$ 200
Excess workers' compensation	Statutory limit	\$ 2,000
Privacy liability	\$ 10,000	\$ 500
Crime	\$ 10,000	\$ 3
Pollution liability	\$ 3,000	\$ 100
Property	\$ 600,000	\$ 50

Prior to July 1, 2001, Alameda Health participated in the County's self-insurance program. The County has recorded an estimate of the ultimate cost of all Alameda Health workers' compensation claims and medical malpractice liability claims incurred before July 1, 2001. Alameda Health is self-insured for workers' compensation for claims incurred after July 1, 2001. For medical malpractice liabilities, all claims made after July 1, 2001, are covered by Alameda Health's purchased claims-made insurance policies with Beta. There are known claims and incidents that may result in the assertion of additional claims as well as claims from unknown incidents that have already occurred.

The estimated liabilities for workers' compensation and hospital liability claims and contingencies are actuarially calculated considering the effects of inflation, recent claim settlement trends, including frequency and amount of pay-outs, and other economic and social factors. The workers' compensation estimate includes allocated loss adjustment expenses, which represent the direct cost associated with the defense of individual claims as well as unallocated loss adjustment expenses, which represent the costs to administer all claims to final settlement, which may be years into the future.

The hospital liability estimate includes allocated loss adjustment expenses, which represent the direct cost associated with the defense of individual claims for medical malpractice, general liability, and director and officer liability. Unallocated loss adjustment expenses are not included in the hospital liability estimate due to the fact that the excess insurance carrier for hospital liability claims provides all claims administration costs. Both estimates made have been discounted to their present value for amounts recorded using a rate of 2.0% as of June 30, 2025.

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

Changes in the self-insurance liabilities for Alameda Health for the year ended June 30, 2025, were as follows:

	Hospital Liability	Workers' Compensation	Total
	(amounts in thousands)		
Balance, June 30, 2024	\$ 8,584	\$ 39,689	\$ 48,273
Current year claims and changes in estimate	1,059	11,867	12,926
Settlements	-	(7,686)	(7,686)
Balance, June 30, 2025	\$ 9,643	\$ 43,870	\$ 53,513

St. Rose – St. Rose has a commercial insurance policy for malpractice and general liability claims. The policy is written on a claims-made basis with a \$100,000 deductible per claim for 2024 and a liability limit of \$20,000,000 per occurrence and in aggregate per policy period. The estimated liability is based on actuarially calculated considering the effects of inflation, recent claim settlement trends, including frequency and amount of pay-outs, and other economic and social factors. The estimate was discounted to their present value for amounts recorded using a rate of 3.0% as of September 30, 2024.

St. Rose has a commercial insurance policy for workers' compensation and employer's liability claims. The deductibles for prior policy periods are: \$500,000 per claim for claims incurred from July 2005 through June 2008; \$150,000 per claim for claims incurred from July 2008 through June 2011; and \$200,000 per claim for claims incurred from July 2011 through June 2024. The policy covers state-required statutory workers' compensation benefits and employer's liability benefits with a limit of \$1,000,000 per claim. The estimated liability is based on actuarially calculated considering the effects of inflation, recent claim settlement trends, including frequency and amount of pay-outs, and other economic and social factors. The estimate was discounted to their present value for amounts recorded using a rate of 3.0% as of September 30, 2024.

Changes in the self-insurance for St. Rose for the year ended September 30, 2024, were as follows:

	Hospital Liability	Workers' Compensation	Total
	(amounts in thousands)		
Balance, October 1, 2023	\$ 665	\$ 2,845	\$ 3,510
Current year claims and changes in estimate	(79)	(667)	(746)
Balance, September 30, 2024	\$ 586	\$ 2,178	\$ 2,764

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

Note 19 – Leases

Lease receivables – St. Rose MOB has noncancelable leases for office space with ranging lease terms extending through 2029 and accounts for these arrangements in accordance with GASB 87. St. Rose MOB does not have any commitments that were incurred at the commencement of the leases. There was no preferential treatment granted to tenants. Variable rent receipts are recorded when incurred as other revenue on the statements of revenues, expenses, and changes in net (deficit) position.

Changes in lease receivable of St. Rose MOB for the year ended September 30, 2024, were as follows:

	<u>October 1, 2023</u>	<u>Increases</u>	<u>Decreases</u>	<u>September 30,</u>	<u>Current Portion</u>
			(amounts in thousands)	2024	
Lease receivable	\$ 5,218	\$ -	\$ (1,266)	\$ 3,952	\$ 1,344

Changes in deferred cash inflows of St. Rose MOB for the year ended, were as follows:

	<u>October 1, 2023</u>	<u>Increases</u>	<u>Decreases</u>	<u>September 30,</u>
			(amounts in thousands)	2024
Deferred inflows of resources lease income	\$ (5,218)	\$ -	\$ 1,765	\$ (3,454)

The future receipts for St. Rose MOB, are as follows:

	<u>Principal</u>	<u>Interest</u>	<u>Total</u>
	(amounts in thousands)		
<u>Years Ending September 30,</u>			
2025	\$ 1,397	\$ 228	\$ 1,625
2026	1,200	189	1,389
2027	678	111	789
2028	497	81	578
2029	180	28	208
	<u>\$ 3,952</u>	<u>\$ 637</u>	<u>\$ 4,589</u>

Right-to-Use lease assets and lease obligations – The Health System has noncancelable leases for buildings and equipment with ranging lease terms extending through 2034 and accounts for these arrangements in accordance with GASB 87. There are no residual value guarantees included in the measurement of the lease obligations nor recognized as an expense in the current fiscal year. The Health System does not have any commitments that were incurred at the commencement of the leases. Variable equipment usage payments are expensed when incurred. There are no amounts recognized as variable lease payments as lease expense on the statements of revenues, expenses, and changes in net (deficit) position. No termination penalties were incurred during the fiscal year.

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

Changes in right-to-use lease assets of Alameda Health for the year ended June 30, 2025, were as follows:

	<u>July 1, 2024</u>	<u>Increases</u>	<u>Decreases</u>	<u>June 30, 2025</u>
		(amounts in thousands)		
Right-to-use assets	\$ 57,881	\$ -	\$ -	\$ 57,881
Less: accumulated amortization	<u>(18,796)</u>	<u>(7,481)</u>	<u>-</u>	<u>(26,277)</u>
Right-to-use assets, net	<u>\$ 39,085</u>	<u>\$ (7,481)</u>	<u>\$ -</u>	<u>\$ 31,604</u>

For the year ended June 30, 2025, Alameda Health recognized \$7.5 million of amortization expense, which is included in depreciation and amortization expense in the statements of revenues, expenses, and changes in net (deficit) position. The Health System evaluated the right-to-use lease assets for impairment and determined that no impairment occurred during the year ended June 30, 2025.

Changes in lease obligations of Alameda Health for the year ended June 30, 2025, were as follows:

	<u>July 1, 2024</u>	<u>Increases</u>	<u>Decreases</u>	<u>June 30, 2025</u>	<u>Current Portion</u>
		(amounts in thousands)			
Lease obligations	\$ 42,618	\$ -	\$ (6,149)	\$ 36,469	\$ 6,730

The future payments of lease principal and interest for Alameda Health are as follows:

	<u>Principal</u>	<u>Interest</u>	<u>Total</u>
	(amounts in thousands)		
<u>Years Ending June 30,</u>			
2026	\$ 6,730	\$ 1,033	\$ 7,763
2027	6,025	837	6,862
2028	3,692	683	4,375
2029	3,821	566	4,387
2030	3,773	446	4,219
2031 - 2035	<u>12,428</u>	<u>700</u>	<u>13,128</u>
	<u>\$ 36,469</u>	<u>\$ 4,265</u>	<u>\$ 40,734</u>

Changes in right-to-use lease assets of St. Rose for the year ended September 30, 2024, were as follows:

	<u>October 1, 2023</u>	<u>Increases</u>	<u>Decreases</u>	<u>September 30, 2024</u>
		(amounts in thousands)		
Right-to-use assets	\$ 1,556	\$ -	\$ -	\$ 1,556
Less accumulated amortization	<u>(194)</u>	<u>(195)</u>	<u>-</u>	<u>(389)</u>
Right-to-use assets, net	<u>\$ 1,362</u>	<u>\$ (195)</u>	<u>\$ -</u>	<u>\$ 1,167</u>

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

For the year ended September 30, 2024, the St. Rose recognized \$0.2 million of amortization expense, which is included in depreciation and amortization expense in the statements of revenues, expenses, and changes in net (deficit) position. St. Rose evaluated the right-to-use lease assets for impairment and determined that no impairment occurred during the year ended September 30, 2024.

Changes in lease obligations of St. Rose for the year ended September 30, 2024, were as follows:

	<u>October 1, 2023</u>	<u>Increases</u>	<u>Decreases</u>	<u>September 30, 2024</u>	<u>Current Portion</u>
		(amounts in thousands)			
Lease obligations	\$ 1,394	\$ -	\$ (171)	\$ 1,223	\$ 179

The future payments of lease principal and interest for St. Rose, are as follows:

	<u>Principal</u>	<u>Interest</u>	<u>Total</u>
	(amounts in thousands)		
<u>Years Ending September 30,</u>			
2025	\$ 179	\$ 57	\$ 236
2026	188	48	236
2027	198	38	236
2028	208	28	236
2029	219	17	236
2030 - 2034	231	6	237
	<u>\$ 1,223</u>	<u>\$ 194</u>	<u>\$ 1,417</u>

Note 20 – Right-of-Use Subscription Assets and Subscription Obligations

The Health System has entered into SBITAs with ranging terms extending until 2030 and accounts for these arrangements in accordance with GASB 96.

Health System – During the year ended June 30, 2025, Alameda Health recognized \$2.9 million of amortization expense, which is included in depreciation and amortization expense in the statements of revenues, expenses, and changes in net (deficit) position. Alameda Health evaluated the right-of-use subscription assets for impairment and determined that no impairment occurred during the year ended June 30, 2025.

Changes in right-of-use subscription assets for the year ended June 30, 2025, were as follows:

	<u>July 1, 2024</u>	<u>Increases</u>	<u>Decreases</u>	<u>June 30, 2025</u>
		(amounts in thousands)		
Right-of-use subscription assets	\$ 942	\$ 10,191	\$ (2,099)	\$ 9,034
Less: accumulated amortization	(246)	(2,870)	2,099	(1,017)
Right-of-use subscription assets, net	<u>\$ 696</u>	<u>\$ 7,321</u>	<u>\$ -</u>	<u>\$ 8,017</u>

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

During the year ended June 30, 2025, total payments under SBITAs were \$4.0 million. Additionally, Alameda Health incurred no variable SBITA expenses during the year ended June 30, 2025. Alameda Health did not enter into any additional SBITAs that have yet to commence as of June 30, 2025.

Changes in subscription obligations for the year ended June 30, 2025, were as follows:

	<u>July 1, 2024</u>	<u>Increases</u>	<u>Decreases</u>	<u>June 30, 2025</u>	<u>Current Portion</u>
		(amounts in thousands)			
Right-of-use subscription liability	\$ 870	\$ 10,191	\$ (4,012)	\$ 7,049	\$ 3,278

The future payments of subscription obligation principal and interest as of June 30, 2025, are as follows:

<u>Year Ending June 30,</u>	<u>Principal Payments</u>	<u>Interest Payments</u>	<u>Total</u>
	(amounts in thousands)		
2026	\$ 3,278	\$ 138	\$ 3,416
2027	1,989	91	2,080
2028	889	77	966
2029	710	63	773
2030	183	2	185
	<u>\$ 7,049</u>	<u>\$ 371</u>	<u>\$ 7,420</u>

St. Rose – During the year ended September 30, 2024, *St. Rose* recognized \$0.3 million of amortization expense, which is included in depreciation and amortization expense in the statements of revenues, expenses, and changes in net (deficit) position. *St. Rose* evaluated the right-of-use subscription assets for impairment and determined that no impairment occurred during the year ended September 30, 2024.

Changes in right-of-use subscription assets for the year ended September 30, 2024 is below:

	<u>October 1, 2023</u>	<u>Increases</u>	<u>Decreases</u>	<u>September 30, 2024</u>
		(amounts in thousands)		
Right-of-use subscription assets	\$ 942	\$ -	\$ -	\$ 942
Less: accumulated amortization	-	(246)	-	(246)
Right-of-use subscription assets, net	<u>\$ 942</u>	<u>\$ (246)</u>	<u>\$ -</u>	<u>\$ 696</u>

St. Rose – During the year ended September 30, 2024, total payments under SBITAs were \$0.3 million. Additionally, *St. Rose* incurred no variable SBITA expenses during the year ended September 30, 2024. *St. Rose* did not enter into any additional SBITAs that have yet to commence as of September 30, 2024. Changes in subscription obligations for the year ended September 30, 2024 is below:

	<u>October 1, 2023</u>	<u>Increases</u>	<u>Decreases</u>	<u>September 30, 2024</u>	<u>Current Portion</u>
		(amounts in thousands)			
Right-of-use subscription liability	\$ 942	\$ -	\$ (268)	\$ 674	\$ 221

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

The future payments of subscription obligation principal and interest as of September 30, 2024, are as follows:

	Principal Payments	Interest Payments	Total
<u>Year Ending September 30,</u>			
2025	\$ 221	\$ 67	\$ 288
2026	248	40	288
2027	205	10	215
	\$ 674	\$ 117	\$ 791

Note 21 – Line of Credit and Notes Payable

Bank Revolving Line of Credit – During the year ended September 30, 2022, St. Rose obtained a revolving bank line of credit from City National Bank (CNB). The revolving line of credit allows for borrowings up to \$10.0 million to provide operating capital as needed. The revolving line of credit bears an interest rate at the Bank’s Prime Rate (currently 8.00%) plus 0.25%, for a current combined rate of 8.25% and with a floor rate provision of 2.50%. The line of credit matures in December 2029. Interest is payable monthly calculated on any current outstanding balance and principal is due at maturity. The outstanding balance for the line of credit at September 30, 2024, is \$10.0 million.

In December 2024, the revolving line of credit was paid in full as part of the loan with a Health Facility Construction Loan Insurance Fund (HFCLII).

Note payable – In September 2022, St. Rose obtained a note payable from CNB in the amount of \$24.4 million, interest rate at 4.44%, principal and interest payable monthly, maturing in December 2029, collateralized by Cal Mortgage loan insurance policy.

California Healthcare Facilities Financing Authority (CHFFA), Distressed Hospital Loan Program (DHLP) – During the year ended September 30, 2024, St. Rose obtained a DHLP loan from CHFFA in the amount of \$17.7 million. The note is noninterest bearing and collateralized by future Medi-Cal payments.

Alameda Health System, A Public Hospital Authority
Notes to Financial Statements

	September 30, 2024 <u>(amounts in thousands)</u>
Note payable	\$ 18,323
DHLP loan	<u>17,650</u>
	35,973
Less current maturity of notes payable	<u>(4,092)</u>
Total assets	<u><u>\$ 31,881</u></u>

Scheduled principal repayments on notes payable for St. Rose are as follows:

Year Ending September 30,	Principal Payments	Interest Payments	Total
		(amounts in thousands)	
2025	\$ 4,092	\$ 758	\$ 4,850
2026	7,176	616	7,792
2027	7,324	469	7,793
2028	7,479	313	7,792
2029	7,644	148	7,792
2030 - 2034	<u>2,258</u>	<u>11</u>	<u>2,269</u>
	<u>\$ 35,973</u>	<u>\$ 2,315</u>	<u>\$ 38,288</u>

In May 2025, the DHLP loan was amended to delay the start of monthly payments and the maturity date. Monthly principal payments in the amount of \$0.3 million are schedule to start July 1, 2026. The note matures December 1, 2030.

Cal-Mortgage Division of Department of Health Care Access and Information (HCAI), HFCLII loan –

In October 2024, St. Rose obtained a HFCLII loan from HCAI, which allows St. Rose to draw a total of \$24.4 million to repay the CNB revolving line of credit and the note payable based on the current terms of those credit facilities. Interest rate at 4.44% is payable monthly. Principal payments of \$0.5 million commence in January 1, 2030, with the loan maturing in December 2034, collateralized by deed of trust. At June 30, 2025, the HFCLII loan payable was \$12.6 million.

St. Rose's loan agreement with CNB contains restrictive covenants. St. Rose's management determined at September 30, 2024, St. Rose was not in compliance with the covenants for the note payable to CNB. St. Rose through issuance of the HFCLII loan received forbearance on CNB covenants through December 31, 2024. In addition, within the HFCLII loan, HCAI issued a contract of insurance to CNB preventing CNB from accelerating the note payable.

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

Note 22 – Alameda Health Medical Group, St. Rose Medical Building Inc., and St. Rose Foundation

As described in Note 1, AHMG is a blended component of Alameda Health, St. Rose MOB, and St. Rose Foundation are components of St. Rose. See below for condensed financial statement data for AHMG, St. Rose MOB, and St. Rose Foundation:

[INSERT TABLE]

Note 23 – Commitments and Contingencies

Other commitment – Under the Master Agreement with the County, Alameda Health has agreed to deposit contributions in a Capital Designation Fund, which it may access for capital projects as approved by the Alameda County Board of Supervisors. Alameda Health will make the contributions by June 30 of each fiscal year as listed below:

<u>Years Ending June 30,</u>	(amounts in thousands)
2026	\$ 7,000
2027	7,000
2028	7,000
2029	7,000
2030	7,000
2031-2034	<u>28,000</u>
	<u><u>\$ 63,000</u></u>

Seismic retrofitting – The State of California has established rigorous seismic safety standards for hospitals to ensure they can provide care during and after seismic events. By January 2030, all general acute care hospitals must be capable of remaining operational after an earthquake, which may require seismic retrofitting to meet structural and nonstructural performance measures.

Alameda Health – Alameda Health is working in partnership with the County to upgrade inpatient facilities, Wilma Chan Highland Hospital and John George Psychiatry Hospital, and with the City of Alameda Health Care District for Alameda Hospital. These facilities are leased by Alameda Health. San Leandro Hospital is owned by Alameda Health, and any required seismic upgrades will be the responsibility of Alameda Health. All facilities are expected to be in compliance by the deadline of January 2030.

St. Rose – The acute care facility is expected to be in compliance by the deadline of January 2030.

Litigation – The Health System are involved in various claims and litigation, as both plaintiff and defendant, arising in the ordinary course of business. In the opinion of management, after consultation with legal counsel, these matters will be resolved without material adverse effect on the Health System's financial position.

Alameda Health System, A Public Hospital Authority

Notes to Financial Statements

Regulatory environment – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, governmental health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in fines and penalties, as well as loss of significant repayment. Patient service revenues previously recognized are subject to future government review and interpretation.

Collective bargaining – As of June 30, 2025, Alameda Health has 6,249 employees. Employees working under union collective bargaining agreements represented 88.8% of the workforce in eighteen different collective bargaining units. Three of the eighteen collective bargaining units were currently in active negotiations.

As of September 30, 2024, St. Rose has 839 employees. Employees working under union collective bargaining agreements represented 75.6% of the workforce in four different collective bargaining units. None of the four collective bargaining units were in active negotiations.

Note 24 – Subsequent Events

Subsequent events are events or transactions that occur after the date of the statement of net (deficit) position, but before the financial statements are issued. The Health System recognizes in the financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the statement of net (deficit) position, including the estimates inherent in the process of preparing the financial statements.

On September 29, 2025, the California Secretary of State approved the dissolution of AHMG. All assets, liabilities, and employees were transferred to AHS.

The Health System has evaluated subsequent events through [REDACTED], 2026, which is the date the financial statements are available to be issued.

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Required Supplementary Information

Alameda Health System, A Public Hospital Authority
Supplementary Pension and Postemployment Benefit Information

Reporting Date per Employer under GASB No. 68 as of June 30	Proportion of Net Plan Liability	Proportionate share of Net Plan Liability	Covered payroll ¹	Proportionate Share of Net Plan Liability as a Percentage of Covered Payroll	Plan Fiduciary Net Position as a Percentage of Total Plan Liability
		(amounts in thousands)			
2016	17.4%	\$ 369,372	\$ 217,863	169.5%	76.9%
2017	17.3%	\$ 387,734	\$ 216,686	178.9%	76.9%
2018	17.0%	\$ 341,502	\$ 239,207	142.8%	81.9%
2019	18.1%	\$ 501,587	\$ 255,247	196.5%	74.6%
2020	16.6%	\$ 355,519	\$ 257,591	138.0%	82.2%
2021	16.2%	\$ 356,559	\$ 257,127	138.7%	82.8%
2022	21.8%	\$ 252,205	\$ 270,985	93.1%	88.4%
2023	23.0%	\$ 512,557	\$ 279,653	183.3%	77.5%
2024	24.4%	\$ 425,726	\$ 200,989	141.4%	82.5%
2025	25.3%	\$ 370,029	\$ 327,392	113.0%	85.5%

¹Covered payroll represents payroll on which contributions to a pension plan are based.

Alameda Health System, A Public Hospital Authority
Schedule of Proportionate Share of the Net OPEB Obligation

Reporting Date for Employer under GASB No. 75 as of June 30,	Proportion of the Net OPEB Liability	Proportionate Share of Net OPEB Liability (Asset)	Covered- Employee Payroll ¹	Proportionate Share of the Net OPEB Liability as a Percentage of its Covered- Employee Payroll	Plan's Fiduciary Net Position as a Percentage of the Total OPEB Liability
(amounts in thousands)					
2017	17.9%	\$ 24,236	\$ 216,686	11.2%	85.5%
2018	18.7%	\$ 5,139	\$ 239,207	2.2%	97.3%
2019	18.8%	\$ 43,743	\$ 255,247	17.1%	77.9%
2020	18.2%	\$ 20,562	\$ 257,591	8.0%	89.6%
2021	17.5%	\$ 1,172	\$ 257,127	0.5%	99.4%
2022	17.8%	\$ (75,165)	\$ 270,985	-27.7%	135.0%
2023	17.6%	\$ 33,671	\$ 279,653	12.0%	84.5%
2024	18.4%	\$ 38,374	\$ 300,989	12.8%	83.6%
2025	18.9%	\$ 43,255	\$ 327,392	13.2%	82.8%

¹ Covered-employee payroll shown represents Compensation Earnable and Pensionable Compensation and is defined as the payroll of employees that are provided with OPEB through the OPEB plan.

ACTION: Staff Requests Board Authorization for the allocation of a not-to-exceed amount of \$10, 507,500 million to support an Intergovernmental Transfer for the benefit of St. Rose Hospital



St. Rose Hospital IGT funding Request, 1/7/26

- FY2026 SRH IGT funding is \$36,015,000; expected to be received in June 2026.
- IGT Local Share is \$18,007,500 comprised of:
 - Alameda County Measure A, \$7,000,000.
 - Eden Health District, \$500,000.
 - AHS contribution (pending board approval), \$10,507,500.

	FY 24-25	FY 25-26	FY 26-27	
Measure A	\$ -	\$ 7,000,000	\$ 7,000,000	
Stanford	-	-	-	Not Used for Local Share
Alameda Alliance	-	-	-	
City of Hayward	1,000,000	-	-	Having financial difficulty
Eden Health District	1,000,000	500,000	500,000	\$2M over 3 years
BOS Marquez	1,000,000	-	-	One time funds in FY24-25
AHS	12,166,000	10,507,500	10,991,000	
Local Share	\$ 15,166,000	\$ 18,007,500	\$ 18,491,000	
IGT funding to SRH	\$ 30,332,000	\$ 36,015,000	\$ 36,982,000	

Consolidated Financial Statement

Fiscal Year 2026 Approved Budget (In Thousands)

	Approved BUDGET		Var (\$)	Var (%)
	Projected 2025*	2026		
Total Net Patient Service Revenue	\$100,944	\$104,044	\$3,100	3.1%
Total Other Revenue	\$40,956	\$39,095	(\$1,861)	-4.5%
TOTAL OPERATING REVENUE	\$141,900	\$143,139	\$1,239	0.9%
Less: Operating Expenses	\$130,390	\$138,719	\$8,330	6.4%
EBITDA	\$11,510	\$4,420	(\$7,091)	-61.6%
Total Non-Operating Exp/(Income)	\$5,070	\$5,393	\$323	6.4%
Non-Recurring Items	(\$4,728)	\$0	\$4,728	-100.0%
NET INCOME/(LOSS)	\$1,713	(\$973)	(\$2,686)	-156.8%

**Projected 2025 excludes:*

- Closed departments: Labor & Delivery and Nursery
- Severance pay paid to Alecto and Director of Nursing , \$3.2M
- Sub Acute: Projected to improve Census, up to maximum of 15 patients
- Other Operating Revenue: Includes IGT/Measure A; MOB Rent Revenue & SRF Donations

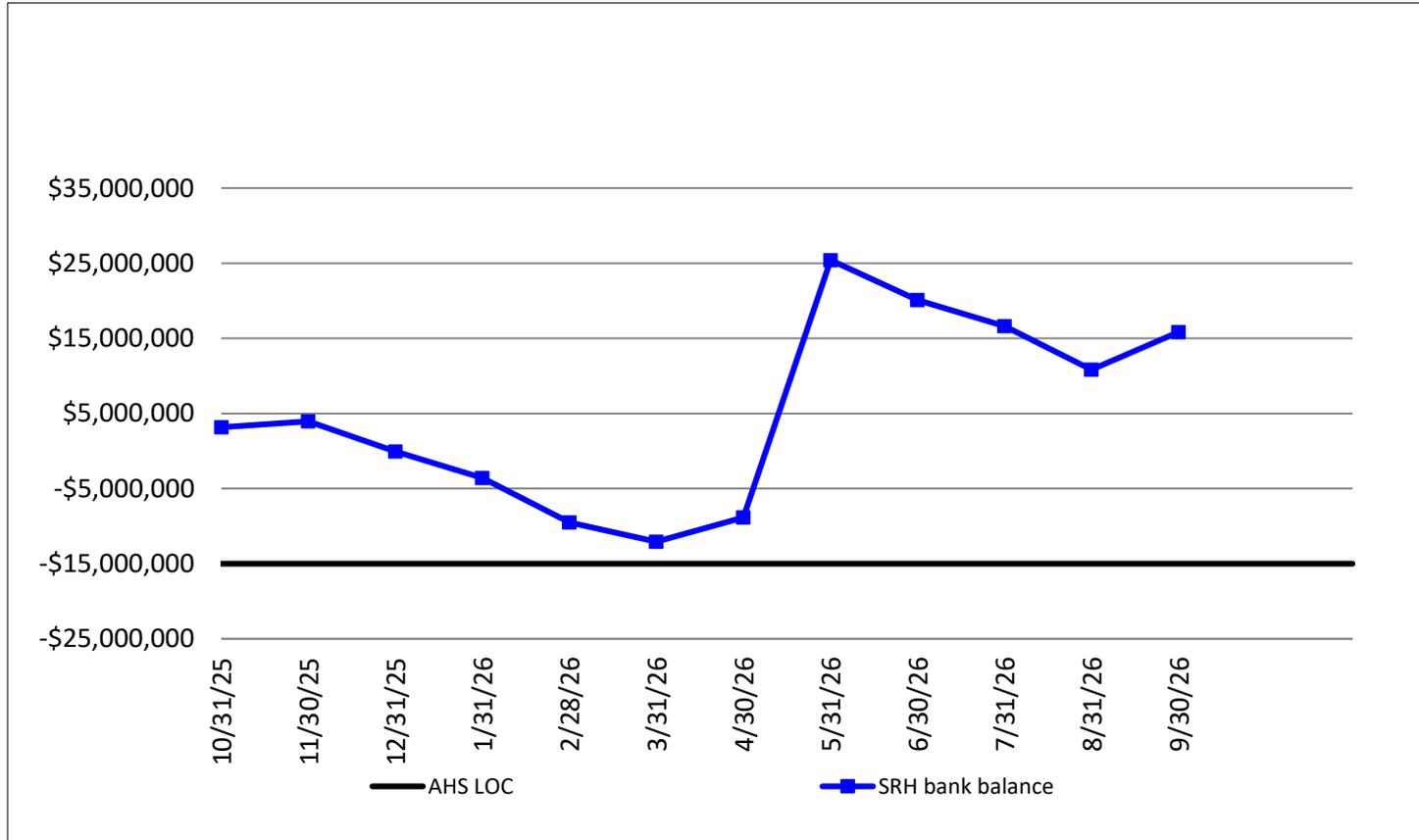
- **Capital Freeze**
 - Limit to maintenance capital for the first three years
 - Capital expenditure not budgeted; release capital as growth targets achieved
- **Cath Lab**
 - Approved Cath Lab project (\$5.2M) anticipated to begin in Nov. with funding secured from donations, incl. \$3.5M from Alameda Alliance. No other capital expenditures are in process
- **BHCIP funding approved - \$62.4M**
 - Building a 20-bed inpatient medical psychiatry unit
 - Building a 20-bed geriatric psychiatry unit

	FY2022	FY2023	FY2024	FY2025
Land Improvements	9,169	80,790	-	-
Building & Building Improvements*	3,563,372	2,080,715	159,528	5,473,357
Capital Leases	182,909	-	718,673	-
Automobiles	33,834	-	-	-
Furniture	-	19,183	-	-
Equipment	625,132	1,218,833	612,100	61,712
Computer Hardware	7,974	98,299	123,946	15,391
Computer Software	51,218	313,869	42,800	61,632
Work-in-Progress	794,571	794,571	307,998	193,936
	5,268,179	4,606,260	1,965,044	5,806,028

*FY2022 - Includes Donation of Radiation Oncology Building to SRH (based on VMG appraisal) - \$3.1M

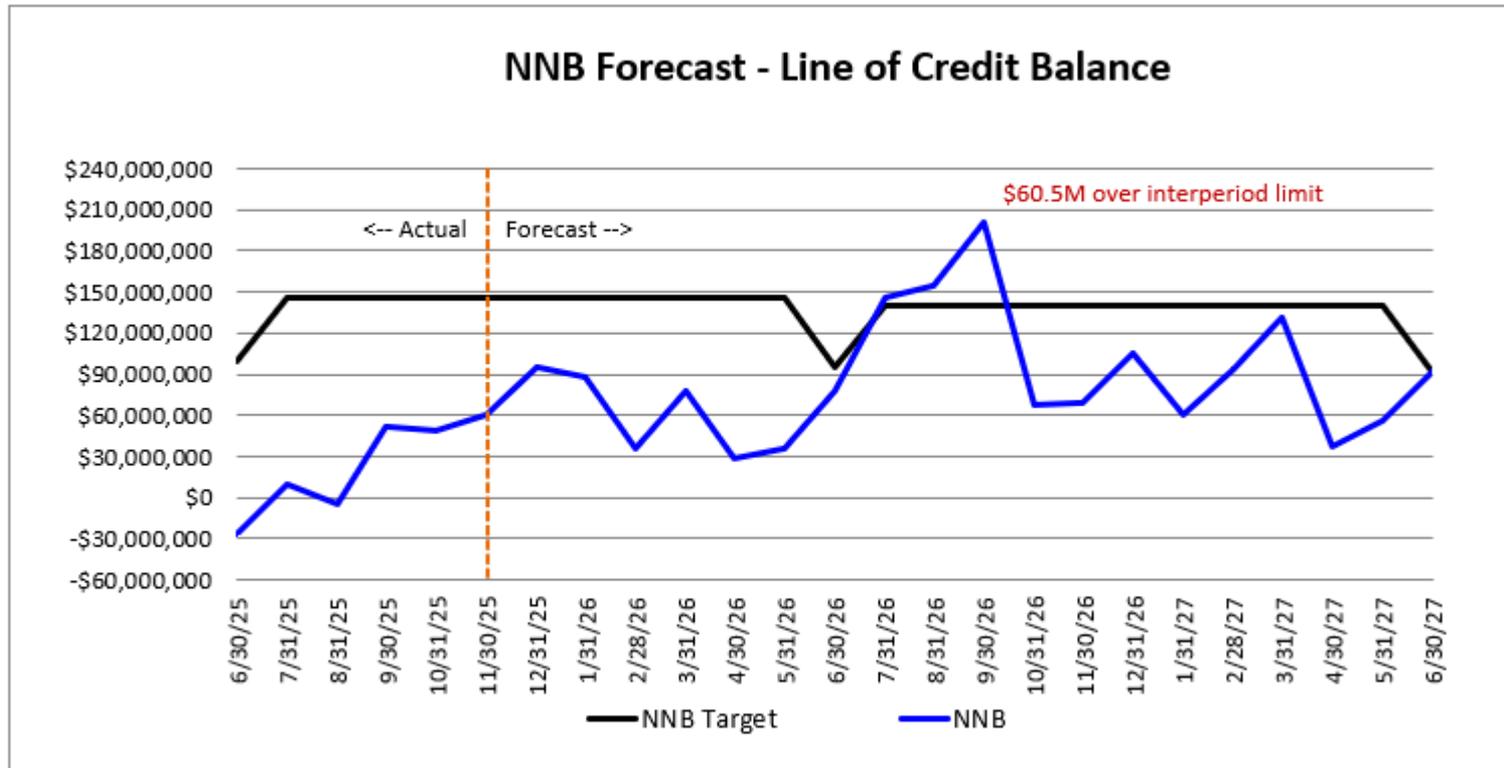
*FY2023 - Includes Donation of Bay Valley Building to SRH (based on appraised value) - \$1.8M

*FY2025 - Includes capitalized Sub Acute project - \$5.4M



- St. Rose has \$15.0M line of credit with AHS and is projecting to draw funds starting January 2026.
- St. Rose is expected to pay off the balance with the IGT funding which is expected to be received in May 2026, same timing as last year.

- St. Rose items included in forecast.
 - Funding for IGT contribution of \$10.5M for FY2026 and FY2027 pending Trustees' approval.
 - Access to the line of credit starting in January 2026 and repaid in full by June 2026.
 - See next slide for timing.



- St. Rose activity is highlighted in yellow.
- Activity has remained constant with the prior forecast.
- Prior year activity for the AB915, Medi-Cal FQHC and Physician SPA settlements are reflected in bottom table as the final settlement and timing are unknown. The Old Waiver FY2011 is expected to finalize in February 2026.

Material Items Included in NNB Forecast									
(in thousands)									
	Dec-25	Jan-26	Feb-26	Mar-26	FY26 Q4	FY27 Q1	FY27 Q2	FY27 Q3	FY27 Q4
GPP (quarterly)	\$ 18,474	\$ 20,100	\$ -	\$ 5,600	\$ 25,700	\$ 23,551	\$ 23,551	\$ 28,651	\$ 19,700
EPP (semi-annual)	-	-	-	-	21,000	-	75,351	-	39,510
QIP	-	-	-	-	34,364	-	51,000	-	51,000
Medi-Cal Rate Range	-	-	45,800	-	-	-	-	51,300	-
Medi-Cal Waiver (fy11)	-	-	-	-	-	-	-	-	-
BHCS (JGP/Alameda County) - fy26	12,167	6,084	6,084	6,084	18,251	12,671	-	-	-
BHCS (JGP/Alameda County) - fy27	-	-	-	-	-	-	18,900	18,900	25,200
HPAC	-	-	-	10,800	21,600	-	21,600	10,800	10,800
AB85 Realignment	-	-	-	-	-	-	4,800	-	-
SNF DP-NF (final pmt Jan-27)	-	25,797	-	-	-	-	-	26,000	-
St. Rose Hospital LOC	-	3,000	3,000	3,000	(9,000)	-	-	-	-
Donation to St. Rose Hospital	-	-	-	10,507	-	-	-	10,507	-
	<u>\$ 30,641</u>	<u>\$ 54,981</u>	<u>\$ 54,884</u>	<u>\$ 35,991</u>	<u>\$ 111,915</u>	<u>\$ 36,222</u>	<u>\$ 195,202</u>	<u>\$ 146,158</u>	<u>\$ 146,210</u>

Prior Year Reimbursement Settlements		
Waiver recoupment (fy11)	\$ 29,169	Payment delayed to Feb-26
AB915 (fy14-fy20)	(17,000)	TBD
Medi-Cal FQHC recoupment (fy08 - fy13)	(40,000)	TBD
Physician SPA (fy08 - fy13)	(25,100)	TBD
	<u>\$ (52,931)</u>	

Fiscal Year 2026 Budget

Board of Directors

➤ Revenue

- Overall increase in charge master at 4.54% starting 10/1/2025.
 - ED increase - 6%
 - All other services – 4%

➤ Volume

- Retain GI cases (100) and Neuro cases (35) transferred last year.
- Sub Acute license expected around second quarter; ramp up starts January, 2026.
- All other volumes consistent with FY2025.

➤ Supplemental Funding

- SCA provided assumptions
 - QAF – Phase IX (Jan25-Dec25) CMS approval is expected by end of 2025 or 1st quarter of 2026.
 - QAF – Phase X (Jan26-Dec26) DHCS started pulling relevant data and HCAI started preparing a model.
 - DSH – 55.31% expected reductions beginning SFY 2026-2027

➤ Labor Expenses

- Salaries and wages are projected to increase by an average of 4.5% in upcoming year due primarily to union contracts that include negotiated wage adjustments.
- In addition, a modest salary adjustments for non-represented are also planned to address/prevent pay disparities as a result of the negotiated union increases.
- Estimated total amount of increases - \$2.0M

- **Labor Expenses (continuation)**
 - Budgeted FTEs based on current staffing
 - Registry – adjusted for hired management positions: HR, Surgery, Radiology, ER/ICU
 - Benefits based on Alliant’s estimates - \$1.3M
 - Overtime was budgeted for a 50% reduction with total elimination in non-patient facing departments. This adjustment reflects the organization’s continuous efforts to improve operational efficiency and align expenditures with current financial realities.

- **Supplies and Purchased Services**
 - CPI assumed to be 3%
 - Subacute increased based on volume

- **Professional Fees/Contracted Physicians**
 - AHS management fee calculated based on existing agreement and estimated collections (\$2.9M).
 - Physician contracts based on contracts in place, with rate adjustments including the following proposed additions/changes: (\$942K)
 - **Associate CMO**, Effective 1/1/2026, offset by cancellation of current medical directorship contract (supporting Case Management/UM), (.5 FTE/20hrs week) ending December 2025.
 - **GI**, Effective 1/1/2026, currently no coverage. This is for 24/7/365 call coverage. Since January 2025, over 100 GI patients were transferred to outside facilities.

- **Professional Fees/Contracted Physicians** (continuation)
 - **Neurology**, Effective 1/1/2026, this is for 24/7/365 call coverage. Since January 2025, over 35 neuro patients were transferred to outside facilities
 - **Orthopedics**, Effective 11/1/2025, anticipated increase.
 - **Nephrology**, Effective 11/1/2025, this is for 24/7/365 call coverage. Existing group, West Coast Kidney Institute has existing coverage at Alameda and San Leandro hospitals. Existing dialysis director agreement will be eliminated, partly offsetting the cost.
 - **Morrison Healthcare**, Café management, started July 15, 2025 (\$74K)

- **Depreciation**
 - Budgeted at 6% (\$250K) increase, due to capitalization of Sub Acute project.

- **General Administrative**
 - Budgeted at 5% increase, due to increasing insurance premiums and taxes.

- **Long Term Debt**
 - Currently assumes \$17.6M Distressed Hospital Loan Program repayment begins July 1, 2026; however, application in progress for 12 months of debt service forgiveness. If awarded, total debt for DHLPP would be reduced by \$3.5M and repayment period would begin July 1, 2027 on balance estimated at \$14.1M.

- **Medical Office Building, Inc. (MOB)**
 - Rental revenue is the only source of cash flow for MOB, projected at \$1.7M, derived directly from signed lease agreements. Annual rent escalations of 3% are applied as outlined in the agreements. Assuming expiring tenant contract will be renewed or will move to month-to-month agreement.
 - The assumptions of 3% increase in operating expenses will clearly be covered by the projected rent revenue.

- **St. Rose Hospital Foundation (SRF)**
 - Contribution reflects a decrease in projected donation. Last year's one-time donations of \$350K are not budgeted.
 - Projected to incur losses of \$895K due to a \$1.0M donation to St. Rose, similar to what occurred in FY2025.

Consolidated Financial Statement

Fiscal Year 2026 Proposed Budget (In Thousands)

	Projected 2025*	Proposed BUDGET 2026	Var (\$)	Var (%)
Total Net Patient Service Revenue	\$100,944	\$104,044	\$3,100	3.1%
Total Other Revenue	\$40,956	\$39,095	(\$1,861)	-4.5%
TOTAL OPERATING REVENUE	\$141,900	\$143,139	\$1,239	0.9%
Less: Operating Expenses	\$130,390	\$138,719	\$8,330	6.4%
EBITDA	\$11,510	\$4,420	(\$7,091)	-61.6%
Total Non-Operating Exp/(Income)	\$5,070	\$5,393	\$323	6.4%
Non-Recurring Items	(\$4,728)	\$0	\$4,728	-100.0%
NET INCOME/(LOSS)	\$1,713	(\$973)	(\$2,686)	-156.8%

*Projected 2025 excludes:

- Closed departments: Labor & Delivery and Nursery
- Severance pay paid to Alecto and Director of Nursing , \$3.2M
- Sub Acute: Projected to improve Census, up to maximum of 15 patients
- Other Operating Revenue: Includes IGT/Measure A; MOB Rent Revenue & SRF Donations

	Proposed			
	Projected 2025	BUDGET 2026	Var (\$)	Var (%)
Gross Patient Revenue				
Inpatient	\$287,507	\$299,484	\$11,977	4%
Outpatient	\$149,878	\$157,526	\$7,648	5%
Sub Acute**	2,424	11,352	\$8,928	368%
Gross Patient Service Revenue	\$439,809	\$468,361	\$28,552	6%
Less: Total Deductions	362,334	388,683	26,348	7%
Net Patient Service Revenue	\$77,475	\$79,679	\$2,204	3%
Collection Ratio	17.6%	17.0%		

- Gross Revenues increase overall 7%
 - CDM increase by 4.54% starting 10/1/2025
 - Sub Acute charges were developed using a staggered census model. Patient volumes are expected to increase throughout the year.

	Projected 2025*	Proposed BUDGET 2026	Var (\$)	Var (%)
HQAF Provider Fee	\$19,239	\$20,640	\$1,401	7.3%
SB DSH	\$4,230	\$3,725	(\$505)	-11.9%
Supplemental Patient Revenue	\$23,469	\$24,365	\$896	3.8%
Other Operating Revenue	\$40,956	\$39,095	(\$1,861)	-4.5%
Total Operating Revenue	\$141,900	\$143,139	\$1,239	0.9%

- The Big Bill (HR1) has changed the applicable standards under which CMS is reviewing the CY2025 HQAF program, but the precise impact is highly uncertain. Currently, the amount will stay equivalent to most recent CY2025 estimate by SCA and not to increase for FY2026 budget year.
- SCA provided \$0.5M estimated reduction due to Medicaid DSH cut effective October 1, 2025.
- Alameda County Measure A funding consistent with prior year
 - IGT maximum funding available - \$36.984M
 - Other revenue: Cafeteria, OP Pharmacy, Opioid-related grant program revenue, etc. - \$412K
- MOB rent revenue - \$1.7M
- Foundation donation - \$1.0M

Fiscal Year 2026 Proposed Budget – Operating Expenses (Excluding Labor) (In Thousands)

	Projected 2025*	Proposed BUDGET 2026	Var (\$)	Var (%)
Operating Expenses				
Labor	83,693	88,840	\$5,147	6%
Professional Fees****	11,731	14,064	2,333	20%
Purchased Services	6,473	6,644	171	2%
Materials and supplies	10,837	11,264	427	4%
Facilities	4,438	4,514	75	2%
HQAF Provider Fee	10,370	10,440	70	1%
General Administrative	2,847	2,954	106	4%
Total Operating Expenses	\$130,390	138,719	\$8,330	6%

➤ Professional Fees

- Associate CMO (offset) – effective January 2026
- GI (new) - effective January 2026
- Neurology (new) - effective January 2026
- Ortho (increased rate) - effective November 2025
- Severance pay paid to Alecto and Director of Nursing , \$3.2M
- Morrison Healthcare, Cafeteria management

➤ **Purchased Services** – 3% increase (\$171K), accounted for rising contractual rates, inflationary cost pressures and continuation of essential service agreements necessary to support daily operation.

➤ **Materials and Supplies** – 3% increase (\$337K), reflected the impact of inflation and vendor price increases

➤ **Facilities** – 3% increase (\$75K), accounted for higher costs associated with building maintenance, utilities and other facility-related services to sustain efficient and safe operation.

➤ **General Administrative** – 5% increase (\$106K), accounted for inflationary adjustments and growth in costs necessary to support core administrative functions.

	Projected 2025	Proposed BUDGET 2026	Var (\$)	Var (%)
Salaries & Wages	\$63,641	68,162	\$4,522	7.1%
Benefits	\$17,321	\$18,648	\$1,326	7.7%
Registry & Contract Labor	\$2,730	\$2,030	(\$701)	-25.7%
Total Labor Costs	\$83,693	\$88,840	\$5,147	6.2%
FTE's	542.2	550.5		

- **Salaries and Wages – average rate increase 4.5%**
 - Non-Union - effective 10/1/2025, excluding recently hired management positions (in market)
 - Teamsters – effective 10/1/2025
 - Stationary Engineers Local 39 - effective 1/1/2026
 - ESC Local 20 - effective 2/1/2026
 - CNA - effective 6/1/2026

- **Benefits** – 7.7% increase, projected increases in health claims, retirement plan contributions and other employee-related benefit costs.

- **Registry and contract labor** – 25.7% decrease (\$701K). The significant reduction is primarily attributed to the successful recruitment and onboarding of key management positions that were previously filled through temporary or contract arrangement – HR, Surgery, Radiology, ER and ICU.

Fiscal Year 2026 Proposed Budget – Non-Operating Expenses/(Income) (In Thousands)

	Proposed			
	Projected 2025	BUDGET 2026	Var (\$)	Var (%)
Depreciation Expense	\$4,079	4,327	\$248	6.1%
Interest Expense	\$1,366	\$1,436	\$69	5.1%
Donation Expense	\$1,000	\$1,006	\$6	0.6%
Non Operating Cost/(Income)	(\$1,376)	(\$1,376)	(\$0)	0.0%
Total Non-Operating Exp/(Income)	\$5,070	\$5,393	\$323	6.4%

- Depreciation to increase due to capitalized projects
- Interest expense expected to increase due to growing unpaid AHS management fee
- Donation expense by Foundation; non-operating income for the Hospital - \$1.0M
- Investment income is expected to remain consistent with prior year.

Fiscal Year 2026 Proposed Budget - Volume

	Actual 2023	Actual 2024	Actual 2025	Proposed BUDGET 2026	Variance	Var (%)
PATIENT DAYS						
Acute	14,392	12,834	11,316	11,386	70	1%
Sub Acute	0	0	1,112	1,112	0	0%
Total	14,392	12,834	12,428	12,498	70	1%
AVERAGE DAILY CENSUS						
Acute	39.4	35.1	31.0	31.0	0.0	0%
Sub Acute*	0.0	0.0	5.2	5.2	0.0	0%
Total	39.4	35.1	36.2	36.2	0.0	0%
DISCHARGES						
Acute	3,484	3,335	3,206	3,241	35	1%
Sub Acute	0	0	30	30	0	0%
Total	3,484	3,335	3,236	3,271	35	1%
Average Length of Stay (ALOS)	4.3	4.0	3.6	3.6	0.0	0%
Geometric Mean Length of Stay (GMLOS)	3.7	3.9	3.9	3.9	0.0	0%
Case Mix Index (CMI)	1.5518	1.4960	1.5430	1.5430	0.0000	0%
OUTPATIENT SERVICES						
Emergency Visits	25,771	26,421	26,216	26,251	35	0.1%
Surgeries	1,126	1,055	975	975	0	0%
Inpatient	694	592	558	558	0	0%
Outpatient	432	463	417	417	0	0%
GI Lab Procedures	290	126	0	65	65	100%
Cath Lab Procedures	568	532	573	573	0	0%

**Sub Acute Budgeted Census:*

- 1st Quarter – 7 patients
- 2nd Quarter – 9 patients
- 3rd Quarter – 11 patients
- 4th Quarter – 15 patients

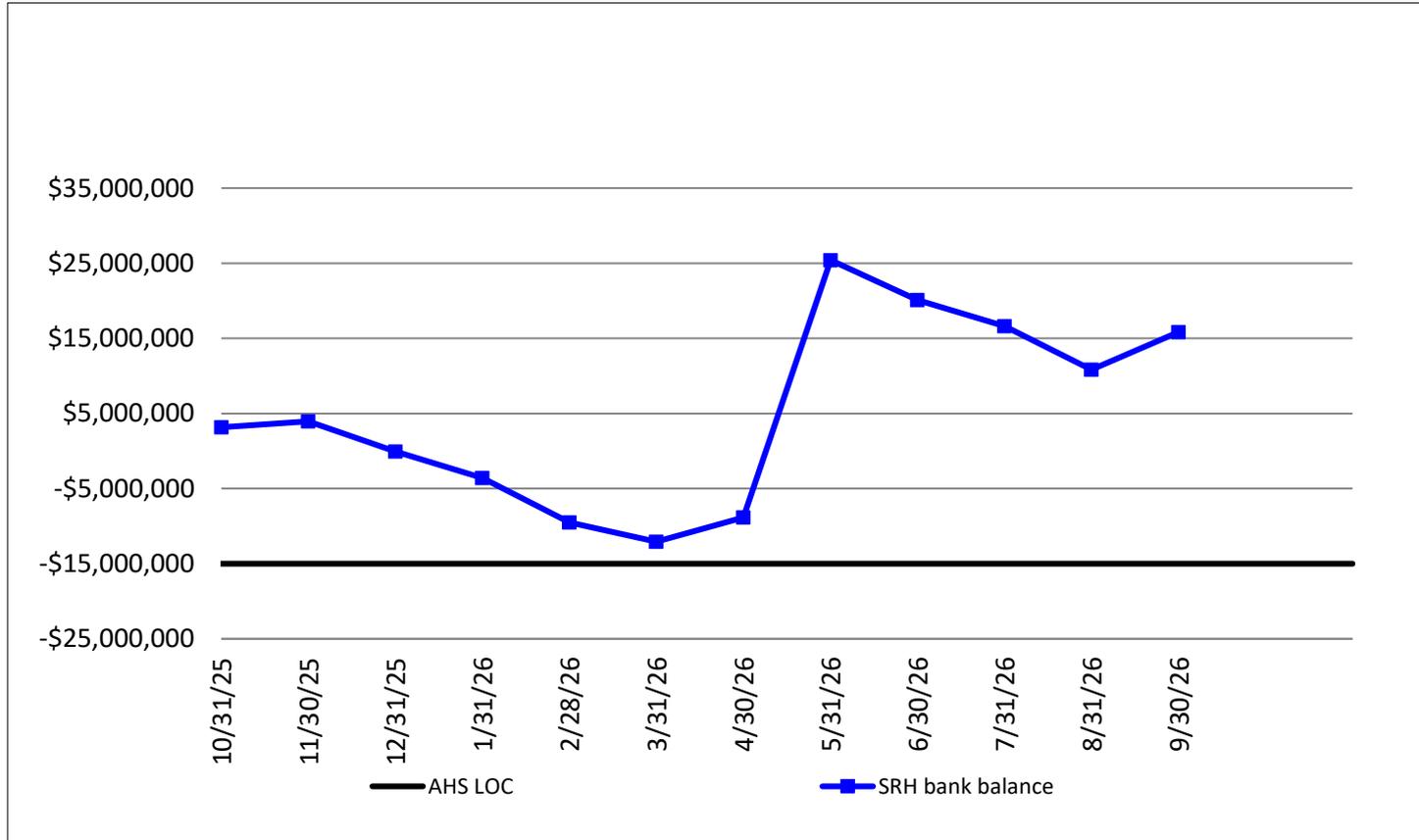
- **Capital Freeze**
 - Limit to maintenance capital for the first three years
 - Capital expenditure not budgeted; release capital as growth targets achieved
- **Cath Lab**
 - Approved Cath Lab project (\$5.2M), anticipated to begin in November, no other capital expenditures are in process
- **BCHIP funding approved - \$62.4M**
 - Building a 20-bed inpatient medical psychiatry unit
 - Building a 20-bed geriatric psychiatry unit

	FY2022	FY2023	FY2024	FY2025
Land Improvements	9,169	80,790	-	-
Building & Building Improvements*	3,563,372	2,080,715	159,528	5,473,357
Capital Leases	182,909	-	718,673	-
Automobiles	33,834	-	-	-
Furniture	-	19,183	-	-
Equipment	625,132	1,218,833	612,100	61,712
Computer Hardware	7,974	98,299	123,946	15,391
Computer Software	51,218	313,869	42,800	61,632
Work-in-Progress	794,571	794,571	307,998	193,936
	5,268,179	4,606,260	1,965,044	5,806,028

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