BOARD OF TRUSTEES MEETING

WEDNESDAY, JANUARY 14, 2026
5:00pm to 9:00pm

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

LOCATION:

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

ZOOM Meeting Link:[1]
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=4JnAmhDnBaLqY4GWf4PQBwp3w0Puy2.1&omn=84575565926
Meeting ID: 936 145 7125
Meeting Password: 20200513

One tap mobile
+14086380968,,9361457125# or
+13462487799,,9361457125#

Dial by your location
+1 408 638 0968 US (San Jose)
+1 346 248 7799 US (Houston)
+1 646 518 9805 US (New York)

Find your local number: https://alamedahealthsystem.zoom.us/u/agoA8zDn2

MEMBERS

Alan E. Fox
Greg Garrett
Lilavati Indulkar, MD
Donna Linton
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 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.

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

OPEN SESSION / ROLL CALL

PUBLIC COMMENT

A. DISCUSSION: EXECUTIVE OFFICERS REPORT

A1. ACTION/DISCUSSION: Election of 2026 Board Officers

A2. DISCUSSION: 2026 Committee Membership and Chairs

A3. ACTION/DISCUSSION: 2026 Board Meeting Calendar

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

C. MEDICAL STAFF REPORTS

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

D. COMMITTEE AND TRUSTEE REPORTS

D1. Audit and Compliance Committee: September 17, 2025
Sblend Sblendorio, Chair

D2. Quality Professional Services Committee: November 19, 2025
Greg Garrett, Trustee

D3. Finance Committee: January 7, 2026
Alan Fox, Committee Chair

E. CONSENT AGENDA: ACTION

E1. Approval of the Minutes of the November 12, 2025 Board of Trustees meeting.

E3. AHS and AH Medical Staff:

New Policy for AHS & AH Medical Staff:

- Medical Staff Credentialing Information Integrity and Data Security

Revised Polices for AHS & AH Medical Staff:

- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Ongoing Monitoring and Evaluation of actions Related to Providers
- Medical Staff Routine Focused Professional Practice Evaluation (FPPE)/Proctoring
- Standardized Procedures for Advanced Practice Providers in the Department of Surgery

Retired Policy for AHS & AH Medical Staff:

- Medical Staff Credentialing Systems Control

F. ACTION/DISCUSSION

F1. ACTION Contracts

F1a. Renewal agreement with Agiliti Health, Inc. for provision of equipment management and rental services. The term of this agreement is effective February 1, 2026 through January 31, 2029. The estimated impact of this agreement is $9,138,690.
Mark Fratzke, Chief Operating Officer

F1b. Renewal agreement with VTP Holdings, LLC for provision of PICC line services. The terms of this agreement is February 1, 2026 through January 31, 2029. The estimated impact of this agreement is $1,620,000.
Romoanetia Lofton, Chief Clinical Officer

F1c. New agreement with SMITH-KARNG ARCHITECTURE for provision of architectural and engineering services for the inpatient medical detox unit remodel at San Leandro Hospital. The term of this agreement is January 15, 2026 through January 15, 2029. The estimated impact of this agreement is $1,492,525.
Mark Fratzke, Chief Operating Officer

F2. DISCUSSION: The Joint Commission Update
Ana Torres, Vice President, Quality
Nilda Perez, System Director of Regulatory Affairs

F3. 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

F3. DISCUSSION: Alameda Health System Governance Structure Update
James E.T. Jackson, Chief Executive Officer
Jeanette Dong, Chief Public Affairs and Community Engagement

G. DISCUSSION: Board Calendar and Tracking

H. STAFF REPORTS (Written)

H1. Chief Financial Officer Report, September Financial Report
Kimberly 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

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

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

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.

DISCUSSION: EXECUTIVE OFFICERS REPORT

ALAMEDA HEALTH SYSTEM

BOARD OF TRUSTEES – COMMITTEE ROSTERS, 2025

STANDING COMMITTEES/MEETINGS

Board of Trustees
Second Wednesday (Except August & December), 5:00pm
- Alan E. Fox, Secretary/Treasurer
- Greg Garrett, Vice President
- Lilavati Indulkar, MD
- Donna Linton
- Nicholas Moss, MD
- Nely Obligacion
- Rachel Richman
- David Sayen, President
- Sblend A. Sblendorio

Audit and Compliance Committee
Third Wednesday (Quarterly), 5:00pm
- Greg Garrett
- Nicholas Moss, MD
- Sblend Sblendorio, Chair

Executive Committee
(as needed)
- David Sayen, President
- Greg Garrett, Vice President
- Alan Fox, Secretary/Treasurer

Finance Committee
First Wednesday (Except August & December), 5:00pm
- Alan E. Fox, Chair
- Greg Garrett
- David Sayen
- Sblend A. Sblendorio

Human Resources Committee
Third Wednesday (Quarterly), 5:00pm
- Lilavati Indulkar, MD
- Donna Linton
- Nely Obligacion
- Rachel Richman
- David Sayen, Chair

Quality Professional Services Committee
Fourth Wednesday (Except December), 5:00pm
- Greg Garrett
- Lilavati Indulkar, MD
- Donna Linton
- Nicholas Moss, MD

AD HOC COMMITTEES/OTHER BOARD APPOINTMENTS

CEO and Board Evaluation Ad Hoc Committee
- Alan Fox
- Nely Obligacion

Homeless Health Center Co-Applicant Board
- Greg Garrett

NON-BOARD APPOINTMENTS

Retirement Plans Investment Committee
- Alan E. Fox

Alameda Hospital Strategic Planning Committee
- David Sayen

Alameda Hospital Strategic Planning Committee
- David Sayen

Health, Equity, Diversity, and Inclusion Committee

ALAMEDA HEALTH SYSTEM

BOARD OF TRUSTEES – ROSTER, 2025

STANDING COMMITTEES BY TRUSTEE

Alan E. Fox – Term two ends 1/1/2027
Executive Committee, Secretary/Treasurer
Finance Committee, Chair

Greg Garrett – Term one ends 12/31/2027
Audit and Compliance Committee
Finance Committee
Quality Professional Services Committee

Lilavati Indulkar – Term one ends 1/1/2027
Human Resources Committee
Quality Professional Services Committee

Donna Linton – Term one ends 1/1/2028
Human Resources Committee
Quality Professional Services Committee

Nicholas Moss, MD– Term one ends 1/1/2028
Audit and Compliance Committee
Quality Professional Services Committee

Nely Obligacion – Term two ends 1/1/2029
Human Resources Committee

Rachel Richman – Term one ends 1/1/28
Human Resources Committee

David Sayen – Term one ends 1/1/2027 (first full term)
Executive Committee, President
Finance Committee
Human Resources Committee, Chair

Sblend A. Sblendorio – Term two ends 1/1/2027
Audit and Compliance Committee, Chair
Finance Committee

Updated: 1/9/2026
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ALAMEDA HEALTH SYSTEM BOARD OF TRUSTEES
REGULAR MEETING SCHEDULE 2026

January		February		March	
Finance:	Jan 7	Finance:	Feb 4	Finance:	March 4
Board:	Jan 14	Board:	Feb 14	Board:	March 14
HR:	Jan 21	QPSC:	Feb 25	Audit/Compliance:	March 18
QPSC:	Jan 28			QPSC:	March 25
April		**May**		**June**	
Finance:	April 1	Finance:	May 6	Finance:	June 3
Board:	April 8	Board:	May 13	Board Retreat*:	June 5
HR:	April 15	QPSC:	May 27	Board:	June 10
QPSC:	April 22			Audit/Compliance:	June 17
				QPSC:	June 24
July		**August**		**September**	
Finance:	July 1	QPSC:	Aug 26	Finance:	Sep 3
Board:	July 8			Board:	Sep 9
HR:	July 15			Audit/Compliance:	Sep 16
QPSC:	July 22			QPSC:	Sep 23
October		**November**		**December**	
Finance:	Oct 7	Finance:	Nov 4		
Board Retreat*:	Oct 9	BOT:	Nov 18		
Board:	Oct 14	QPSC:	Nov 18	**No Meetings**	
HR:	Oct 21				
QPSC:	Oct 28				

- Meeting agendas are posted the Friday before the scheduled meeting at the Alameda Health System Website: http://www.alamedahealthsystem.org/about-us/ and include participation instructions, including the Zoom links or physical locations as appropriate.
- **Audit and Compliance** meetings are scheduled for the third Wednesday in March, June, and September. Meetings are scheduled from 4:00 to 5:30pm, unless otherwise noticed.
- **Board Meetings** are scheduled for the second Wednesday of each month, except August and December when the Board is on break. Meetings are scheduled from 5:00pm to 9:00pm unless otherwise noticed.
- ***Board Retreat** dates are tentative. Dates and times will be noticed per the Brown Act.
- **Executive Committee Meetings** are scheduled as needed.
- **Finance Committee** meetings are scheduled for the first Wednesday of each month, except August and December when the Board is on break. Meetings are scheduled from 5:00pm to 7:00pm unless otherwise noticed.
- **Human Resources Committee** meetings are scheduled for the third Wednesday in January, April, July, and October. Meetings are scheduled from 5:00pm to 7:00pm unless otherwise noticed.
- **Joint Meeting** dates between the Board of Trustees and the Board of Supervisors will be announced as scheduled, per Brown Act rules.
- **Quality Professional Services Committee** meetings are scheduled for the fourth Wednesday of every month except November and December. The meeting will be held on the third Wednesday of November to accommodate the holidays. There will be no meeting in December when the Board is on break. Meetings are scheduled from 5:00pm to 7:00pm unless otherwise noticed.

Board of Trustees Calendar 2026

January

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March

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June

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July

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September

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October

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November

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December

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- Full Board
- Audit and Compliance Committee
- Finance Committee
- Human Resources Committee
- Quality Professional Services Committee
- Packet Day
- Holiday
- Joint BOS/BOT

CEO REPORT

No Written Materials

Agenda Item B CEO Report

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

MEDICAL STAFF REPORTS

Alameda Health System
Medical Executive Committee
Report to
Board of Trustees

January 14, 2026

Berenice Perez, MD, AHS Chief of Staff

ALAMEDA HEALTH SYSTEM

Guiding Principles

Responsible for the "***quality of medical care to patients and for the ethical and professional practices of its members***" --Board of Trustees Bylaws.

Joint Commission Standard -- MS.03.01.01: The organized medical staff (OMS) ***oversees the quality of patient care***, treatment and services provided by licensed independent practitioners (LIPs) privilege through the medical staff process.

Medical Executive Committee Focus for 2026

- Medical Staff Self-Governance
  - Participation in decisions affecting patient care including the policies and planning
- Restructure and Redesign of the Medical Executive Committee Meetings
  - Collaborative and proactive approach for patient care
  - Engagement with leadership, nursing support, equipment, interdependence of patient facing roles
- Quality and Patient Safety
  - Patient Safety Committee
  - Peer Review Redesign with a focus on the process for OPPE and FPPE
- Survey Readiness for unannounced The Joint Commission (TJC) survey including:
  - Leadership and governance, credentialing, privileging, policies & procedures

ALAMEDA HEALTH SYSTEM

COMMITTEE AND TRUSTEE REPORTS

No Written Materials

Agenda Item D Committee Reports

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

CONSENT AGENDA: ACTION

BOARD OF TRUSTEES MEETING

WEDNESDAY, NOVEMBER 12, 2025
5:00pm to 9:00pm

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

LOCATION:
Open Session, In Person: HCP Conference Center, see above address
Teleconference Location: 4501 Pleasanton Avenue, Pleasanton, CA 94566

MEMBERS

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

THE MEETING WAS CALLED TO ORDER AT 5:04 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Alan Fox, Lilavati Indulkar, MD, Donna Linton, Nicholas Moss, MD, Rachel Richman, David Sayen and Sblend Sblendorio (arrived at 5:21 pm)

ABSENT: Greg Garrett, Nely Obligacion, excused

PUBLIC COMMENT:

Nicole Giovando requested consideration of SEIU/UHW contract to include the affordability for staff live in the city and county where they work. Their contract was up at the end of the month and they were requesting raises.

Rexie Dizon said frontline healthcare workers were struggling with the combination of rising inflation and Medicare cuts. Their paychecks no longer covered the cost of living in the Bay Area.

Donna Mapp said they (SEIU/UHW) were in negotiations, and they offered a generous proposal but the people at the table said they did not have the power to make decisions, and they had to ask the Board.

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

Trustee Sblendorio arrived at 5:21pm

B. MEDICAL STAFF REPORTS

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

Trustee Fox asked if the $20M savings for the REACH program (Resources and Engagement After Care in the Hospital) was just for the 450 patients reached or was it projected for the whole organization. Dr. Perez said she believed it was projected for the organization.

Trustee Fox said if those numbers were near the correct projection, COT should work on having all patients called after discharge. Mr. Fratzke said he had not seen this data before but would take a look at it.

Trustee Sayen asked if the savings in the REACH program were savings to AHS or medical costs that were avoided by the patients. Dr. Wu said it was the cost to the system per hospital day that was avoided by calling a patient and addressing their needs.

Trustee Linton said she noticed that the Radiology and Imaging slide did not include St. Rose. She asked if the Enterprise Imaging Program slide included data for St. Rose. Dr. Perez said they were a different medical staff, so this data did not include them.

C. COMMITTEE AND TRUSTEE REPORTS

C1. Human Resources Committee: October 15, 2025
David Sayen, Chair

C2. Quality Professional Services Committee: October 22, 2025
Lilavati Indulkar, MD, Chair

C3. Finance Committee: November 5, 2025
Alan Fox, Committee Chair

D. CONSENT AGENDA: ACTION

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

D1. Approval of the System Wide Policies and Standardized Procedures listed below

- Personal Appliance Policy

Recommendation from the Quality Professional Services Committee on October 22, 2025 to approve the policies listed below.

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

- Medication Aerosolized Epoprostenol Sodium (Flolan® OR Veletri®) Continuous Administration Policy
- Medication Administration Chemotherapy Antidotes for Extravasation Management
- Medication carts, Kits and Transport Boxes for Specific Depts. and Divisions

- Procedural Sedation Policy
- Patient Complaints and Grievances Policy
- 2026 Quality Assurance and Performance Improvement Plan (QAPI)
- Against Medical Advice Policy (AMA)
- School of Nursing and Paraprofessional Affiliation Requirements Policy
- PCP Assignment and Panel Size Policy
- Responsible Use of AI Policy
- Patient Non-Discrimination to Access Health Care Services

Recommendation from the Quality Professional Services Committee on October 22, 2025 to approve the policies listed below.

D3. Approval of the AHS Medical Staff Policies and Procedures listed below:

AHS and AH Medical Staff:

- Standardized Procedures for Advanced Practice Providers in The Department of Orthopaedic Surgery

Recommendation from the Finance Committee on November 5, 2025 to approve the contracts listed below.

D4. Contracts

D4a. Renewal agreement with Symplr Care Management LLC for provision of patient safety and quality reporting software applications. The term of this agreement is effective January 1, 2026 through December 31, 2028. The estimated impact of this agreement is $1,112,847.
Christine Yang, Chief Information Officer

D4b. New agreement with LAZ Parking California, LLC for provision of parking services. The term of this agreement is effective January 1, 2026 through December 31, 2028. The estimated impact of this agreement is $6,937,194.
Mark Fratzke, Chief Operating Officer

Recommendation from the Finance Committee on November 5, 2025 to approve the St. Rose Budget listed below.

D5. St. Rose Budget FY 26

Moved by Trustee Sblend and seconded by Trustee Fox to approve the consent agenda.

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

E. ACTION/DISCUSSION

E1. DISCUSSION: Department of Medicine Overview
Indhu Subramanian, Vice Chair Medicine and Program Director Internal Medicine Residency

Trustee Linton was impressed at the improvement in the number and scope of services without increasing FTEs. Dr. Subramanian said there were some places where FTEs did increase. They were getting more credit for the work already being done through improved productivity assessments, including improved clinical documentation and finding charges that were previously left on the table, improving no-show rates, and increasing the number of patients.

Trustee Sayen asked if they were at a disadvantage regarding research compared to a university hospital. Dr. Subramanian said they were. It was difficult when there was not a full infrastructure. They did have an infrastructure but not one that could support all of the activities. It was difficult for the oncologists to not be able to have their patients participate in clinical trials and access the most innovative and newest treatments for rare or unusual diagnoses.

Trustee Sayen asked how they could be an age friendly system if they did not have a geriatrician on staff. Dr. Subramanian said they had to ask if they should create an age-friendly system or wait to have a strong geriatrician who can build the program. There were very few geriatricians out there, and very few who had the skills to build a program. As a result, they would have to lay a foundation, become geriatricized, and then a geriatrician will want to come and build the program from there. Dr. Swift said this was an important equity concern as well. They had many patients who may be younger but experience the things that typically people in their older age do, such as heart failure. This one intervention could impact multiple populations at the same time.

Trustee Sblendorio asked if the building out of a geriatric division was market or demographic driven. Dr. Subramanian said there were three prime motivators. The most growth they were going to see in a vulnerable population was our elders. Having a geriatrics-trained individual to see patients of a certain age was a level one trauma certification. Additionally, orthopedic outcomes for hip and knee replacements were better when there was a perioperative evaluation and outpatient preoperative evaluation by a geriatrician.

Trustee Sblendorio asked if there was a demonstrated revenue generating aspect to having a geriatric program. Dr. Subramanian said there were indirect revenue impacts such as improving time to a surgery, decreasing length of stay, decreasing readmission, decreasing falls, as a few examples. Mr. Jackson said this was holistically looking at how they can best serve the community. They were collaborating with the Asian Health Center on their Program of All-Inclusive Care for the Elderly. We serve a lot of their patients. Being able to do safe discharges faster by virtue of their affiliation with a program like this is good for patient throughput, good for outcomes, and reduces readmissions.

E2. ACTION/DISCUSSION: Labor Efficiencies to Address Budget Shortfalls
Kim Miranda, Chief Financial Officer
Alexander Gallo, Vice President Financial Transformation

Trustee Richman asked if all employees would receive the letters regarding voluntary retirement or separation. Ms. Chapman confirmed the offers would go to all employees.

Trustee Richman asked if HR, Finance, and COT would work together to ensure all unions would receive a whole and realistic picture. Ms. Chapman said all three were going to present at two different meetings. COT would provide an overview of their work, Finance would provide an overview of HR1 and the impacts, and HR would present on the work being done regarding next steps.

Trustee Richman asked if there was concern about too many resignations happening as a result of this program, particularly for positions that are hard to fill. Ms. Chapman said that was a concern. There were criteria that would be set to protect essential positions. And all submissions for early retirement or voluntary resignations had to be approved.

Trustee Linton asked if the Board had to approve the voluntary resignation and early retirement programs. Mr. Azizi said Board approval was not required.

Trustee Sayen asked if there was a financial benefit to the employees for signing up for early retirement or voluntary resignation. Ms. Chapman said previously there were 17 weeks of severance and two weeks of COBRA, she would have confirmation on the current offer by Friday.

Trustee Sayen said there was not much appetite for the offer when it was made last year and asked if the offer was changed to get more response. Mr. Fratzke said they dropped the retirement age. Mr. Jackson said they were also looking at other ways to make the offer more appealing.

Trustee Sblendorio asked if the terms last year were more or less similar to this year's offer. Ms. Chapman said at this time they were similar, but it was still being reviewed.

Trustee Sblendorio said HR1s impact was going to be felt over the next few years. He asked if staff might be waiting to see if there would be a better deal next year or the year after. Mr. Jackson said that was a possibility. But they had a specific number they had to get to and they would get there. Staff who waited to see if they could get a better offer did run the risk of having that discretion taken away. He would prefer people to do it voluntarily, but they would get to the needed reduction either way.

Trustee Linton asked if the first round was trying to right-size the labor costs and current FTEs to the budgeted number. Mr. Fratzke said the current FTE was only a little higher than budget. They had to lower that.

Trustee Linton asked if they were looking at it by service. Mr. Fratzke said they were looking at FTEs across programs, services, and leadership. Mr. Jackson said it would be easier and incorrect to just make a unilateral cut. They had to consider what services they provided that were not available elsewhere in the community, for example.

Trustee Linton asked if there was a role for the Board to express priorities in terms of services lines and areas that they felt were important and should be made. Mr. Jackson said

the Supervisors empowered the Board with stewardship and oversight. Leadership and staff were the operators. They would present what they thought was right, but it would make sense to do so in concert with the Board.

F. DISCUSSION: Board Calendar and Tracking

Trustee Sayen said that in 2026 they wanted to be better about making sure the Board has opportunities to consider things before they are due to be approved.

G. STAFF REPORTS (Written)

G1. Chief Financial Officer Report, September Financial Report
Kimberly Miranda, Chief Financial Officer

Trustee Indulkar said she would recuse herself from agenda item 4, as a member of SEIU.

Trustee Obligacion said she would recuse herself from agenda item 4, as an employee of SEIU.

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

CLOSED SESSION

1. **THREAT TO PUBLIC SERVICES OR FACILITIES**
   (Gov. Code § 54957)
   Consultation with Ian Rodriguez, Deputy Director of Security

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

3. **Labor Negotiation**
   [Government Code Section 54957.6]
   AHS Designated Representatives: David Sayen, Board President
   Unrepresented Employee: Chief Executive Officer

4. **Conference with Labor Negotiators**
   [Government Code Section 54957.6]
   AHS Designated Representatives: Ulysses Madison, Director of People Operations
   Employee Organization: UAPD, ILWU, ACMEA, SEIU, CNA, SEIU-UHW

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

(Reconvene to Open Session)

General Counsel Report on Action Taken in Closed Session

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

OPEN SESSION

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

Moved by Trustee Sayen and seconded by Trustee Fox to approve a 7.5% incentive bonus for the year that ended on June 30th.

ACTION: A motion was made and seconded to approve a 7.5% incentive bonus for the year that ended on June 30th A roll call was taken, and the motion passed.
AYES: Trustees Fox, Indulkar, Linton, Moss, Richman, Sayen, Sblendorio
NAYS: None
ABSTENTION: None

ADJOURNMENT: 7:38 pm

ALAMEDA HEALTH SYSTEM

November 19, 2025

TO: Quality Professional Services Committee

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

SUBJECT: **Agenda Item:** A3

Meeting Date: November 19, 2025

Item Description: Medical Staff Policies and Procedures

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

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

New policies are developed and existing policies are revised in accordance with best practice, legal and regulatory requirements.

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

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

Board Action Requested: Approval of Policies

New Policy for AHS & AH Medical Staff:

- Medical Staff Credentialing Information Integrity and Data Security

Revised Polices for AHS & AH Medical Staff:

- Medical Staff Credentialing and Privileging of Providers
- Medical Staff Ongoing Monitoring and Evaluation of actions Related to Providers
- Medical Staff Routine Focused Professional Practice Evaluation (FPPE)/Proctoring

- Standardized Procedures for Advanced Practice Providers in the Department of Surgery

Retired Policy for AHS & AH Medical Staff:

- Medical Staff Credentialing Systems Control

Alameda Health System

MEDICAL STAFF CREDENTIALING INFORMATION INTEGRITY AND DATA SECURITY

Department	Medical Staff Services	***Effective Date***	11/19/2025
Campus	AHS, AH	***Date Revised***	
Unit	All	***Next Scheduled Review***	11/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies: Medical Staff Credentialing System Controls		***Responsible Person***	Vice President, Physician Services

Purpose

This purpose of this policy is to describe the ongoing monitoring process the Alameda Health System follows for storing, modifying, and safeguarding credentialing information.

Policy Statement

Alameda Health System maintains and safeguards the information used in the Alameda Health System and Alameda Hospital Medical Staff's credentialing and recredentialing process against inappropriate documentation and updates.

Procedure

A. Scope of Credentialing Information

Credentialing information protected under this integrity policy will include:

- Provider applications and attestations
- Primary source verifications
- Credentialing activity documents:
  - Verification dates
  - Report dates
  - Credentialing/privileging dates
  - Credentialing/privileging decisions
  - Signature/initials of the verifier or reviewer
- Credentialing Committee minutes
- Application level
- Checklists/audits

B. Staff Responsibilities/Access

Staff are assigned user roles based on areas of responsibility as defined in their job description. Each user role is assigned specific view/edit system access as needed to perform their duties which may include editing or updating the credentialing information; only administrators or end user-super users have access to delete images and records, when appropriate. Modifications can be made to credentialing information when there is supporting information for the change.

Other credentialing activities and documents may be updated if the policy identifies that credentialing information changes and/or updates are appropriate.

The Medical Staff Manager, or designee, is responsible for the oversight of credentialing information integrity functions, including the audit monitoring process and corrective actions.

The staff responsible for documenting credentialing activities are categorized below, there are no facility restrictions with the exception that the ARM reviewers are limited to their assigned department/medical staff:

Group	Position/Title	Group Function
Administrator	VP Medical Staff Services; Systems Analysts; Medical Staff Manager	Full access to Credentialing module.
Apogee Administrator (Network Management/Provider Enrollment)	Provider Enrollment Manager; Sr. System Analyst	Full access to Network Management module.
Apogee Super User	Provider Enrollment Coordinators	Restricted access to Network Management module (excludes backend table and system maintenance). Update function in Credentialing module.
User Groups - End User-Super User	Senior Credentialing Coordinator	Restricted access to Credentialing module (excludes system maintenance).
User Groups – End User Access and ARM	Medical Staff/Credentialing Coordinators; Administrative Project Assistants	Limited access to Credentialing module (excludes backend table and system maintenance). No ability to delete images or records (except to correct covering/supervising provider to pull from system).
User Group: APA Users	Administrative Project Assistants, Interns	Minimal access to Credentialing module to upload documents, access practitioner task list and record/field entries. No ARM access, with the exception of ARM audit.
Administrative Reviewers	Medical Staff Division/Department Chairs; Chiefs of Staff; Chief Executive Officer/Chief	Administrative review module only, write function limited to evaluation and requested privilege approval.

	Medical Officer, or designee	

C. Documenting Updates to Credentialing Information

Updates to existing credentialing information is appropriate if credentialing information changes.

When an update is made to credentialing information, the Credentialing system Audit Detail Train will automatically record what was updated, the date and time the update was made and who made the update; the Credentialing Staff will include relevant explanations and reasons regarding what information was updated. When a new verification is required, the verification will be initiated, or the system will automatically generate, (via webcrawl) all appropriate documentation requirements to include the credentialing staff (user) identifier date of the verification and stored in the applicant's credentialing file. When a verification is retrieved manually (not via webcrawl), commentary may be stamped on a primary source document to identify receipt or reference additional supporting information if not included. Automated webcrawl results may be relied upon as the acquired date and updated expiration date (if available functionality) for primary source verification performed between credentialing cycles.

Primary source verifications may not be modified (edited/updated) when verification information changes, rather a new primary source verification will be completed.

When data requires an update, such as when the element expires requiring reverification, the previously primary source verified record is not altered, rather a new verification will be completed and the relevant data fields updated. The original verification documentation is retained in the credential file.
When updates are made, supporting documentation will include what was updated, why it was updated and by whom. File notes, comments or corresponding documents may be used to document supplemental information not otherwise automatically documented. Supporting documentation is not required when updates are made to correct typos/punctuation, add organizational assigned elements (i.e., office address, malpractice insurance) and when deleting a duplicate entry.

The Credentialing Staff enters information regarding the update into the appropriate field (described above).

Type of updates to existing credentialing that are appropriate:

- Error/Omission identified such as typographical errors.
- New information is available and needs to be added.
- Documents appended to incorrect provider profile.
- Updates to expired credentials.
- Updating or changing provider data information.

D. Inappropriate Documentation and Updates

The following documentation and updates to credentialing information outlined above are inappropriate:

- Falsifying credentialing dates (i.e., staff verification date, attestation date, credentialing decision date, etc.)
- Creating documents without performing the activity (i.e., photocopying a prior credential and updating information as a new credential.)
- Fraudulently altering existing documents (i.e., committee minutes, clean-file reports, ongoing monitoring logs, etc.)
- Attributing verification or review to an individual who did not perform the activity.
- Updates to information by unauthorized individuals.

E. Auditing, Documenting and Reporting Information Integrity

Alameda Health System completes an annual credentialing information integrity audit of the credentialing staff's documentation and updates to the credentialing information.

The credentialing information integrity audit will be completed using the Credentialing Information Integrity Audit and Analysis tool. Inappropriate documentation or updates identified will be tracked on this tool and the findings will be reported to the Vice President of Physician Services for review and determination of actions as appropriate.

The audit universe includes the provider files for all initial and reappointments made during the look-back period (prior 12 months). A random sample of provider files will be selected using 5% or 50 files, whichever is less.

The random sample includes at least 10 initial applications and 10 reappointment applications. If fewer than 10 providers were appointed and/or reappointed within the look-back period, all files will be included.

The audit tool includes the following information:

1. Report date
2. Title of individuals who conducted the audit
3. The 5% or 50 files auditing methodology.
   a. auditing period
   b. file audit universe size
   c. audit sample size
4. The audit log:
   a. file identifier
   b. type of credentialing information audited
5. Findings for each file.
   a. rationale for inappropriate documentation and updates, if applicable
6. The number or percentage and total inappropriate documentation and updates by type of credentialing information.

The CII Audit and Analysis tool will be completed and maintained even if no inappropriate documentation and updates are found.

F. Analysis, Corrective Action and Follow-Up of Information Integrity Issues

An annual qualitative analysis will be conducted for each instance of inappropriate documentation or update identified during the audit to determine the underlying cause.

If an instance of inappropriate documentation or update is identified, the CII Audit and Analysis tool will include the following:

- Titles of credentialing staff involved in conducting the qualitative analysis
- The identified cause of each finding

Documentation of the corrective actions planned or taken will be documented on the audit tool, including dates of action and who is responsible for implementation, to address all inappropriate documentation and updates.

A reaudit of the inappropriate documentation or updates identified will be conducted and documented in the tool within 3-6 months following the annual audit to evaluate the effectiveness of the corrective actions taken.

The reaudit will include practitioner files for all credentialing decisions made, or due to be made, 3–6 months after the annual audit.

If noncompliance with integrity policies and procedures is identified during the reaudit, a qualitative analysis will also be included to assess the nature and cause of the noncompliance.

If inappropriate documentation and updates are identified during the credentialing information integrity audit, consequences will be determined based on the severity of the issue. These may include, but are not limited to:

- Coaching/mentoring
- Implementation of a Performance Improvement Action Plan
- Disciplinary action

G. Information Integrity Training

Alameda Health System will conduct training to the credentialing and enrollment staff on inappropriate documentation and updates to the credentialing information as defined in this policy.

Training will be provided annually to all existing staff and upon new hire orientation for any new staff. Documentation of training material and attendance will be kept on file in the medical staff office.

H. Confidentiality and Information Security

In accordance with the AHS/AH medical staff bylaws and policies, medical staff records are confidential and access is limited to duly appointed officers and committees of the medical staff.

Medical Staff services personnel are granted access to the credentialing database in accordance with their assigned user role defined in this policy. Electronic files are primarily maintained within the credentialing database; however, supporting materials may also be electronically stored in a network folder, accessible to all medical staff

personnel. Personnel shall secure all confidential information when not in use. Workstations shall be in physically secure areas and computer screens should be positioned to prevent viewing form unauthorized individuals.

File location/storage and release of credentials information to third parties is addressed in the medical staff policy titled "Access to Medical Staff Records". Any historical, hard copies files are stored in on or off-site locations in locked files accessible by the Vice President of Physician Services, or designee.

In addition to the annual training for information integrity, medical staff services personnel are provided with orientation to the location and security of credentialing files, and all relevant polices, upon hire. Existing medical staff service personnel are oriented to updates and revisions of any relevant policies. All medical staff services personnel annually attest to maintain the confidentiality and protection of such information during and after employment.

Alameda Health System secures and backs-up electronic information in accordance with system-wide policies. Medical staff credentialing files are maintained indefinitely. Disposal of any duplicate or erroneous credentialing information would be deleted (electronically) or shredded (physical, paper) in a secure shredding bin.

References:

1. AHS/AH Medical Staff Bylaws
2. AHS/AH Medical Staff policy titled "Access to Medical Staff Records"
3. AHS Information Security System-wide policies titled:
   - Information System Access Policy
   - Information Systems Activity Review
   - Information Security Risk Management
   - AHS Remote Access to Information Systems
   - Acceptable Use of Information Systems Policy

		AHS	**AH**
Credentials Committee	**Date:**	**11/13/25**	
Medical Executive Committee	**Date:**	**11/19/25**	**11/14/25**
QPSC	**Date:**	**11/19/25**	
Board of Trustees	**Date:**		

Alameda Health System

MEDICAL STAFF CREDENTIALING AND PRIVILEGING OF PROVIDERS

Department	Medical Staff	***Effective Date***	5/2011
Campus	AHS, AH	***Date Revised***	5/2011, 6/2014, 6/2017, 6/2019, 2/2020, 1/2022, 4/2022; 4/2023; 5/2023; 10/2023; 11/2023; 2/2024; 3/2024; 3/2025; 4/2025; 8/2025; 11/2025
Unit	Medical Staff	***Next Scheduled Review***	11/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose

As an extension of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staff Bylaws this policy will establish the mechanism for gathering relevant data, which involves the collection, verification and assessment of applicant information that will serve as the basis for decisions regarding credentialing and privileging of licensed practitioners and Advanced Practice Providers (APP), collectively referred to herein as "provider",who provide patient care services within the Alameda Health System.

Policy Statement

It is the policy of the AHS/AH Medical Staff to ensure that licensed practitioners and APPs meet minimum credentialing, privileging and performance standards for membership and/or privileges/practice prerogatives as outlined in the Medical Staff Bylaws and policies. The credentialing process is performed jointly where applicable, however, membership appointments and granting of privileges are independently recommended to the Governing Body by the respective Medical Staff.

All applications for appointment and/or reappointment to the Medical Staff/Advanced Practice Provider, and requests for clinical privileges, will be evaluated based on critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Any applications that meet the application criteria during the verification process shall be categorized in accordance with policy.

Credentialing is required for all physicians (medical or osteopathic), dentists, podiatrists, or clinical psychologists as well as those advanced practice providers approved by the Board of Trustees, which include acupuncturists, audiologists, optometrists, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives and physician assistants.

Nondiscriminatory Statement and Audit Process

The AHS and AH Medical Staff credentialing, and privileging process acts in compliance with all federal and state and local laws and regulations governing discrimination involving patients, employees, vendors, visitors and other individuals and entities associated or involved with AHS. This policy reaffirms the commitment of the AHS Medical Staff and AH Medical Staff to maintaining a discrimination-free credentialing and privileging process.

The AHS and AH Medical Staff will not engage in discrimination or harassment of any person employed or seeking employment or medical staff credentialing or patient care within AHS on the basis of race, color, natural origin, age, disability, religion, sexual orientation, gender identity, gender expression, physical or mental disabilities, medical condition, pregnancy, HIV status, ancestry, marital status, citizenship, or status as a covered veteran or the type of procedure patients in which the provider specializes. The Medical Staff does not retaliate against a person for pursuing their right under this policy and/or for the purpose of investigatory proceedings. Non-discriminatory information is available in alternative forms of communication to meet the needs of persons with sensory impairments.

The AHS and AH Medical Staff will not discriminate against a licensed provider solely on the basis of a civil judgment, criminal conviction, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is solely based on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California

On an annual basis, each member of the AHS and AH Credentials Committee will sign a confidentiality statement that will include an affirmative statement that all decisions are made in a non-discriminatory manner.

The Medical Staff Services Department will monitor through periodic audits of credentials files and provider complaints about possible discrimination, by performing audits of decisions recommended by the Credentials Committee. The findings will be reported to the Credentials Committee and the Medical Executive Committee on an annual basis to protect against discrimination and to maintain a nondiscriminatory credentialing process.

Procedure

All applications for appointment, reappointment, and requests for clinical privileges are processed as described below. The initial application process requires completion of a pre-application step prior to the initial application being issued. Telemedicine credentialing by proxy will be processed in accordance with policy.

Applicants will provide an attestation that all information submitted for credentialing and privileging is accurate and agree to immediately report any change in status of the information maintained in the Credentials files.

If any submitted items differ from information received through the verification process, the applicant will be required to resolve discrepancies. This may require further consultation between the applicant and the Department Chair or Division Chief.

Applications for membership and clinical privileges will be processed and verified as indicated herein.

Pre-Application

A pre-application will be issued via email to potential applicants requesting staff membership and/or clinical privileges. The pre-application will be used to determine if the applicant meets the basic qualification for medical staff membership/advanced practice provider status as delineated in the Medical Staff Bylaws, Rules, and Policies.

Potential applicants will be provided instructions outlining the basic requirements to apply for membership and/or privileges along with a link to an electronic pre-application. Once the pre-application is submitted a cursory review of the applicants' qualifications will be performed including review of the following:

1. Professional license(s); including all states and other jurisdictions
2. Medical Board of California License Verification System (LVS) – Health Facility/Peer Review Reporting Form (805 report)
3. Drug Enforcement Administration (DEA) registration, if applicable
4. National Provider Identifier Registry (NPI)
5. National Practitioner Data Bank (NPDB)self-query
6. Office of Inspector General (OIG) exclusion database
7. System for Award Management (SAM) exclusion list
8. Department of Health Care Services (DHCS) Medi-Cal Providers Suspended and Ineligible Provider list
9. California Secretary of State Business look-up
10. Centers for Medicare and Medicaid Services (CMS) Opt Out List
11. Internet search query

The applicant will be notified if they do not meet criteria and the initial application will not be released. Such action shall not give rise to hearing and appeal rights pursuant to the Medical Staff Bylaws, nor require reporting to the National Practitioner Data Bank and/or licensing body. If a potential applicant believes that they meet the criteria, that individual must submit evidence to substantiate such, in writing, to the Medical Staff within thirty (30) days after notice that criteria was not met.

If the applicant meets criteria, instructions and a link to the portal to access the initial application packet and privilege forms approved by the Medical Executive Committee will be sent. The communication will outline the time frame and basic requirements for processing the request.

Initial Application for Appointment

Providers who meets criteria to apply for membership and/or privileges must submit a complete application along with copies of other documents as applicable including, but not limited to, the following:

1. California Medical License (copy required)
2. Out of State License, if applicable
3. DEA registration, if applicable
4. Other relevant certificates or permits (i.e., PALS, BLS/ACLS, Fluoroscopy, etc.)
5. Diploma, Education and Training Certificates
6. Curriculum vitae (CV) / Resume
7. Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
8. Board Certification or Advanced Practice Provider National Certification
9. NPI Number
10. Evidence of current and any prior malpractice coverage of $1 million per occurrence/$3 million aggregate
11. Malpractice Insurance Declaration of Coverage for the past 10 years (recent graduates must provide malpractice during their residency)
12. Copy of a California State-issued photo identification (i.e., driver's license). The name on this document will be used as the provider's official name of record.
13. Privilege Request, if applying for privileges, which shall include any relevant documentation to support the qualifying criteria
14. Procedure or clinical case log activity for the last two years
15. Application fee
16. Immunization/Vaccines in accordance with policy
17. Written documentation explaining gaps in education, practice and work history of 90 days or more Covering provider(s)

The following forms must be completed and signed:

1. Background Investigation Acknowledgement Form
2. Information Release/Acknowledgment
3. AHS/AH Medical Staff Sharing Agreement
4. Confidentiality and Security Agreement
5. Confidentiality Agreement form for Medical Staff Affairs
6. Medical Staff Quality and Assessment and Peer Review Agreement
7. Information Services (IS) Epic Training Data Collection Form
8. Electronic Signature authorization
9. Photography and Videotaping Attestation
10. Medicare and Tricare Acknowledgement
11. Professional Code of Conduct Agreement
12. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.
13. Relevant APP agreements and standardized procedures as applicable.

The applicant's identity must be verified via presentation of an original government-issued identification document prior to appointment/granting of privileges.

Reappointments

Reappointment to the Medical Staff and requesting of clinical privileges shall occur within a period not to exceed 24 months. The provider shall be required to submit a complete application along with copies of documents as applicable including, but not limited to, the following:

1. New Malpractice Insurance Declaration of Coverage not currently on file
2. Any new, relevant licensure or certification not currently on file
3. An update CV/Resume, if applicable
4. Privilege Request, if applying for privileges, which shall include any relevant documentation to support the qualifying criteria
5. Reappointment application fee

The following forms must be completed and signed.

1. Background Investigation Acknowledgement
2. Information release/acknowledgment
3. Sharing agreement
4. Confidentiality and Security Agreement
5. Confidentiality Agreement form for Medical Staff Affairs
6. Medical Staff Quality and Assessment and Peer Review Agreement
7. Professional Code of Conduct Agreement
8. Attestation Questionnaire: including applicant attesting to perform privileges as requested, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity.
9. Relevant APP agreements and standardized procedures as applicable.

Reappointment Applications will be sent via the Practitioner Portal to provider approximately four (4) months prior to their appointment expiration date and are expected to be completed on-line and submitted within 60 days.

Medical Staff Services sends reappointment applications as outlined in the Medical Staff Bylaws. Communication templates are outlined in Attachment A.

If the provider fails to submit a completed application by the date as stated on the written notice, a final reminder will be made to the provider, which includes an attempt to reach the provider via phone call. Failure to do so shall be deemed as a voluntarily resignation of membership and/or privileges. The procedural rights set forth in the Medical Staff Bylaws shall not apply to voluntary resignation.

Verification and Processing

When the application for appointment or reappointment is submitted, a review for completeness is performed by Medical Staff Services. If additional information is required, or if questions are left blank, the applicant is contacted and informed that processing will not begin until the application is entirely complete. The applicant is responsible for providing the information to satisfy the process, including resolution of any discrepancies. Failure to submit the requested

information within thirty (30) days shall be considered a withdrawal of the application. Such withdrawal shall not give rise to hearing and appeal rights pursuant to the Bylaws. In accordance with the Bylaws, the Medical Staff will not take action on an application that is not "complete".

All information gathered on the application will be verified by the primary source (when applicable). Primary source may include oral verification which requires a dated, signed note in the credentialing file stating who at the primary source verified the item, and the date and time of verification.

The following queries, along with the applicable source/location, will be conducted:

1. California Professional License/Professional Licenses from Other States
   Current California State professional licensure must be obtained by direct confirmation from the appropriate licensing board via the California Department of Consumer Affairs Licensing Board Website. Other State Medical and Professional Boards for active professional licenses will be verified with the relevant State Board.

2. DEA Certification
   All providers must have a valid DEA certificate, with a California address, with the exception of Pathologists. For Advanced Practice Providers, DEA requirements are based on scope of service. Providers who are required to have a DEA, must have an unexpired DEA, without limited schedules or an out of state address, otherwise privileges shall be suspended until evidence of a valid DEA is verified. Primary source verification is obtained via the DEA Controlled Substances Act Registration Information Database.

3. Fluoroscopy or Radiography Certification
   A copy of the permit/certification is required for all radiologists and non-radiologists who will be using fluoroscopy equipment in the operating rooms or other procedure areas. Radiography Certificate is not acceptable as a Fluoroscopy Certificate. Temporary primary source verification will be obtained via the California Department of Public Health (CDPH) Radiologic Health Branch (RHB).

   Medical Staff Services shall provide a monthly report to Radiology and Perioperative Services of all providers with a valid Fluoroscopy certificate.

4. Hospital Affiliations and/or Work History
   Written verification of ten (10) years of clinical work history from hospitals or other health care organization affiliations is required for initial appointment and the prior two (2) years for reappointment. Verifications must be received directly from the organization or their designated third party.

   If verification of an affiliation is not obtained after three attempts with the applicant's assistance, including a phone call to the facility, the file may then move through the evaluation process without verification. In such instance, a file note will be recorded.

5. Graduation from Medical/Professional School and Completion of Residencies and Fellowships
   Verification of medical/professional school graduation and completion of residency and fellowship training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed a primary source verification, such as the American Medical Association (AMA) Physician Masterfile or American Osteopathic Association (AOA) Physician Database, National Student Clearing House (NSCH) (upon confirmation the organization uses NSCH as their 3rd party) or Federation of State Medical Boards (FSMB) for closed residency programs or state licensing agency, if the state verifies.

   Foreign Medical Graduates from schools of medicine other than those in the United States and Canada must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG) or successful completion of a fifth pathway, or successful passing of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Verification of foreign graduation will be conducted.

6. Board Certification
   Board Certification is verified querying the American Board of Medical Specialties on-line database, American Osteopathic Association (AOA), or primary source verification directly from the certification board.

   Advanced Practice Registered Nurses and Physician Assistants are required to maintain national certification by any of the following bodies:
   - American Academy of Nurse Practitioners (AANP)
   - American Nurses Association – American Nurses Credentialing Center (ANCC)
   - Pediatrics Nursing Certification Board (PNBC)
   - National Certification Corporation (NCC) for Nurse Practitioner certification
   - American Association of Critical-Care Nurses (AACN)
   - American Midwifery Certification Board (AMCB)
   - National Board of Certification & Recertification for Nurse Anesthetist (NBCRNA)
   - National Commission on Certification of Physician Assistants (NCCPA)

7. Current, Adequate Malpractice Insurance
   Professional Liability Insurance coverage and the amount of coverage must be verified directly with the carrier.

8. Professional Liability Claims History
   Verification of ten (10) years of claims history for new appointments and the previous two (2) years for reappointments must be obtained from the current and/or previous carriers. If after three (3) attempts with the applicants' assistance, including a phone call to the facility, the insurance carrier does not respond, the NPDB will be used as primary source verification. The NPDB query may be used as evidence of settlement and judgment history.

9. Background Checks
   Background checks will be conducted on all applicants at the time of initial appointment and reappointment in accordance with state and federal laws. Applicants must consent to this

process by signing and submitting the Notice Regarding Background Check Investigation. Failure to complete this form shall result in the application being deemed incomplete.

Signature on the Notice Regarding Background Investigation acknowledges and authorizes Medical Staff Services to search the following databases:

- Social Security Number (SSN) Trace and Death Index
- Maiden & Alias Name Search
- Criminal Records Search – Federal, State and County Levels
- National Wants and Warrants
- National Sex Offender Registry
- General Services Administration (GSA)
- U.S. Government Terrorist List/Office of Foreign Assets Control (OFAC)

10. National Practitioner Data Bank (NPDB)
    The NPDB must be queried for all new appointments, reappointments and at the time of the request for additional privileges. Each query to the NPDB is facility specific therefore there will be a query for every facility to which the provider is applying. All providers will be enrolled in the NPDB Continuous Query and will be reviewed at initial appointment, reappointment, temporary privileges, and request for additional privileges.

11. Medicare/Medicaid Sanctions
    Sanction verifications for Medicare and Medicaid will be obtained via Sanctions Exclusions Report published by the Office of Inspector General (OIG) and Excluded Parties List System (EPLS) for all new appointments and reappointments.

12. Centers for Medicare & Medicaid Services (CMS) Opt Out
    CMS will be queried for all new appointments and reappointments to confirm whether a provider has opted out of participating in the Medicare program.

13. Professional References
    Three (3) professional references for providers with the same credentials are required for new applicants and two (2) for reappointments. For reappointments, the Department Chair or an AHS Division Chief may serve as the peer reference. These references must be from individuals familiar with a provider's work, either via direct clinical observations or through a close working relationship within the prior two years. For an Advanced Practice Provider (APP) one of the references should be from a physician within the same department that has direct observation of care provided.

14. Continuing Medical Education
    A statement documenting Continuing Medical Education must be included with the application for appointment or reappointment or a signed statement indicating that the provider has met or exceeded continuing medical education requirements for licensure. Courses must reflect appropriate training for the specialty and privileges requested and meet any state-mandated CME requirements.

15. Provider Enrollment
    For applicants who are assigning billing, collected information will be distributed to health plans as required for purposes of billing and enrollment. Providers may be required to complete various payor-specific forms. Provider Enrollment has access to the information in the Medical Staff Services database for the purpose of providing accurate credentialing information to health plans and for the publishing of provider directories.

16. Ongoing Professional Practice Evaluation (OPPE)
    Ongoing Professional Practice Evaluation (OPPE) is the continuous evaluation of provider's performance. Information contained in OPPE reports are factored into the decision to maintain existing clinical privilege(s), to revise, or to revoke an existing clinical privilege prior to or at the time of reappointment.

17. Additional Information
    Departments and Clinical Services may also require additional documentation or standards. Privilege criteria is defined in the specialty-specific privilege request forms.
    Other information as deemed necessary may also be collected and considered at the request of the Medical Executive Committee or designee.

18. Timeliness of Information
    The established processing time is estimated at 60-90 days following receipt of completed application. Applications for Behavioral Health providers will be assessed for completion and verification of qualifications within 60 days of receipt of an application. Such applicants will be notified within seven (7) business days of receipt and confirmation of whether the application is complete. An application must be signed within 120 days of Credentials Committee review. The attestation must be signed within 180 days of Credentials Committee review. Verification of licensure, board certification, sanctions, current work history, malpractice claims history must be verified within 120 days of Credentials Committee review.

Requests for Modification of Privileges
Providers may request a modification of additional privileges at any time. These requests are handled as follows:

1. The provider must complete the request for a modification of privileges request and privilege form along with any supporting documentation regarding training or experience, as required.

2. The following primary source verification will be conducted:
   - CA Medical or Professional License(s)
   - LVS 805 Report
   - NPDB

3. FPPE/Proctoring shall be considered by the Department Chair at the time of a request for additional privileges.

4. The privileges requested and supporting documentation is made available to the appropriate Division Chief and/or Department Chair/designee for review and recommendation to the Credentials Committee with final review and recommendation for approval by the Medical Executive Committee (MEC) to the Governing Board.

Appointment/Privilege Approval Notifications
Following Board approval, providers will be issued a Board approval notification letter outlining the approved membership and privileges within ten (10) business days of the Quality Professional Services Committee (QPSC)/Board determination.

Application Fees
Providers are required to submit an application fee for membership and/or privileges. An application is incomplete until payment is received. Application fees are non-refundable once the submitted application has been received and processing has started. Reappointment fees are applied in full, regardless of the reappointment term.

1. Medical Staff Fees:
    a. AHS/AH application fee for Temporary Privileges ONLY of $100.00.
    b. AHS application fee of $300.00 and reappointment fee of $500.00.
    c. AH application fee of $300.00 and reapplication fee of $500.00.

2. Advanced Practice Provider (APP) e.g., PA, NP, etc. Fees:
    a. AHS application fee of $150.00 and a reappointment fee of $150.00.
    b. AH application fee of $200.00 and a reappointment fee of $200.00.

3. Providers who apply for membership or privileges at more than one Medical Staff within Alameda Health System the provider will receive a 50% discount of their initial application and/or reappointment fees at the second facility.

AHS and AH Category Assessments
The number(s) of patient care activities for the associated status categories are defined in the AHS/AH Medical Staff Bylaws. During the reappointment process, each applicant's clinical care activity reports will be reviewed to determine accurate category assignment.

Voluntary Resignation
Providers who wish to resign their Medical Staff membership and/or privileges shall complete a Voluntary Resignation form.

Medical Staff Services will process the voluntary resignation and complete the necessary steps for deactivation of Alameda Health System computer access. The provider will attest that their charting and medical records for any care provided will be completed on or before their voluntary resignation (H&Ps, procedure notes, orders, discharge summaries). In addition, they will acknowledge that their AHS network logon and all application access will be automatically deactivated on the indicated date of their voluntary resignation. Any changes to the voluntary resignation date or a desire to rescind this resignation MUST be communicated verbally and in writing to the Medial Staff Office and the Department Chair. Failure to communicate any

changes in dates will result in the resignation being effective as of the date on the Voluntary Resignation Form and all systems access will cease as outlined in the deactivation process.

PROVIDER RIGHTS TO AMEND APPLICATION AND REVIEW CREDENTIALS FILE

Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be notified, asked to resolve this discrepancy, and expected to do so within thirty (30) days of the request. All identified and/or requested amendments will be included in the provider's file for consideration.

Providers are allowed access to their own credentials files as outlined in the respective Medical Staff policy.

Providers have a right to be informed of the status of their application. Upon submission of an application, an auto-generated email confirming receipt is sent to the provider. Initial applicants are provided with an estimated board appointment date. Applicants may request the status of their application via email or phone call to the medical staff office. Contact information for medical staff services is provided in application correspondence and is posted on the intranet. A representative of the medical staff office will respond within three (3) business days.

RELATED DOCUMENTS
Alameda Health System and Alameda Hospital Medical Staff Bylaws, Rules & Regulations, Privilege Forms, Policies and Procedures

Approvals:

		AHS	AH
Credentials Committee	**Date:**	**11/13/25**	
Medical Executive Committee	**Date:**	**11/19/25**	**11/14/25**
QPSC	**Date:**	**11/19/25**	
Board of Trustees	**Date:**		

Medical Staff Credentialing and Privileging of Providers
Attachment A

The email templates below will be used at the point where the Credentials Coordinators stop any additional work on collecting an application for reappointment.

The provider will receive two courtesy reminder emails with language in the second reminder as follows:

Subject Line: **Action Needed** Application for Reappointment AHS / AH

Reappointment Failure to Submit Application Reminder: *Used for the second notice that a reappointment application was not submitted.*

Dear (insert provider's name),

This is a second reminder to notify that your application for reappointment to the <Alameda Health System/Alameda Hospital> Medical Staff has not been received. It has been 20 days since the initial notification to apply for reappointment was sent. Your application for reappointment is due within 35 days from the date of initial notification. Should your application not be submitted, it will be considered a voluntary resignation of medical staff membership and privileges at <Alameda Health System/Alameda Hospital>.

Following voluntary resignation, you will be required to reapply for membership and privileges via initial application for appointment. If you have any questions, please contact the Medical Staff Services Department at <Alameda Health System/Alameda Hospital>.

Sincerely,

Medical Staff Services
AHS Phone: 510-437-6535
SLH Phone: 510-297-5404
AH Phone: 510-814-4035
Email: medicalstaff@alamedahealthsystem.org

If the provider fails to submit a completed application in the timeframe outlined on the written notice, a final reminder will be made to the provider by telephone requesting communication with Medical Staff Services within 24 hours. Failure to do so shall be deemed to have voluntarily resigned their Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws shall not apply to a voluntary resignation under this section.

The following two email templates would be the standard work when sending email communication to address applications for reappointment which have not been submitted after three (3) automated efforts. If an application for reappointment has been started and is in progress, the applicant will be sent The Partial Action on Application for Reappointment notification.

Subject Line: **Final Notice** Application for Reappointment AHS / AH
Cc: Department Chair, Division Chief (if applicable), Credentials Committee Chair(s), MSS Director, Manager

Regular Failure to Submit Email: *Used for the final notice that an application was not submitted, and patient care is ending.*

Dear (insert provider's name),

Medical Staff Services has not received your application for reappointment to the Medical Staff of Alameda Health System and/or Alameda Hospital.

The invitation to the online application portal was sent on month/date/year, and the application remains at 0% complete. The following reminders were sent to your email(s) on file, on the below dates:

- First reminder – month/date/year
- Second reminder - month/date/year
- Third reminder – month/date/year

As of today's date, you have exceeded the 35-day application for reappointment period, as outlined in the invitation to apply for reappointment. Per the Medical Staff Bylaws, failure to submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.

In effect, this results in termination of membership and/or privileges as a voluntary resignation from the Alameda Health System Medical Staff.

As of month/date/year, your Medical Staff Membership and/or Privileges at Alameda Health System will expire, with no patient care permitted.

Please contact your Department Chair, regarding the above.

Partial Action on Application for Reappointment: *Used only if the Department Chair wants them to stay on staff or they are close to having the application completed.*

Subject Line: **Final Notice Requiring Action** Application for Reappointment AHS / AH
Cc: Department Chair, Division Chief if applicable, Credentials Committee Chair(s), MSS Director, Manager

Dear (insert provider's name)

Medical Staff Services has not received your application for reappointment to the Medical Staff of Alameda Health System and/or Alameda Hospital.

The invitation to the online application portal was sent on month/date/year, and the application remains at 14% complete. The following reminders were sent to your email(s) on file, on the below dates:

- First reminder – month/date/year
- Second reminder - month/date/year
- Third reminder – month/date/year

As of today's date, you have exceeded the 35-day application for reappointment period, as outlined in the invitation to apply for reappointment. Per the Medical Staff Bylaws, failure to

submit a completed application for reappointment with all supporting or requested documentation shall result in automatic termination of your Medical Staff Membership and/or Privileges.

In effect, this results in termination of membership and/or privileges as a voluntary resignation from the Alameda Health System Medical Staff.

Please consider this our final attempt to collect your application for reappointment for processing, which if not received by COB month/date/year, will result in expiration of Medical Staff Membership and/or Privileges.

As of month/date/year, your Medical Staff Membership and/or Privileges at Alameda Health System will expire, with no patient care permitted.

Please contact your Department Chair, regarding the above.

Alameda Health System

MEDICAL STAFF ONGOING MONITORING AND EVALUATION OF ACTIONS RELATED TO PROVIDERS

Department	AHS Medical Staff	***Effective Date***	3/2022
Campus	AHS, AH	***Date Revised***	8/2023; 3/2025; 4/23/25; 11/19/25
Unit	All	***Next Scheduled Review***	11/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose

This policy describes the ongoing monitoring process the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs follow in response to alerts related to a member or privileged provider of the Medical Staff or Advanced Practice Providers, by establishing a systematic process for reviewing and evaluating such events.

Policy Statement

To ensure the quality and safety of care, the Alameda Health System Medical Staff office conducts ongoing monitoring and review of any sanctions, complaints and adverse events between credentialing cycles for Medical Staff members or privileged providers.

The ongoing review process is designed to ensure allegations and reports are reviewed timely, objectively and that actions taken are considered and instituted where appropriate to comply with the Medical Staff Bylaws and to maintain safety of care delivered to patients. Any data or information as part of the medical staff oversight and review process, are protected by California Evidence Code section 1157. Pertinent information identified in the review process shall be factored into decisions regarding what actions will be taken.

Procedure

Ongoing monitoring of provider sanctions, complaints and adverse events between credentialing cycles will be monitored via the following mechanisms:

1. Basic Responsibilities of Medical Staff
   Providers are required to notify the Medical Staff in writing within seven (7) days of any of the events listed in the Medical Staff Bylaws Section captioned "Basic Responsibilities of Medical Staff. The foregoing includes, but is not limited to, events related to their licensure, certification, registration, loss of membership, restriction or denial of privileges, employment, inability to provide care for more than 30 days, liability insurance, participation in federally funded health care organizations, professional liability suits, mental/physical health, felony or misdemeanor.

2. Licensing Boards
    a. **California Medical Board**: Medical Staff office personnel receives and reviews the Board's proactive disclosure notifications of actions via periodic, automated emails from the Medical Board of California subscription (MBC-ACTIONS@SUBSCRIBE.DCALISTS.CA.GOV).
    b. **California Osteopathic Medical Board:** Medical Staff office personnel receives and reviews the Board's proactive disclosure notifications of actions via periodic, automated emails from the Medical Board of California subscription (OMBC-GENERAL@SUBSCRIBE.DCALISTS.CA.GOV)
    c. **Dental Board of California**: The Dental Board of California publishes monthly information "Hot Sheets" (summaries of board enforcement actions). The report is retrieved monthly and cross-referenced to identify affiliated providers. (https://www.dbc.ca.gov/consumers/hotsheets.shtml).
    d. **California Physician Assistant Board**: The Department of Consumer Affairs Physician Assistant Board publishes monthly information regarding administrative disciplinary actions. The report is retrieved monthly and cross-referenced to identify affiliated providers. (https://pab.ca.gov/consumers/disciplinaryactions.shtml)
    e. **California Board of Psychology**: Medical Staff office personnel receives and reviews the Board's proactive disclosure notifications of actions via periodic, automated emails from the Board of Psychology (LISTSERV@SUBSCRIBE.DCALISTS.CA.GOV)
    f. **California Board of Podiatric Medicine:** The Podiatric Medical Board of California publishes Recent Disciplinary Actions reports for actions against their licentiates (https://pmbc.ca.gov/consumers/dispsumm.shtml). The report is retrieved monthly and cross-referenced to identify affiliated providers.
    g. **California Board of Optometry**: The Department of Consumer Affairs California State Board of Optometry publishes citations and disciplinary actions against their licentiates (https://www.optometry.ca.gov/consumers/2025_disciplinary.shtml). The report is retrieved monthly and cross-referenced to identify affiliated providers.
    h. **Acupuncture Board:** The Department of Consumer Affairs California State Acupuncture Board publishes citations and disciplinary actions against their licentiates (https://www.acupuncture.ca.gov/consumers/board_actions.shtml). The report is retrieved monthly and cross-referenced to identify affiliated providers.
    i. **California Board of Registered Nurses:** Advanced Practice nurses are enrolled in the National Council of State Boards of Nursing, Inc., Nursys electronic verification system using their registered nurse license number. Medical Staff office personnel receives and reviews the Board's proactive disclosure notifications of disciplinary actions via periodic, automated emails from Nursys for enrolled nurses. (https://www.nursys.com/EN/ENDefault.aspx)

    The providers listed on these notices/reports are cross-referenced against AHS/AH affiliated providers to identify matches, if any.

3. National Practitioner Databank (NPDB)
   All providers are enrolled in the NPDB Continuous Query. Enrolled practitioners are continuously monitored, and an alert is emailed when a new report is received or an existing report is revised, corrected, or voided. The credentialing database interfaces with the NPDB to automatically receive NPDB reports.

4. Federal and State Exclusions
   Monthly provider rosters are uploaded to Verify Comply (vendor platform solution for comprehensive exclusion screening services) to screen for exclusions in all US States and Federal databases. Databases include the following:
   a. U.S. HHS OIG List of Excluded Individuals and Entities (LEIE)
   b. U.S. GSA System for Award Management (SAM)
   c. Suspended/Excluded Providers for All States
   d. U.S. Dept of the Treasury Office of Foreign Assets Control (OFAC)
   e. CMS Opt Out NPI Only

Review and findings of each of the above notices/reports are logged. Any provider matches are addressed in accordance with this policy.

If the action triggers an automatic action, such as an automatic termination, suspension or restriction of membership and/or privileges under the Medical Staff Bylaws, the automatic action shall be immediately imposed in accordance with the Bylaws.

Actions will be evaluated as follows:
1. Reports will be sent to the Department Chair/Division Chief (if applicable) along with any supporting information.
2. The Division Chief (if applicable)/Department Chair (if no Division Chief) will review what is reported and assess if further information is required from the provider. If further information is required, the provider will be sent a letter that requires additional information. The response will be reviewed by the Department Chair/Division Chief (if applicable). Upon completing a review of what is reported and any response, the Department Chair/Division Chief (if applicable) will complete an Action Assessment Form (Attachment A to document their review of the report and recommend the next steps.)
3. If the Chief/Chair is uncertain how to address a situation, the Chief/Chair may refer information to Credentials and/or Medical Executive Committee for further review and recommendation.
4. Documentation related to the report will be maintained in the provider's credentialing file.
5. Actions will be logged and reported to the Credentials Committee.

Quality of Care complaints/concerns will be facilitated in accordance with the Medical Staff Peer Review policy.

Behavior concerns/complaints will be facilitated in accordance with Medical Staff Professionalism and Conduct policy.

Reporting Requirements:

In accordance with the California Business and Professions Code §805, a report must be filed for physicians and podiatrists within 15 days after one of the following actions occurs:

1. Denial or rejection of privileges or membership for a medical disciplinary cause or reason;
2. Revocation of privileges or membership for a medical disciplinary cause or reason;
3. Restrictions imposed, or voluntarily accepted, on privileges or membership for a total of 30 days or more within any 12 month period for medical disciplinary reasons;
4. If a resignation, leave of absence, withdrawal or abandonment of application or for renewal of privileges occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason;
5. Summary suspension of staff privileges or membership is imposed for a period in excess of 14 days.

In accordance with the California Business and Professions Code §805.01, a report of a final decision or recommendation to terminate, revoke, summarily suspend or restrict privileges or membership must be filed for physicians, physician assistants and podiatrists within 15 days if the reason for the investigation was one of the following:

1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.
2. The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
3. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.
4. Sexual misconduct with one or more patients during a course of treatment or an examination

In accordance with the California Business and Professions Code §805.08, a report must be filed with 15 days of receiving a written allegation of sexual abuse or sexual misconduct by a provider.

In accordance with the National Practitioner Databank, a report must be submitted for physicians and dentists within 30 days of one of the following occurrences:

1. Professional review actions - based on reasons related to professional competence or conduct - adversely affecting clinical privileges for a period longer than 30 days.
2. Voluntary surrender or restriction of clinical privileges while under, or to avoid, an investigation

Approvals

		AHS Core	AH
Credentials Committee	**Date:**	**11/13/25**	
Medical Executive Committee	**Date:**	**11/19/25**	**11/14/25**
QPSC	**Date:**	**11/19/25**	
Board of Trustees	**Date:**		

Attachment A

Alameda Health System Medical Staff Action/Allegation/Accusation Assessment Form

Date: _____

Provider Name: _____

Report of action/allegation/accusation made by or received from: _____
Reported on: _____

Brief summary of report: _____

Division Chief (if applicable)/Department Chair Recommendation:

As Chair of the Provider's Department or Division Chief, I have reviewed the reported action/allegation/accusation and recommend the following:

☐ No action at this time.
☐ Track/Trend and/or monitor for final outcome.
☐ Request additional information from the provider.
☐ Refer to QRC/Peer Review.
☐ Initiate FPPE.
☐ Refer to Well-Being Committee
☐ Limit/restrict privileges and/or membership (refer to MEC)
☐ Refer to the Credentials Committee and/or Medical Executive Committee for further review/recommendation.
☐ Other

Explanation/details supporting the above recommendation(s):
_____
_____
_____
_____

_____	_____	_____
Name	Signature	Date

This is a quality improvement/peer review document of the hospital. It includes privileged and confidential information which is protected from disclosure pursuant to California Evidence Code, Section 1157 and other provisions of state and federal law.

Alameda Health System

MEDICAL STAFF ROUTINE FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) / PROCTORING

Department	Medical Staff	***Effective Date***	12/07
Campus	AHS. AH	***Date Revised***	12/07, 3/2011, 6/2014, 6/2017, 6/2019, 6/2022, 11/2025
Unit	All	***Next Scheduled Review***	11/2028
Manual	Medical Staff	***Author***	Manager, Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief of Staff

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

Purpose

To establish mechanisms and define the process for satisfying the routine focused professional practice evaluation (FPPE) / proctoring requirements of the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs.

Proctoring as described in this policy is designed to meet the intent of Joint Commission Standards related to FPPE at the time of initial privileges or the granting of new privileges. This policy does not address FPPE/Proctoring for cause, which is based upon identified concerns with a particular individual's care or conduct, which is addressed in accordance with the applicable Medical Staff bylaws and policy.

Policy

It is the policy of the AHS and AH Medical Staffs to require FPPE/proctoring anytime privileges are initially granted.

1. FPPE/proctoring
    a. FPPE/proctoring requirements are outlined on each privilege delineation form, representing the minimum required number of cases to be proctored. At the discretion of the Department Chair/designee, additional proctoring may be assigned when there is not enough activity to represent the scope of privileges granted.
    b. FPPE/proctoring may include both concurrent, direct observation of any care/ procedure performed, and/or retrospective review of medical care via medical record review
    c. A proctor who is not providing direct clinical care is not required to have a California medical license. The proctor must, however, have a valid medical license in at least one state. If the proctor is participating in direct clinical care, he or she must hold similar privileges.
    d. FPPE/proctoring information is used as part of the Medical Staff's Peer Review program..

2. FPPE/Proctoring is required for:
    a. Upon initial granting of privileges for all providers .
        i. Proctoring for providers who have recently (within the prior two years) completed an AHS residency/fellowship program may be reduced at the discretion of the Department Chair or designee accompanied by documentation of relevant activity and verified competency by the Program Director.Approved requests for new/additional privileges from existing Medical Staff/Advanced Practice Providers (APP)..
    b. Upon granting of temporary privileges.
    c. External proctoring evaluations from another Joint Commission (TJC) accredited hospital or from a TJC/AAACH accredited Surgery Center may be used to supplement.

3. FPPE/Proctoring may be required at the discretion of the Medical Executive Committee:
    a. As a condition for privilege renewal for privileges performed so infrequently that assessment of current competence is not feasible.
    b. Whenever the Medical Executive Committee determines that additional information is needed to assess a practitioner's current competence.

4. FPPE/Proctoring by qualified practitioners who are not currently members of the AHS or AH Medical Staff must be appointed as Administrative Staff.

<u>Assignment of Proctors</u>

1. All members of the Medical Staff/APP who have themselves completed FPPE/proctoring and hold unrestricted privileges to perform the procedures and/or manage the clinical cases to be proctored.

2. FPPE/Proctoring may be performed by Medical Staff/APP members who hold related privileges sufficiently similar to the privileges being proctored to allow them to make prudent and informed judgments regarding competence.

3. If no member of the Medical Staff/APP possessing the requisite expertise is available to serve as a proctor, arrangements may be made by the Department Chair/Designee for FPPE/proctoring by a qualified practitioner who is not currently a member of the Medical Staff.

4. All proctors will be assigned by the Department Chair/Designee at the time of review and recommendation for privileges to the Medical Executive Committee.

5. Whenever reasonably possible, both a primary proctor and an alternate proctor will be assigned to assure timely availability. More than two proctors may be assigned at the discretion of the Department Chair/Designee.

Scope and Timeliness of FPPE/Proctoring

1. All basic and advanced FPPE/proctoring requirements may be met through direct observation of procedures and/or concurrent chart review of clinical care.

2. Subject to emergencies exceptions, both basic and advanced FPPE/proctoring should include the "first" cases performed by the practitioner in each category requiring proctoring.

3. If the practitioner who is subject to FPPE/proctoring requirements provides emergency care without concurrent FPPE/proctoring, the practitioner shall promptly report the case to both the proctor for review and the Director of Medical Staff Services, who will notify the Department Chair/Designee or Chief of Staff to review if the emergency necessitated proceeding without a proctor.

Supplemental Proctoring from an External Source

External proctoring may be used to supplement local proctoring for providers with limited activity; however, supplemental data must not replace the internal process of capturing data at the facility where the privileges are held.

Completion of FPPE/Proctorship

FPPE/proctoring is not considered complete until such recommendation by the Medical Executive Committee has been approved by the Board of Trustees.

Failure to Satisfactorily Complete FPPE/Proctoring Requirements

If a provider fails to satisfy the basic FPPE/proctoring requirements solely because of the failure to perform the required number of cases, the provider will remain under proctoring until sufficient activity is achieved.

Procedure

Department Chair/Designee

1. Provide the names of the primary, alternative, and other proctors at the time the chairperson recommends clinical privileges.
2. Assure that providers are proctored in a timely and in accordance with assignments.
3. Address any unfavorable or questionable evaluations.
4. Intervene at the request of the proctor or provider being proctored when there is a conflict regarding appropriate care.
5. Submit recommendation for release of proctoring upon satisfactory completion of assigned proctoring, upon review and acceptance of proctored evaluations.

Medical Staff Services Duties

1. Notify the provider of their assigned proctor(s) and proctoring plan.
2. Notify the proctor when they have been designated as the proctor.
3. Report proctoring activity to the Credentials Committee.

FPPE/Proctored Practitioner Duties

1. Assure that the first procedures or medical admissions and the first performance of any procedures are proctored in a timely manner.
2. Notify the proctor of each case where care is to be evaluated and do so in sufficient time to allow the proctor to observe or review concurrently. For elective surgical or invasive procedures where direct observation is required, the practitioner must secure agreement from the proctor to attend the procedure before the procedure is scheduled. If an emergency situation exists and the practitioner must admit and treat a patient, the practitioner must notify the proctor as soon as is reasonably possible to continue with the concurrent FPPE/proctoring process..
3. Provide the proctor with the patient's clinical history, pertinent physical findings, pertinent laboratory and x-ray results, the planned course of treatment or management and the rational for its use.

Proctor Duties

1. Directly observe the procedure being performed and/or concurrently observe medical management by reviewing the medical record and complete the appropriate FPPE/proctoring form.
2. The proctoring evaluation must be completed on the approved form and shall include an evaluation of the provider's performance of patient care, medical clinical knowledge, practiced based learning, interpersonal and communication skills, professionalism, system-based practice and an overall impression.
3. Make reasonable accommodation to be available for cases that require direct observation or concurrent review.
4. Direct observation of procedures or medical admissions may be continued beyond the minimum FPPE/proctoring requirements, if needed, until the proctor has observed a sufficient number of cases to make an informed judgment regarding the clinical performance of the individual being proctored. A request for additional FPPE/proctoring requirements may be made by the proctor and submitted to the Department Chair for review and approval.
5. While the proctor's primary responsibility is to observe care and evaluate performance, if the proctor reasonably believes that intervention is warranted to prevent harm to the patient, the proctor may take whatever action is reasonably necessary to protect the patient. The proctor is authorized at the proctor's sole discretion to delay, postpone, or terminate any proposed treatment and/or procedure pending immediate notice to the Department Chair/Designee and/or Chief of Staff.
6. In procedural FPPE/proctoring, a proctor may act as a surgical assistant for the provider being proctored. If the proctor acts as surgical assistant, the proctor then has the responsibilities of an assistant to the patient.

7. The FPPE/proctor must assure the confidentiality of the FPPE/proctoring evaluation form. The FPPE/proctor evaluation forms should be timely submitted to the Medical Staff Services Office. Proctoring evaluations should not be attached to the patient's medical record and copies should not be kept by the proctor.

FPPE/Proctoring Forms

Approved FPPE/proctoring evaluation forms are to be utilized when documenting FPPE/proctoring activities/evaluation.

Approvals

		AHS	AH
Credentials Committee	**Date:**	**11/13/25**	
Medical Executive Committee	**Date:**	**11/19/25**	**11/14/25**
QPSC	**Date:**	**11/19/25**	
Board of Trustees	**Date:**		

Alameda Health System

STANDARDIZED PROCEDURES FOR ADVANCED PRACTICE PROVIDERS IN THE DEPARTMENT OF SURGERY

Department	Surgery/Trauma Dept	***Effective Date***	3/2013
Campus	Highland	***Date Revised***	2/2013; 8/2024; 11/2025
Unit	Inpatient/Outpatient	***Next Scheduled Review***	11/2028
Manual	Interdisciplinary Practice	***Author***	Juan Casillas, NP
Replaces the following Policies:		***Responsible Person***	Chief of Staff

Procedure Statement

This standardized procedure fulfils Alameda Health System requirements and expectations for defining the scope of practice for Advanced Practice Providers. Standardized procedures are developed collaboratively by nursing, medicine, and administration to comply with the California Business and Profession Code, Nursing Practice Act (NPA) Section 2725 and further clarified in California Code of Regulation (CCR 1480).

Purpose

It is the intent of this document to authorize the Advanced Practice Providers (APP) within Highland Hospital Department of Surgery to implement the Standardized Procedures without the immediate supervision or approval of a physician. The Standardized Procedures, including all the policies and protocols, are defined in this document, and will be referred to generally as the "Standardized Procedures".

Standardized procedures will be maintained in Policy Tech and reviewed every three (3) years.

Definitions

1. Advanced Practice Provider refers to either Nurse Practitioner or Physician Assistant
    a. **Nurse Practitioner** by definition shall be:
        i. Master's or Doctoral Degree in Nursing
        ii. Current license as a Registered Nurse in California
        iii. Current certification by the State of California, Board of Registered Nursing as a Nurse Practitioner
        iv. California-issued BRN Furnishing Number
        v. Current National Certification
        vi. Active DEA registration number
        vii. National Provider Identification Number
    b. **Physician Assistant** by definition shall be:
        i. Successful completion of a Physician Assistant program of instruction in primary health care approved by the Physician Assisting Examining Committee; OR NCCPA for Physician's Assistant
        ii. Possession of a valid Certificate as a Physician Assistant issued by the California Board of Medical Quality Assurance
        iii. A valid Drug Enforcement Agency (DEA) Number AND Certification by the National Commission on Certification of Physician Assistants (NCCPA)
        iv. National Provider Identifier Number.

All requirements, applications, procedures and duties are the same for both APP provider classifications, with the exception of issuing drug orders and furnishing, as discussed herein.

2. **Supervising Physician** shall be an attending physician who is a current member in good standing of the Medical Staff, and who holds privileges in the Department of Surgery.

Application

1. In addition to general requirements set forth and described in the Medical Staff Bylaws, Rules and Regulations, policies and privileges forms, the following criteria shall specifically apply to any APPs applying for privileges in the department of Surgery:
   a. Current Advanced Cardiac Life Support (ACLS) Certification

Conditions and Standards of Practice

1. **General Conditions**
   a. The Advanced Practice Provider (APP) shall render all care within the standards provided in this document.
   b. The APP shall provide all care in accordance with the laws and regulations of the State of California, and with the Bylaws and Regulations of the Medical Staff and the Department of Surgery.
   c. At no time shall the care rendered by the APP exceed the scope of the licensure. All cases beyond the scope of practice of the APP, and those with which the APP has questions will be referred to the consulting physician
   d. The APP agrees to work cooperatively with the consulting physician, nursing staff and other health professionals
   e. The APP shall immediately notify his/her Division Chief in the event that the practitioner's license to practice is revoked, limited or otherwise affected by action of the Federal or State Health Care Agency, or in the event that he/she receives any notification or investigation of his/her license.

2. **Focus Professional Practice Evaluation (FPPE)/Proctoring**

The routine FPPE/Proctoring plan is outlined on the NP or PA privilege form. Once all elements of the FPPE/Proctoring are complete, the outcome of the FPPE will be recorded in the confidential Quality section of the credentials file (maintained by the Medical Staff Office).

During the initial proctoring period the charts of each patient seen by the PA/NP will be reviewed by the Supervising Physician.

Formal review will be made in writing by the Department Chair or designee initially, and annually, thereafter. The content of such formal evaluation will be discussed with the PA/NP as part of their annual review and kept on file.

3. **Patient Records**

The APP will be responsible for the preparation of a complete medical record for each patient contact per existing Alameda Health System policies and Medical Staff Bylaws, Rules & Regulations and policies.

4. **Supervision**

The APP is authorized to implement the Standardized Procedures in this document without the direct or immediate observation, supervision or approval of a physician, except as may be specified in the Scope of Practice. In accordance with Medical Staff Bylaws, Rules & Regulations and policies, the supervising physician is ultimately responsible for adherence to this protocol and for the quality of care provided by APP in their respective areas. Physician consultation is available at all times, either on-site, telephone, or

by electronic means.

Scope of Practice

1. **Policy**

Advanced Practice Providers are authorized to diagnose and treat emergency medical problems according to accepted criteria and management including, but not limited to:

a. Health Care Maintenance and Promotion, all Ages
b. Preoperative, intraoperative and postoperative care
c. Patients entering the hospital as trauma activations
d. Patients seen as consultations to the trauma/surgery service
e. Traumatic conditions, for example:
    i. Head/Neuro trauma
    ii. Facial trauma
    iii. Neck trauma
    iv. Chest trauma
    v. Abdominal trauma
    vi. Extremity trauma
    vii. Blunt trauma
    viii. Penetrating trauma

2. **Authorized Duties and Practice**

The APP is authorized to do the following patient-related activities within the scope of practice defined by Title 16:

a. Take the patient's medical history and perform a physical examination for any presenting problem;
b. Order specific laboratory studies and x-rays, and other studies as appropriate for that patient;
c. Collect specimens as indicated for additional tests;
d. Perform pertinent laboratory tests;
e. Perform any other procedure for which he/she has been granted privileges;
f. Counsel patients and their families on health promotion, diagnosis and management options;
g. Diagnose and treat conditions listed above;;
h. Complete medical records for every patient encounter in the department of surgery computer based format followed by all providers in the Department of Surgery.

3. **Emergency Care**

The APP may perform life sustaining measures, whenever necessary. This includes, but is not limited to those found in the Advanced Cardiac Life Support text and in the Advanced Trauma Life Support text.

4. **Procedures and Minor Surgeries**

a. APP at time of hire will need to demonstrate competency in each of the basic surgery/trauma skills. Advanced procedures require proctoring and advanced attending approval before procedure is initiated in the trauma patient. The APP will follow existing surgery department protocols for each procedure done in the trauma patient, including sterile procedure, sedation, observation and confirmatory testing.
b. For procedures that require consent APP will be responsible for obtaining informed consent from the patient
c. At the completion of the procedure the APP will write a procedure note that includes and complications and the name of the attending Surgery Physician.
d. The following list of procedures APP can do for trauma patients once granted privileges and demonstrated competency by direct observation or documented prior work experience.

i. Surgery/trauma procedures
   - Anesthesia, local infiltration, regional blocks
   - Nasal Packing, ant/posterior
   - Foreign Body removal from the cornea
   - Arthrocentesis
   - Joint aspiration/injection
   - Fracture treatment/splinting and casting
   - Joint reductions/simple closed fracture reductions
   - Debridement, Suture repair of wounds
   - Debridement and care of burns
   - Incision and drainage of hematoma or abscess
   - Wound Care, including complex
   - Treatment of nail avulsion, paronychia
   - Arterial puncture
   - Arterial Line
   - Central Venus Line
   - Biopsy: skin/muscle
   - Excision of skin and subcutaneous lesions
   - Thoracentesis
   - Paracentesis
   - IV catheterization
   - Foley catheter placement

ii. Advanced procedures, performed only at Highland Hospital, requiring proctoring in the ED/ICU/OR/PACU/Floors and patient specific pre-approval and supervision by the surgical attending for each patient.
   - Suprapubic catheter insertion
   - Endotracheal intubations
   - Chest tube insertion and removal
   - Venous cut down
   - First Assistant in the Operating Room (certification required for NPs)
   - Vascular Surgery: Bedside endovenous procedures (e.g., varicose veins)
   - Vascular Surgery: Dialysis access procedures (e.g., percutaneous balloon fistuloplasty)
   - Vascular Surgery: ultrasound performance and interpretation
   - Moderate Sedation (requires competency assessment)

iii. Procedures requiring additional training and proctoring.
   - Ultrasound: Proof of competency (confirmation of active privileges at another organization) or fellowship training OR participation in training remote/asynchronous and in-person through Alameda Health System with concurrent proctoring.

5. **Protocols**
   a. The nurse practitioner/physician assistant has been granted privileges within the Alameda Health System to perform the requested procedures.
   b. The nurse practitioner/physician assistant has been trained to perform the procedure(s), has been observed satisfactorily performing the procedure(s) by another provider competent in that skill, and continued competency is assessed per AHS policy.
   c. The nurse practitioner/physician assistant is following standard medical technique for the procedures as described in the Resources listed in this document.

d. Appropriate patient consent is obtained, if necessary, before the procedure.
e. All biopsied tissue is sent for a pathology report.
f. All other applicable Standardized Procedures in this document are followed during health care management.
g. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

Drug Orders and Furnishing

POLICY
The advanced practice provider is authorized to furnish or order drugs and devices under the following protocols:

PROTOCOLS
1. The nurse practitioner/physician assistant has a current Furnishing, NPI, and DEA number.
2. The drugs and devices ordered or furnished are consistent with the APP's educational preparation or for which clinical competency has been established and maintained and listed in the AHS formulary, the patient's insurance formulary, non-formulary medications for which there are no substitutes, or practice recommendations listed in the Resources in this document. Examples are listed in the "Formulary" document at the end of this Standardized Procedure.
3. The drug or device furnished or ordered is appropriate to the condition being treated.
4. APPs may order or prescribe those medications that are FDA approved unless done through protocol registration in a United States Institutional Review Board or Expanded Access authorized clinical trial.
5. "Off label" use, or prescription of FDA-approved medications for uses other than that indicated by the FDA, is permitted when such practices are within the current standard of care for treatment of the disease or condition.
6. Patient education is given regarding the drug or device.
7. The Statement of Approval and Agreement signed by the nurse practitioners/physician assistants will act as the record of advanced practice providers authorized to Furnish.
8. No single physician will supervise more than four advance practice providers at any one time.
9. A physician must be available at all times in person or by telephonic contact.
10. All other applicable Standardized Procedures in this document are followed during health care management.
11. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

Ordering scheduled Controlled Substances

POLICY
The nurse practitioner/physician assistant is authorized to furnish or order scheduled controlled substances per the following protocols:

PROTOCOLS
1. The advanced practice provider follows the provisions of the Standardized Procedure for Furnishing.
2. The controlled substances that may be ordered are included in the formulary(s) or references listed in this document.

3. Relevant scheduled drug contracts, DEA requirements, and all State and Federal regulations are adhered to.
4. Schedule II & III controlled substances are furnished or ordered following the Patient Specific Protocol, in addition to these General Protocols for Scheduled Controlled Substances.
5. The nurse practitioner/physician assistant may furnish, prescribe or order any medications on the patient's insurance formulary or non-formulary medications for which there is no substitute, within the scope of the provider's license and within the scope of AHS ordering policies.
6. All other applicable Standardized Procedures in this document are followed during health care management.
7. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

SCHEDULE III PATIENT SPECIFIC PROTOCOL

1. Schedule III substances may be furnished or ordered when the patient is in one of the following categories, including but not limited to the following conditions:
    a. Acute Illness, Injury or Infection: such as cough, fractures
    b. Acute intermittent but recurrent pain: such as headache
    c. Chronic continuous pain
    d. Hormone replacement

2. Limit order for acute illness, injury or infection to a maximum of 30 days & no refills without reevaluation.

3. For chronic conditions:
    a. Pain management protocol or department guidelines is/are adhered to, if appropriate.
    b. Amount given, including all refills (maximum of 5 in 6 months per DEA regulations, is not to exceed a 120 day supply as appropriate for the condition.
    c. Treatment plan must be established in collaboration with the patient's primary care provider and reviewed, with documentation, every 6-12 months.
    d. No further refills without reevaluation.

4. Education and follow-up is provided.

SCHEDULE II PATIENT SPECIFIC PROTOCOL

1. Schedule II controlled substances may be ordered when the patient has one of the following diagnoses and under the following conditions.
    a. Pain from cancer, post-operative pain, and trauma.
    b. Pain unresponsive to, or inappropriately treated by CS III-V substances
    c. Attention Deficit Hyperactivity Disorder (ADHD)
    d. Neuropsychiatric Conditions

2. Limit order for acute and chronic conditions as specified above in Schedule III Protocol.
3. No refills for CS II medications are authorized except where authorized by the DEA.
4. Pain Management Protocol or Department guidelines is/are adhered to if appropriate.

Medication Management

POLICY
The advance practice provider is authorized to manage drugs and devices under the following protocols:

PROTOCOLS
1. The management of drugs or devices includes evaluating, initiating, altering, discontinuing, furnishing and ordering of prescriptive and over-the-counter medications.
2. Medication evaluation includes assessment of:
   - Other medications being taken.
   - Prior medications used for current condition.
   - Medication allergies and contraindications, including appropriate labs and exams.
3. The drug or device is appropriate to the condition being treated, and:
   - Accepted dosages per references.
   - Generic medications are ordered if appropriate.
4. A plan for follow-up and refills is written in the patient's chart.
5. The prescription must be written in patient's chart including name of drug, strength, instructions and quantity, and signature of the advance practice provider.
6. All other applicable Standardized Procedures in this document are followed during health care management.
7. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force

Authorizations

POLICY
The advanced practice provider is authorized, under the following protocols, to:
- Assess Worker's Compensation injuries and illnesses
- Certify Disability
- Manage Home Health and Personal Care Services
- Order Restraint and Seclusion

PROTOCOLS
1. Workers' Compensation: The Doctor's First Report of Occupational Injury or Illness for a workers' compensation claim can be for a period of time off in relation to injury. The treating physician is required to sign the report and to make any determination of any temporary disability.
2. Certify Disability: The advance practice provider has performed a physical exam and collaborated with a physician and surgeon.
3. Home Health and Personal Care Services: Approval, signing, modifying, or adding to a plan of treatment or plan of care
4. Restraint and Seclusion: The Advanced Practice Provider must be knowledgeable and competent in the Hospital Conditions of Participation for Patients' Rights including the Interpretive Guidelines. Ordering physical or chemical restraint, and/or seclusion, is in strict accordance with the protocols adopted in the Resources section of this document which include the extent of implementation and which meets the intent of the acute medical and surgical hospitals Conditions of Participation for Rights.
5. All other applicable Standardized Procedures in this document are followed during health care management.

6. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in these standardized procedures are in force.

6. **Standard of Care**

Standards for adequacy of diagnosis, management and treatment shall be in accordance with hospital Policy and Procedure, clinic protocols, current community standards of care, Surgery Department protocols or current texts/articles on Trauma Care found in the Department of Surgery.

7. **Consultation and Referral**

The APP will be providing health care as outlined in this document. In general, communication with a physician who is a current member in good standing of the Medical Staff, and who holds privileges in the Department of Surgery will be sought for all the following situations, and any others deemed appropriate. Whenever a physician is consulted, a notation to that effect, including the physician's name, must be made in the chart.

a. Conditions that do not follow clinical protocols, procedures, classic diagnostic patterns, or that have failed to respond to standardized treatments and/or management.
b. Any significant unexplained physical or historical findings.
c. Emergency situations after initial care.
d. When the patient expresses a desire to see a physician.

The following situations are examples (not exhaustive) of those that will likely require physician advice or consultation:

i. General
   - Full thickness burns
   - Shock
   - Probable or proven malignancy
   - Unresponsiveness
ii. Dermatology
   - Laceration involving nerve, tendon, muscle, artery, joint
iii. Eye
   - Diplopia
   - Papilledema
   - Foreign body
   - Vision loss
iv. ENT/Respiratory
   - Abnormal CXR
   - Head and neck masses
   - Respiratory distress and tachypnea
   - Hoarseness/voice loss
v. Cardiovascular
   - Abnormal EKG
   - Leg ulcers
   - Aneurysm
   - Bruit
   - Peripheral edema, new
   - Chest pain, new or changed
   - Pulmonary edema
   - Syncope
   - Heart murmur, not functional; new or changed
vi. Gastrointestinal
   - Peritonitis

- Organomegaly
- Abdominal distention
- Persistent vomiting/diarrhea
- Abdominal pain, persistent or severe

vii. Genitourinary
- GU Trauma

viii. Obstetrics
- Pregnant victim of trauma

ix. Musculoskeltal
- Radicular pain/weakness
- Unstable sprain
- Fractures

x. Hematology
- Anemia
- Unexplained abnormal lab test

xi. Neuro/Psych
- Acute change in mental status/behavior
- Acute sensory, strength or coordination change
- Suicidal ideation
- New onset or uncontrolled seizures
- Pupil changes
- Severe headache

8. **Other duties**

The patient must be informed that the provider is an APP and be given the opportunity to request care by a physician should the patient desire it.

9. **APP - Nursing Staff Relationship**

The APP is authorized to give nursing personnel orders for all laboratory and x-ray studies, treatment and medication for those patients for whom the APP is providing medical care. Orders given by the APP are orders generated in agreement with the Consulting Physician. Any questions regarding these orders that are not satisfactorily resolved through discussion with the APP should be brought to the Consulting Physician before being carried out.

10. **Agreement Review**

The signature on the Attestation by the APP acknowledges agreement to practice within the limits of the foregoing standardized procedures/practice guidelines. Upon its review, if changes are made, new signatures will be necessary.

11. **References/Resources**

- AHS/AH Medical Staff Bylaws
- Medical Staff Advanced Practice Provider policy and procedure manual
- Medical Staff Privilege forms
- Nurse Practice Act in the California Business and Professions Code
- Physician Assistant Practice Act
- References that define Standard of care for the Surgery include, but are not limited to:
  o UpToDate
  o Roberts and Hedges Procedural Book
  o AHS Formulary for drug use and current antibiogram

Approvals:

	AHS	**AH**
Interdisciplinary Practice Committee	10/29/25	
Credentials Committee	11/13/25	
Medical Executive Committee	11/19/25	11/14/25
QPSC	11/19/25	
Board of Trustees		

Signature:

Signature implies the following: approval of all the policies and protocols in this document, the intent to abide by the Standardized Procedures, the willingness to maintain a collegial and collaborative relationship with all the parties, and agreement of all collaborating/supervising physicians within the department.

Nurse Practitioner/Physician Assistant (Printed Name): _____

Signature:_____ Date: _____

Alameda Health System

STANDARDIZED PROCEDURES FOR ADVANCED PRACTICE PROVIDERS IN THE DEPARTMENT OF SURGERY

Department	Surgery/Trauma Dept	***Effective Date***	3/2013
Campus	Highland	***Date Revised***	2/2013; 8/2024; 11/2025
Unit	Inpatient/Outpatient	***Next Scheduled Review***	11/2028
Manual	Interdisciplinary Practice	***Author***	Juan Casillas, NP
Replaces the following Policies:		***Responsible Person***	Chief of Staff

Procedure Statement

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   d. The APP agrees to work cooperatively with the consulting physician, nursing staff and other health professionals
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1. The advanced practice provider follows the provisions of the Standardized Procedure for Furnishing.
2. The controlled substances that may be ordered are included in the formulary(s) or references listed in this document.

3. Relevant scheduled drug contracts, DEA requirements, and all State and Federal regulations are adhered to.
4. Schedule II & III controlled substances are furnished or ordered following the Patient Specific Protocol, in addition to these General Protocols for Scheduled Controlled Substances.
5. The nurse practitioner/physician assistant may furnish, prescribe or order any medications on the patient's insurance formulary or non-formulary medications for which there is no substitute, within the scope of the provider's license and within the scope of AHS ordering policies.
6. All other applicable Standardized Procedures in this document are followed during health care management.
7. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

SCHEDULE III PATIENT SPECIFIC PROTOCOL

1. Schedule III substances may be furnished or ordered when the patient is in one of the following categories, including but not limited to the following conditions:
    a. Acute Illness, Injury or Infection: such as cough, fractures
    b. Acute intermittent but recurrent pain: such as headache
    c. Chronic continuous pain
    d. Hormone replacement

2. Limit order for acute illness, injury or infection to a maximum of 30 days & no refills without reevaluation.

3. For chronic conditions:
    a. Pain management protocol or department guidelines is/are adhered to, if appropriate.
    b. Amount given, including all refills (maximum of 5 in 6 months per DEA regulations, is not to exceed a 120 day supply as appropriate for the condition.
    c. Treatment plan must be established in collaboration with the patient's primary care provider and reviewed, with documentation, every 6-12 months.
    d. No further refills without reevaluation.

4. Education and follow-up is provided.

SCHEDULE II PATIENT SPECIFIC PROTOCOL

1. Schedule II controlled substances may be ordered when the patient has one of the following diagnoses and under the following conditions.
    a. Pain from cancer, post-operative pain, and trauma.
    b. Pain unresponsive to, or inappropriately treated by CS III-V substances
    c. Attention Deficit Hyperactivity Disorder (ADHD)
    d. Neuropsychiatric Conditions

2. Limit order for acute and chronic conditions as specified above in Schedule III Protocol.
3. No refills for CS II medications are authorized except where authorized by the DEA.
4. Pain Management Protocol or Department guidelines is/are adhered to if appropriate.

Medication Management

POLICY
The advance practice provider is authorized to manage drugs and devices under the following protocols:

PROTOCOLS
1. The management of drugs or devices includes evaluating, initiating, altering, discontinuing, furnishing and ordering of prescriptive and over-the-counter medications.
2. Medication evaluation includes assessment of:
   - Other medications being taken.
   - Prior medications used for current condition.
   - Medication allergies and contraindications, including appropriate labs and exams.
3. The drug or device is appropriate to the condition being treated, and:
   - Accepted dosages per references.
   - Generic medications are ordered if appropriate.
4. A plan for follow-up and refills is written in the patient's chart.
5. The prescription must be written in patient's chart including name of drug, strength, instructions and quantity, and signature of the advance practice provider.
6. All other applicable Standardized Procedures in this document are followed during health care management.
7. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force

Authorizations

POLICY
The advanced practice provider is authorized, under the following protocols, to:
- Assess Worker's Compensation injuries and illnesses
- Certify Disability
- Manage Home Health and Personal Care Services
- Order Restraint and Seclusion

PROTOCOLS
1. Workers' Compensation: The Doctor's First Report of Occupational Injury or Illness for a workers' compensation claim can be for a period of time off in relation to injury. The treating physician is required to sign the report and to make any determination of any temporary disability.
2. Certify Disability: The advance practice provider has performed a physical exam and collaborated with a physician and surgeon.
3. Home Health and Personal Care Services: Approval, signing, modifying, or adding to a plan of treatment or plan of care
4. Restraint and Seclusion: The Advanced Practice Provider must be knowledgeable and competent in the Hospital Conditions of Participation for Patients' Rights including the Interpretive Guidelines. Ordering physical or chemical restraint, and/or seclusion, is in strict accordance with the protocols adopted in the Resources section of this document which include the extent of implementation and which meets the intent of the acute medical and surgical hospitals Conditions of Participation for Rights.
5. All other applicable Standardized Procedures in this document are followed during health care management.

6. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in these standardized procedures are in force.

6. **Standard of Care**

Standards for adequacy of diagnosis, management and treatment shall be in accordance with hospital Policy and Procedure, clinic protocols, current community standards of care, Surgery Department protocols or current texts/articles on Trauma Care found in the Department of Surgery.

7. **Consultation and Referral**

The APP will be providing health care as outlined in this document. In general, communication with a physician who is a current member in good standing of the Medical Staff, and who holds privileges in the Department of Surgery will be sought for all the following situations, and any others deemed appropriate. Whenever a physician is consulted, a notation to that effect, including the physician's name, must be made in the chart.

a. Conditions that do not follow clinical protocols, procedures, classic diagnostic patterns, or that have failed to respond to standardized treatments and/or management.
b. Any significant unexplained physical or historical findings.
c. Emergency situations after initial care.
d. When the patient expresses a desire to see a physician.

The following situations are examples (not exhaustive) of those that will likely require physician advice or consultation:

i. General
   - Full thickness burns
   - Shock
   - Probable or proven malignancy
   - Unresponsiveness
ii. Dermatology
   - Laceration involving nerve, tendon, muscle, artery, joint
iii. Eye
   - Diplopia
   - Papilledema
   - Foreign body
   - Vision loss
iv. ENT/Respiratory
   - Abnormal CXR
   - Head and neck masses
   - Respiratory distress and tachypnea
   - Hoarseness/voice loss
v. Cardiovascular
   - Abnormal EKG
   - Leg ulcers
   - Aneurysm
   - Bruit
   - Peripheral edema, new
   - Chest pain, new or changed
   - Pulmonary edema
   - Syncope
   - Heart murmur, not functional; new or changed
vi. Gastrointestinal
   - Peritonitis

- Organomegaly
- Abdominal distention
- Persistent vomiting/diarrhea
- Abdominal pain, persistent or severe

vii. Genitourinary
- GU Trauma

viii. Obstetrics
- Pregnant victim of trauma

ix. Musculoskeltal
- Radicular pain/weakness
- Unstable sprain
- Fractures

x. Hematology
- Anemia
- Unexplained abnormal lab test

xi. Neuro/Psych
- Acute change in mental status/behavior
- Acute sensory, strength or coordination change
- Suicidal ideation
- New onset or uncontrolled seizures
- Pupil changes
- Severe headache

8. **Other duties**

The patient must be informed that the provider is an APP and be given the opportunity to request care by a physician should the patient desire it.

9. **APP - Nursing Staff Relationship**

The APP is authorized to give nursing personnel orders for all laboratory and x-ray studies, treatment and medication for those patients for whom the APP is providing medical care. Orders given by the APP are orders generated in agreement with the Consulting Physician. Any questions regarding these orders that are not satisfactorily resolved through discussion with the APP should be brought to the Consulting Physician before being carried out.

10. **Agreement Review**

The signature on the Attestation by the APP acknowledges agreement to practice within the limits of the foregoing standardized procedures/practice guidelines. Upon its review, if changes are made, new signatures will be necessary.

11. **References/Resources**

- AHS/AH Medical Staff Bylaws
- Medical Staff Advanced Practice Provider policy and procedure manual
- Medical Staff Privilege forms
- Nurse Practice Act in the California Business and Professions Code
- Physician Assistant Practice Act
- References that define Standard of care for the Surgery include, but are not limited to:
  o UpToDate
  o Roberts and Hedges Procedural Book
  o AHS Formulary for drug use and current antibiogram

Approvals:

	AHS	**AH**
Interdisciplinary Practice Committee	10/29/25	
Credentials Committee	11/13/25	
Medical Executive Committee	11/19/25	11/14/25
QPSC	11/19/25	
Board of Trustees		

Signature:

Signature implies the following: approval of all the policies and protocols in this document, the intent to abide by the Standardized Procedures, the willingness to maintain a collegial and collaborative relationship with all the parties, and agreement of all collaborating/supervising physicians within the department.

Nurse Practitioner/Physician Assistant (Printed Name): _____

Signature:_____ Date: _____

Alameda Health System

MEDICAL STAFF CREDENTIALING SYSTEM CONTROLS

Department	AHS Medical Staff	***Effective Date***	4/2022
Campus	AHS, AH	***Date Revised***	
Unit	All	***Next Scheduled Review***	4/2025
Manual	Medical Staff	***Author***	Director of Medical Staff Services
Replaces the following Policies:		***Responsible Person***	Chief Medical Officer

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

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Purpose

This purpose of this policy is to describe the ongoing monitoring process the Alameda Health System (AHS) and Alameda Hospital (AH) Medical Staffs follow for storing, modifying, and securing credentialing information.

Policy Statement

Alameda Health System and Alameda Hospital Medical Staffs require that Medical Staff Services monitor compliance with the Credentials Systems Control policy and procedures. The systems controls requirements align with the Medical Staff Bylaws in that any data or information as part of the credentialing process, are protected by California Evidence Code section 1157. Access to the data and information contained in the credentialing and privileging database is limited and access to the electronic credentials file is outlined in the Medical Staff Bylaws.

Procedure

1. **Primary source verification information (NCQA CR 1.C.1.)**
   Credentialing applications, supporting documents and verifications are received via (electronic application, online portal, mail, email, fax, internet web site or web crawler). All documents are dated electronically when they are received and reviewed by Credentialing Staff. File progress is tracked via internal credentialing checklist in the electronic database workflows. All files are stored in locked cabinets, confidential share drives and/or password protected databases.

2. **Tracking modifications (NCQA CR 1.C.2.)**
   If a modification needs to be made to credentialing information, the credentialing system will automatically document the date the modification was made, and who made the modification within the credentialing system. Electronic Audit files maintain a record of when the information was modified, how the information was modified and who made the modification. The Audit also maintains before and after values of each field, date/time stamps and information on who made the

change. Modifications may be made when updated credentials information is acquired. File notes may be included in the appropriate section in the credentialing system.

3. **Authorization to modify information (NCQA CR 1.C.3)**
   - **a.** Credentialing Coordinators and Provider Enrollment staff are assigned user roles within the credentialing database which based on areas of responsibility as defined in their job description. Each user role is assigned specific read/write system access as needed to perform their duties which may include adding, modifying, and deleting information. Additionally, the Medical Staff Services office employs both a Database Administrator and Sr. System Analyst who both have administrative access to the database and perform routine maintenance and data validation within the credentialing software.
   - **b.** Verification information may be modified by Credentialing Coordinators, Enrollment Coordinators, or Managers when verification information changes – examples include but are not limited to (see below). If credentialing information changes, new verifications will be obtained, date stamped by the credentialing software and stored in the provider's electronic credentialing file.
     - i. Updates to expired licensure or other documents
     - ii. Changes/updates to education, training, or privileges
     - iii. To correct data entry errors
     - iv. Duplicate profiles
     - v. Documents appended to incorrect provider profile

4. **Securing information (NCQA CR 1.C.4)**
   - **a. Limiting physical access to Credentialing Information:** Physical access includes information on servers, hardware, and physical records/credentials files. Hard copy data (any printed confidential/ sensitive document or file) must be stored out of sight and not be accessible to anyone who does not have a business need to view the contents. Credentialing staff shall secure all practitioner files and information when not in process and during non-work hours in locked cabinets in a restricted area that is only accessible to authorized staff. Workstations are in physically secure areas. Computer screens should be positioned to prevent viewing by unauthorized individuals. All password-based systems on workstations must mask, suppress, or otherwise obscure the passwords so that unauthorized persons are not able to observe them. Authorized users are prohibited from allowing others to access computer systems or restricted areas with their account, password, badge, or unique ID information. The IT department enforces 2 level authentication for access to the network and requires password resets every six months or can be modified by the staff at any time. IT security policy states that you use strong passwords and never write them down. All credentialing users must first have a unique AHS Network ID and password established before they can be added to the Credentialing system using single sign-on authentication. Users are disabled and passwords removed from the credentialing system by the MSS DBA, and network access is removed by

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the IT Security team when a user has left the organization.

b. Release of Credentialing Information:

i. Credentialing information regarding any member or applicant to the Medical Staff shall, to the fullest extent permitted by law, be confidential and protected from disclosure pursuant to California Evidence Code 1157. Dissemination of such information and records shall only be made where expressly required by law, to other peer review bodies for peer review purposes, pursuant to officially adopted policies of the Alameda Health System Medical Staff and Alameda Hospital Medical Staff.

ii. Access to medical staff records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirements that confidentiality be maintained.

iii. Requests for release of information from Risk Management, corporate attorney, Credentialing Committee Chair, Department Chair, etc. will be reviewed with the Medical Staff Officers and the Medical Staffs' legal counsel. If approval for release of information occurs, reasonable efforts will be made to notify the impacted provider(s) prior to disclosure of information to attorney(s).

iv. Regulatory or accreditation agencies - access will require direct supervision by the Medical Staff Director /Credentialing Manager to ensure no data is accessed without authorization.

v. Third parties or organizations (health plans, MCOs, etc.) with whom delegate is contracted. Every credentialed provider is required to submit a signed authorization and release of information form as part of their credentialing and recredentialing processes.

5. **Credentialing Process audit for factors 1-4 (NCQA CR 1.C.5)**

This section describes how Alameda Health System Medical Staff Services monitors compliance with the AHS/AH policies and procedures for credentialing system controls that address factors 1-4 at least annually and takes appropriate actions when applicable.

a. Frequency and methods of monitoring activities.

The monitoring process must occur at least annually, however the AHS or AH Medical Staff can request a review audit of credentialing modifications more frequently. These audits will be performed by one of the System Administrators, i.e. Senior System Analyst in the Medical Staff Services Department. These audits may include but are not limited to the following:

i. A description of the system functionality that prevents or disallows modifications of credentialing information.

ii. If the CR system allows modifications only under specific circumstances, an annual process for identifying all changes to established policies within the past 12 months and then updating the system controls accordingly.

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iii. A review of automatic system alerts or flags for modifications or events in real time and a separate process for annually testing the performance of the system's automatic alerts or flags.

b. When auditing is used as the method for monitoring, sampling using the "5% or 50 files" audit method, with a minimum of 10 credentialing files and 10 recredentialing files shall occur. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits will audit 100% of the credentialing and recredentialing files.

c. Annual review of job roles and current user access to ensure system access is still appropriate for the role requirements.

d. Monthly, quarterly, semiannual, or annual review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic system's audit trail function reporting capability.

e. Credentialing, privileging, and enrollment are paperless processes that have very limited paper documents due to requirements for wet signatures. For paper documents/files, leadership conducts periodic walk-throughs of the department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours – i.e., in locked drawers/filing cabinets, not left on workstations, etc.

f. Incorporate review of data modifications/changes/updates to credentialing data (both electronic and paper as applicable) into file Q&A process. Assess for accuracy, appropriateness, compliance with policies. Findings will be documented and stored in a network folder.

g. Credentialing staff and anyone who has access to credentialing information is required to sign an annual confidentiality form. These forms will be stored in a Medical Staff Services folder.

6. **Credentialing System Controls Oversight (NCQA CR 1.D)**

At a minimum, an annual monitoring report will be required to show compliance with our Credentialing System Controls policies, procedures shall be reported to the AHS and AH Credentials Committee and Medical Executive Committee. The report will need to include:

a. A review of all modifications that did not meet the policies and procedures

i. Conduct a qualitative and quantitative analysis of all modifications that did not meet policies.

ii. Actions taken to address any modifications that did not meet established policy.

iii. Implement quarterly monitoring when there are elements that did not meet the policies and procedures and provide written documentation in a report of this review.

b. The report shall include the person/role/title of the person performing the monitoring.

c. The report shall include the person/role/title of the person who has oversight of the monitoring process if different from who performs monitoring.

d. **<u>Oversight Reports:</u>**

i. **Credentialing System Controls Oversight Report** – this template will be included in the request for documents at the time of the annual oversight assessment.

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ii. **Monitoring and Reporting of Inappropriate Modifications** this template will be included in the request for documents at the time of the annual oversight assessment. AHS would need to submit this report if inappropriate modifications were identified. MSS will continue to monitor the report until it demonstrates improvement for three consecutive quarters. If improvement isn't demonstrated for at least one finding, all quarterly reports will be submitted to the MSS Director.

Approvals

		AHS Core	AH
Credentials Committee	**Date:**	**4/14/22**	**4/12/22**
Medical Executive Committee	**Date:**	**4/20/22**	**4/15/22**
QPSC	**Date:**	**4/20/22**	
Board of Trustees	**Date:**	**5/11/2022**	

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ACTION Contracts

Contract Approvals
January 2026

1. Renewal agreement with Agiliti Health, Inc. for provision of equipment management and rental services. The term of this agreement is effective February 1, 2026 through January 31, 2029. The estimated impact of this agreement is $9,138,690.
Mark Fratzke, Chief Operating Officer

2. Renewal agreement with VTP Holdings, LLC for provision of PICC line services. The terms of this agreement is February 1, 2026 through January 31, 2029. The estimated impact of this agreement is $1,620,000.
Romoanetia Lofton, Chief Clinical Officer

Contract Approvals
January 2026

3. New agreement with SMITH-KARNG ARCHITECTURE for provision of architectural and engineering services for the inpatient medical detox unit remodel at San Leandro Hospital. The term of this agreement is January 15, 2026 through January 15, 2029. The estimated impact of this agreement is $1,492,525.
Mark Fratzke, Chief Operating Officer

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

Contractor/Vendor Name:	Agiliti Health, Inc. ("Agiliti")
Description:	In recognition of Alameda Health System's ("AHS") continued efforts to maintain high quality services while minimizing fiscal impact, AHS has partnered with Agiliti for biomedical and imaging maintenance services. We have also partnered with Agiliti for minor medical equipment management (IV pumps, wound vacs, beds and surfaces) at the Wilma Chan Highland Hospital Campus ("HGH") and equipment rentals across the system. AHS leadership reviewed the current equipment management and rental contract with Agiliti ("M360" or "Agreement") and determined that while it offered significant value to AHS, it did not encompass all the facilities, leading to elevated equipment rental costs and lost equipment. Per terms of the Agreement, Agiliti provides staff and round several times daily at the Highland campus locating equipment and beds as patients are discharged. This service is not currently available at Alameda and San Leandro Hospitals ("Community Hospitals") or wellness centers/clinics. AHS solicited quotes to identify the vendor best able to meet our needs in continuance of the services contemplated under the Agreement. Suppliers participating included Agiliti, US Medical Equipment and iMedical. Under the Agreement, Agiliti provides fixed levels of certain items for which AHS pays daily rental regardless of use. In their renewal quote, Agiliti proposed a pay-per-use model that even after adding staff to expand services to our Community Hospitals will save $1.2M over the contract's lifetime. Upon careful review of the quotes, AHS leadership determined that Agiliti was best positioned to meet our equipment management and rental service needs going forward. Agiliti has been our supplier since 2008 and has many years of experience in the industry and an extensive healthcare portfolio. As a member of the Vizient Group Purchasing Organization ("GPO"), AHS receives discounts on goods and services purchased from vendors who are also members of the GPO. Agiliti is a GPO member which results in additional savings in the form of a small share-back rebate amounting to approximately $178K over the 3-year term of the proposed renewal agreement ("Renewal"). AHS leadership remains firmly committed to delivering high-quality service to both patients and staff. Following a thorough assessment of minor medical equipment service needs at AHS facilities, AHS leadership evaluated the feasibility of managing these services internally through AHS operations. This evaluation included assessment of bringing this service in-house as another option. When factoring in the costs associated, including hiring and training new AHS staff and acquisition of asset tracking software, AHS leadership determined total additional costs would exceed those quoted by Agiliti by an additional $330K over the 3-year renewal period and be coupled with a 6-9 month implementation period. Given the preceding, AHS leadership has determined that entering a Renewal with Agiliti on the terms outlined below is the best option and requests Board approval to proceed.

Contract Type and Term:	Services Agreement February 1, 2026 – January 31, 2029
Termination Clause:	Without Cause Termination: Either party may terminate this agreement without cause after 18 months from contract execution date, provided that 180 days' written notice is given.
Total Spend with Vendor:	

Description	Board Approval	Total
Equipment Management and Rental Services Agreement (2/1/26 – 1/31/29)	**Approval Requested**	**$8,703,514**
5% Contingency	**Approval Requested**	**$435,176**
Total Estimated Spend:	**Approval Requested**	**$9,138,690**

Estimated Cost Savings:	AHS leadership negotiated $1,214,813 in savings through negotiated reductions in vendor rates and utilization. Including negotiated reductions and the GPO rebate ($178K), AHS will realize total savings of $1.4M over the 3-year term of the proposed Renewal.
Fiscal Implications:	The proposed agreement is included in FY 26 budget and will be included in future years' budget requests.
Reasons for Recommendation:	Agiliti Health has proven itself to be a high-performing service provider to AHS for many years. Through the assessment process, Agiliti has demonstrated the willingness and ability to quickly and reliably adjust service delivery to support our changing needs.
Impacted Facilities:	

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

Coordination with Medical Staff:	N/A
Administrative Review:	VP of Support Services
Prior BOT Review/Action:	N/A
Executive Sponsor	Chief Operating Officer

Contractor/Vendor Name:	VTP Holdings, LLC dba VIC the PICC ("VTP")
Description:	As part of standard care for patients with indicating diagnoses and treatment plans, AHS needs to place peripherally inserted central catheter ("PICC") lines in patients requiring intravenous access that can be used for a prolonged period of time for procedures such as long chemotherapy regimens, extended antibiotic therapy, or total parenteral nutrition. Proper insertion of PICC lines requires that it be performed by a trained and certified registered nurse. An ultrasound or chest X-ray, or the use of fluoroscopy, can be used during insertion and to confirm placement. The insertion is a sterile procedure requiring proper equipment and setting. Once placed, PICC lines require care and maintenance to prevent clots and to prevent the site from becoming a source of infection or sepsis. AHS utilizes an outside vendor to supplement our in-house PICC line-qualified staff, allowing AHS to maintain a base of in-house expertise deployed in our high-volume facilities during peak times coupled with vendor augmented staffing to address less frequent care needs during evenings/weekends and at our lower volume facilities. This ensures flexible and timely access for all patients while allowing space for AHS to maintain and continue to grow our existing in-house staff who are trained and experienced in this important skill. VTP is a Northern California-based provider of vascular access device related services, including insertion and troubleshooting of PICC lines with whom AHS has contracted for provision of PICC line placement and management services ("Services") since 2021. VTP continues to supplement AHS in-house provision of Services. AHS is in the process of further refining the ordering algorithm for outside services as it is not considered an emergent procedure, thus reducing the need to utilize outside services. AHS nursing is planning to increase its in-house staff that manages central venous access, further decreasing the need to use outside services In light of the ongoing need to maintain access to a flexible supplier of Services to supplement existing AHS in-house resources, AHS leadership is requesting Board approval to enter a renewal agreement ("Renewal") with VTP on the terms described below.
Contract Type and Term:	Professional Services Agreement. February 1, 2026 through January 31, 2029
Termination Clause:	Either party may terminate this Agreement upon a thirty (30) day written notice.
Total Spend with Vendor:	**Description**: **Renewal (2/01/2026 – 1/31/2029)** **Board Approval**: **Board approval requested** **Total**: **$1,620,000**
Estimated Cost Savings:	In the 4 years since the initial contract with VTP, annual utilization has been reduced $322,500 or by 39.5% reduction. By using in-house services, AHS has the opportunity to also control the supply chain-associated costs of the vascular access devices that would otherwise be provided by the vendor. Further expansion of in-house staffing qualified in the provision of Services to enhance coverage at our community hospitals (San Leandro and Alameda Hospitals) will further reduce VTP utilization and associated expenses going

	forward.

Fiscal Implications:	This expense has been included in the FY 26 budget.
Reasons for Recommendation:	As long as long-term medicinal therapy and fluids are a part of a patient's regimen, these services will be needed whether provided by a contractor or by in-house staff. Funding will ensure that patients will have access to long-term IV therapy, regardless of who does the procedure. These IV therapies include chemotherapy and IV antibiotics, necessary for very serious patient care regimens. VTP is a proven and reliable supplier of these essential services with a demonstrated ability to partner effectively with AHS.
Impacted Facilities:	

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

Coordination with Medical Staff:	The Providers have been satisfied with the Services provided by VTP. Having 24/7 availability of a company to provide Services has been crucial for the care of AHS patients.
Epic Coordination:	These procedures are currently documented in EPIC.
Administrative Review:	VP of Patient Care Administrative Services
Prior BOT Review/Action:	This vendor was approved in a previous Board Approved contract in November 2023.
Executive Sponsor	Chief Clinical Officer

Contractor/Vendor Name:	SMITH-KARNG ARCHITECTURE ("SKA")
Description:	Alameda Health System ("AHS") has secured funding through the Behavioral Health Continuum Infrastructure Program ("BHCIP"), supported by Proposition 1 bond funds, to expand behavioral health services on the San Leandro Hospital ("SLH") campus. This includes the establishment of a 10-bed inpatient Substance Use Disorder Detoxification unit ("Unit"- American Society of Addiction Medicine Level 3.7 – Medically Monitored Intensive Inpatient Withdrawal Management). The Unit will provide high intensity, medically monitored detoxification and stabilization services for patients with substance use disorders ("SUD"), particularly those with co-occurring stable medical and psychiatric conditions. This development addresses a critical gap in Alameda County's behavioral health continuum, offering essential inpatient addiction treatment where demand currently exceeds capacity. SKA, a healthcare-specialized architectural firm, has submitted a proposal for full architectural and engineering ("A/E") services for the 3rd Floor Inpatient Medical Detox Remodel project at SLH. The scope includes multi-phased design and construction oversight to remodel the existing unit, converting it into a secure inpatient medical detoxification unit. The project aligns with the BHCIP grant application documents (dated December 2024) and represents a component of the broader behavioral health expansion previously approved by the Board of Trustees. SKA acknowledges the grant's stipulations, including the requirement that the project be completed within 3 years of the funding award (estimated deadline: May 2028). In light of the secured BHCIP funding and the urgent need for expanded SUD treatment services, AHS leadership recommends that the Board of Trustees approve engagement of SKA for architectural and engineering services for the 3rd Floor Inpatient Medical Detox Unit remodel project at SLH as described below. This approval will enable timely advancement of the project in compliance with grant requirements.
Contract Type and Term:	Statement of Work ("SOW") #31 - Fee Proposal for SLH 3rd Floor Medi-Detox Remodel (December 2024 BHCIP Grant Application) January 15, 2026 – January 15, 2029
Termination Clause:	AHS may terminate without cause by providing 30 days' advance notice.
Total Spend with Vendor:	

Description	Board Approval	Estimated Total
Maximum Lump Sum Fee	Approval Requested	$1,492,525
Total	**Approval Requested**	**$1,492,525**

Estimated Cost Savings:	N/A
Fiscal Implications:	There is no net fiscal impact as total funding has been secured through the Behavioral Health Continuum Infrastructure Program (BHCIP), supported by Proposition 1 bond funds,

<table>
<tr><td></td><td>to expand behavioral health services in California. This proposal represents a portion of the expense for the total construction project.</td></tr>
<tr><td>Reasons for Recommendation:</td><td>Approval will enable timely advancement of the project in compliance with grant requirements.</td></tr>
<tr><td>Impacted Facilities:</td><td><table><tr><th>JGPH</th><th>Highland</th><th>Fairmont</th><th>San Leandro</th><th>Alameda</th><th>Clinic(s)</th></tr><tr><td></td><td></td><td></td><td>X</td><td></td><td></td></tr></table></td></tr>
<tr><td>Coordination with Medical Staff:</td><td>Coordination and impact to the facility will be closely coordinated with the San Leandro Hospital Clinical teams as needed.</td></tr>
<tr><td>Administrative Review:</td><td>Primary: VP of Business Planning and VP of Support Services</td></tr>
<tr><td>Prior BOT Review/Action:</td><td>The Board of Trustees approved submittal of the application for this project prior to the December 2024 submission deadline.</td></tr>
<tr><td>Executive Sponsor:</td><td>Chief Operating Officer</td></tr>
</table>

ALAMEDA HEALTH SYSTEM

BOT Previously Approved Contracts - FY26 (July 1, 2025 - June 30, 2026)

#	Vendor	Amount Requiring BOT Approval	Start Date	Ending Date	BOT approved Date	Agenda Summary	Expectation	Executive Sponsor
1	Alliance HealthCare Services, Inc. dba Alliance HealthCare Radiology	$3,333,044	4/23/2025	4/22/2028	FC - 7-2-25 BOT Approved 7-9-25	Provision of mobile imaging services.		Chief Operating Officer
2	CareFusion Solutions, LLC	$7,206,000	8/19/2025	8/18/1930	FC - 7-2-25 BOT Approved 7-9-25	Provision of infusion pumps and supplies.		Chief Clinical Officer
3	East Oakland Community Project	$1,593,600	8/1/2025	7/31/2028	FC - 7-2-25 BOT Approved 7-9-25	Provision of respite care services.		Chief Clinical Officer
4	The Regents of the University of California on behalf of the University of California, San Francisco, Department of Neurological Surgery	$7,594,371	8/1/2025	7/31/2027	FC - 7-2-25 BOT Approved 7-9-25	Provision of neurological surgery professional services.		Chief Medical Officer
5	Entisys Solutions, Inc. dba E360	$1,499,410	9/29/2025	9/28/2028	FC - 9-3-25 BOT Approved 9-17-25	Citrix virtual access platform		Chief Information Officer
6	GuidePoint Security LLC	$1,457,310	9/30/2025	6/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Arctic Wolf cybersecurity monitoring and recovery services		Chief Information Officer
7	Xerox, Inc.	$3,983,160	11/1/2025	10/31/1930	FC - 9-3-25 BOT Approved 9-17-25	Printer equipment and services.		Chief Information Officer
8	Anthem Blue Cross Life and Health Insurance Company	$5,930,739	1/1/2025	12/31/2027	FC - 9-3-25 BOT Approved 9-17-25	Third-party administrator services for AHS employee health insurance plan.		Chief Human Resources Officer
9	Cardea Health	$6,394,800	10/1/2025	9/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Respite housing services.		Chief Clinical Officer
10	Lifepoint Rehabilitation of California, LLC	$4,211,233	10/1/2025	9/30/2028	FC - 9-3-25 BOT Approved 9-17-25	Inpatient rehabilitation management services.		Chief Operating Officer

11	McKesson Corporation	$447,180,000	4/1/2026	3/31/1931	FC - 9-3-25 BOT Approved 9-17-25	Wholesale pharmaceutical supply services.		Chief Clinical Officer
12	Quest Diagnostics	$13,280,743	3/1/2022	2/28/2026	FC - 9-3-25 BOT Approved 9-17-25	Reference laboratory services.		Chief Clinical Officer
13	Nelson T. Lewis Construction Co., Inc.	$3,197,080	10/15/2025	6/15/2026	FC - 10-1-25 BOT Approved 10-8-25	St. Rose Hospital cath lab upgrade.		St. Rose Chief Administrative Officer
14	ePlus Technology, Inc.	$1,800,000	11/1/2025	10/31/2028	FC - 10-1-25 BOT Approved 10-8-25	Data loss protection services.		Chief Information Officer
15	Switch, Ltd.	$1,509,294	2/16/2026	2/15/1931	FC - 10-1-25 BOT Approved 10-8-25	Data center services.		Chief Information Officer
16	Lescure Company, Inc.	$1,668,200	11/1/2025	3/31/2027	FC - 10-1-25 BOT Approved 10-8-25	Architectural and structural work for Alameda Hospital HVAC replacement project.		Chief Operating Officer
17	Matrix HG, Inc.	$1,214,436	11/1/2025	10/31/2026	FC - 10-1-25 BOT Approved 10-8-25	Installation of COVID prevention HVAC upgrades at JGPH.		Chief Operating Officer
18	Symplr Care Management LLC	$1,112,847	1/1/2026	12/31/2028	FC - 11-5-25 BOT Approved 11-12-25	Patient safety and quality reporting software.		Chief Information Officer
19	LAZ Parking California, LLC	$6,937,194	1/1/2026	12/31/2028	FC - 11-5-25 BOT Approved 11-12-25	Parking services.		Chief Operating Officer
	Total Amount for FY 25 year to date	$521,103,461						

DISCUSSION: The Joint Commission Update

ALAMEDA HEALTH SYSTEM

Board of Trustees
- Regulatory Affairs Update -

Nilda Perez
System Director, Regulatory Affairs / Environmental Health & Safety
01.14.26

UPCOMING JOINT COMMISSION SURVEY

- AHS CORE Facilities (Highland, San Leandro, John George, Fairmont hospitals) will have a triennial accreditation survey between now and April 22, 2026.
- It will be a 5-day survey with a survey team that will include both acute care and behavioral evaluators, in addition to a Life Safety Engineer.
- Joint Commission sites include inpatient and outpatient settings. Excluding the off-site Wellness Centers and Skilled Nursing Facilities.
- Exact number of surveyors to be determined.
- A Virtual Command Center will be implemented as part of our standard "Survey Response Plan" to manage survey logistics and communication.
- AHS will be surveyed under the new "Accreditation 360" methodology.

The New Standard! Accreditation 360: Change Effective Jan. 1, 2026

- ✓ The Joint Commission is transforming its accreditation process by reducing the number of requirements by 50% — from 1,551 to 774 standards — in its most significant rewrite since Medicare was established in 1965.
- ✓ Announced in June 2025, Accreditation 360 aims to reduce burden on clinicians and health systems while maintaining rigor and sharpening the focus on quality and safety areas that matter, all in service of delivering better patient care.

DAY 1 – IMMEDIATE NOTIFICATIONS

Once survey team arrives on site and announces the start of a survey…

Regulatory Affairs Lead notifies:

- ❑ Regulatory Affairs Team
- ❑ VP Quality
- ❑ CMO
- ❑ Alert all AHS staff by sending email with survey announcement and command center information

VP Quality notifies the following key stakeholders:

- ❑ Executive Leadership Team

** *Each ELT member initiates notifications to their respective department leaders*

- ❑ Executive Office Manager/Special Assistant to the CEO notifies Board of Trustees (BOT)
- ❑ Quality Team

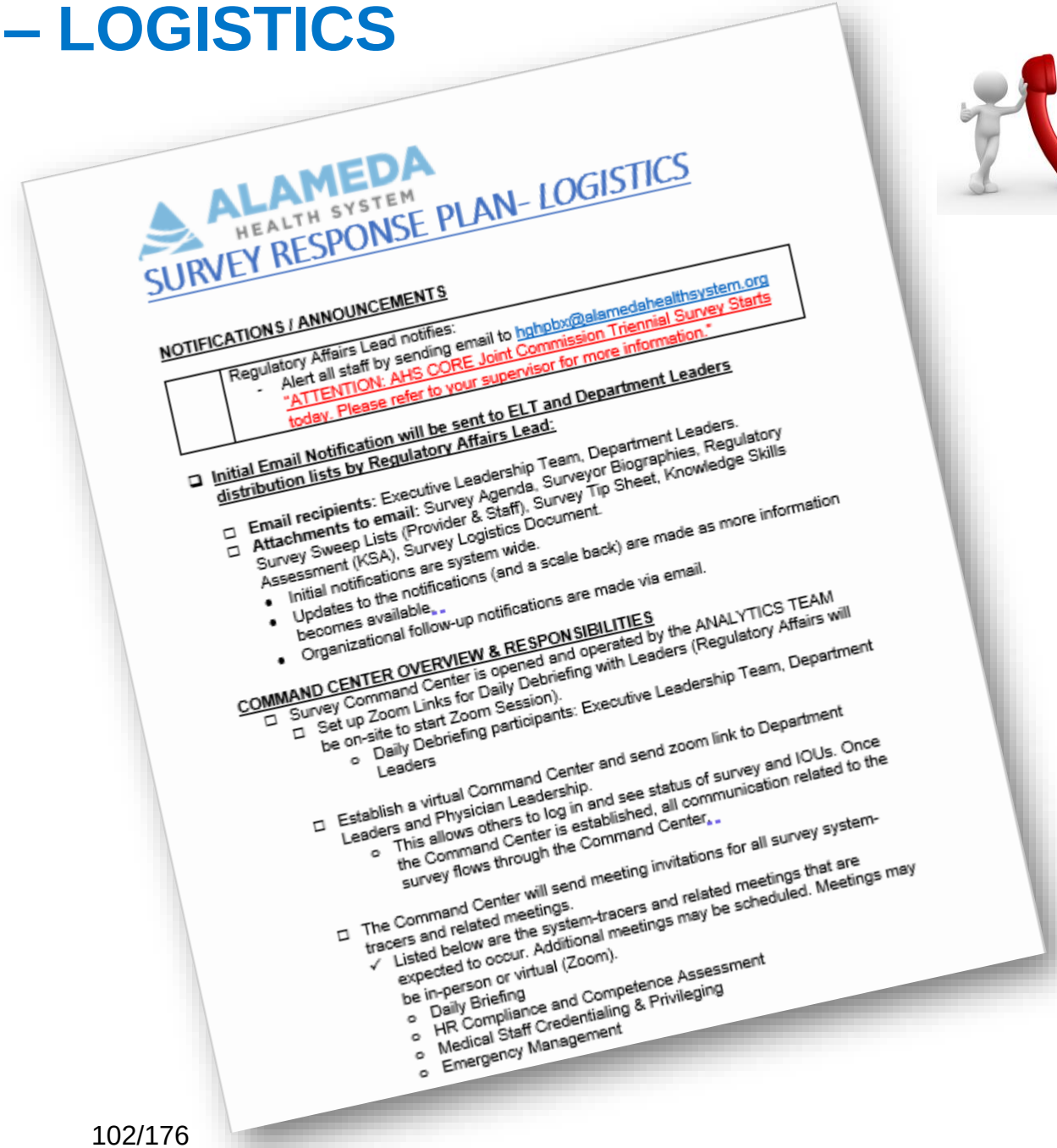
VP of Medical Staff (MS) or designee

- ❑ Notifies the Physician Leadership for all involved facilities.

ALAMEDA HEALTH SYSTEM

SURVEY RESPONSE PLAN – LOGISTICS

- ✓ Regulatory Affairs developed an AHS "roadmap" for best first impression!
- ✓ The "Survey Response Plan" guides logistics and communication for the organization, starting with the arrival of surveyors.
- ✓ Includes the setup of our Command Center.



ALAMEDA HEALTH SYSTEM

SURVEY RESPONSE PLAN- LOGISTICS

NOTIFICATIONS / ANNOUNCEMENTS

Regulatory Affairs Lead notifies:
- Alert all staff by sending email to hghpbx@alamedahealthsystem.org "ATTENTION: AHS CORE Joint Commission Triennial Survey Starts today. Please refer to your supervisor for more information."

☐ **Initial Email Notification will be sent to ELT and Department Leaders distribution lists by Regulatory Affairs Lead:**

☐ **Email recipients**: Executive Leadership Team, Department Leaders.

☐ **Attachments to email**: Survey Agenda, Surveyor Biographies, Regulatory Survey Sweep Lists (Provider & Staff), Survey Tip Sheet, Knowledge Skills Assessment (KSA), Survey Logistics Document.

- Initial notifications are system wide.
- Updates to the notifications (and a scale back) are made as more information becomes available.
- Organizational follow-up notifications are made via email.

COMMAND CENTER OVERVIEW & RESPONSIBILITIES

☐ Survey Command Center is opened and operated by the ANALYTICS TEAM

☐ Set up Zoom Links for Daily Debriefing with Leaders (Regulatory Affairs will be on-site to start Zoom Session).

- Daily Debriefing participants: Executive Leadership Team, Department Leaders

☐ Establish a virtual Command Center and send zoom link to Department Leaders and Physician Leadership.

- This allows others to log in and see status of survey and IOUs. Once the Command Center is established, all communication related to the survey flows through the Command Center.

☐ The Command Center will send meeting invitations for all survey system-tracers and related meetings.

✓ Listed below are the system-tracers and related meetings that are expected to occur. Additional meetings may be scheduled. Meetings may be in-person or virtual (Zoom).

- Daily Briefing
- HR Compliance and Competence Assessment
- Medical Staff Credentialing & Privileging
- Emergency Management

OPENING CONFERENCE / ORIENTATION TO ORGANIZATION

- On 1st day, takes place as early as possible, approximately 1-2 hours after surveyors review the agenda.
- Surveyors will describe the structure of the survey, and answer questions about the survey at the Opening Conference.
- During Orientation to the Organization, the surveyors(s) will learn how our organization is governed and operated, discuss AHS planning priorities, and explore our organization's performance improvement process.
- Suggested participants are senior leadership representing the accredited program and services; **member(s) of the governing body**, or organization trustee; administrators; leader(s) of the medical staff; leader(s) of the nursing staff; and accreditation contact.
- You will be contacted at the start of the survey and provided more details on the time and format for the session. *(same process for survey EXIT)*

LEADERSHIP SESSION

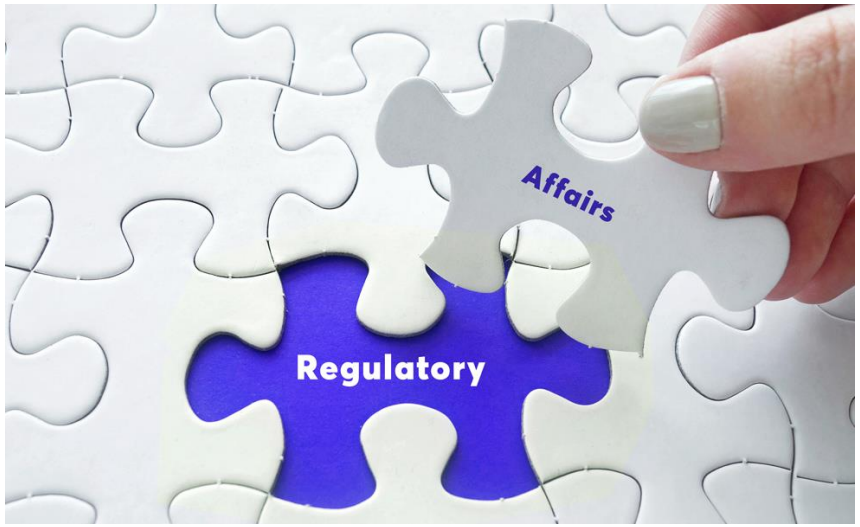
- A special system-tracer is held with representatives from organization governance, administration, & management.
- The surveyor will evaluate the responsibilities and accountabilities of leaders for the hospital's total operation (including priority setting) and for administering policies to provide quality health care in a safe environment.
- This is a group interview at a time negotiated with the organization. BOT members will receive notice once scheduled.
- Participants include senior leaders who have responsibility and accountability for design, planning, and implementation of organization processes. Leaders typically include but are not limited to members of the governing body/trustee, CEO, and leaders of the medical staff and clinical staff.

POTENTIAL DISCUSSION TOPICS FOR THE BOARD OF TRUSTEES

Governing Body structure, oversight	• Awareness of CMS Conditions of Participation; Resource allocation; • Accountability
Quality of Care	• Policy Approvals; standard operations • Continuous Improvement; Patient-Centered Approaches
Culture of Safety	• Just Culture ; Reporting & Transparency; Continuous Learning
High Reliability	• Culture of Excellence • Engaged, expert workforce • Resilience

ONGOING PREPAREDNESS ACTIVITIES
- CONTINUOUS READINESS

- ✓ Regulatory Affairs standard work and preparation activities implemented and ongoing.
- ✓ Activities include education, compliance monitoring through audits/rounding, validation rounding and follow-up on mock survey and previous findings.
- ✓ Engagement/ communication with Department Leaders regarding standards and any non-compliance; escalation to VPs.



THANK YOU!

F3.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

ALAMEDA HEALTH SYSTEM

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 diffeculty
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**	

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

Consolidated Financial Statement
Fiscal Year 2026 Approved Budget (In Thousands)

	Projected 2025*	Approved 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

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

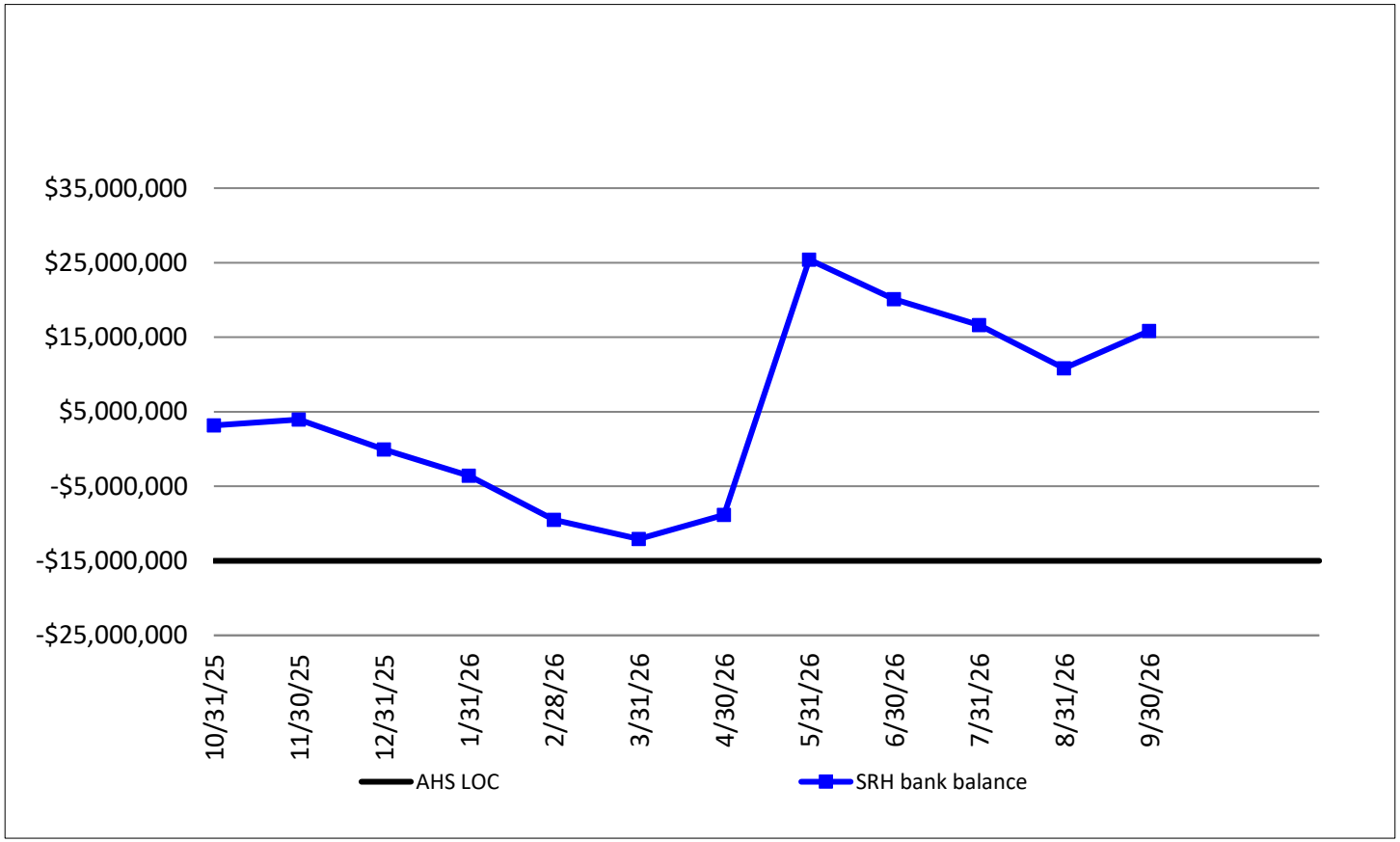
Fiscal Year 2026 Proposed Budget – Capital Expenditures

- **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**

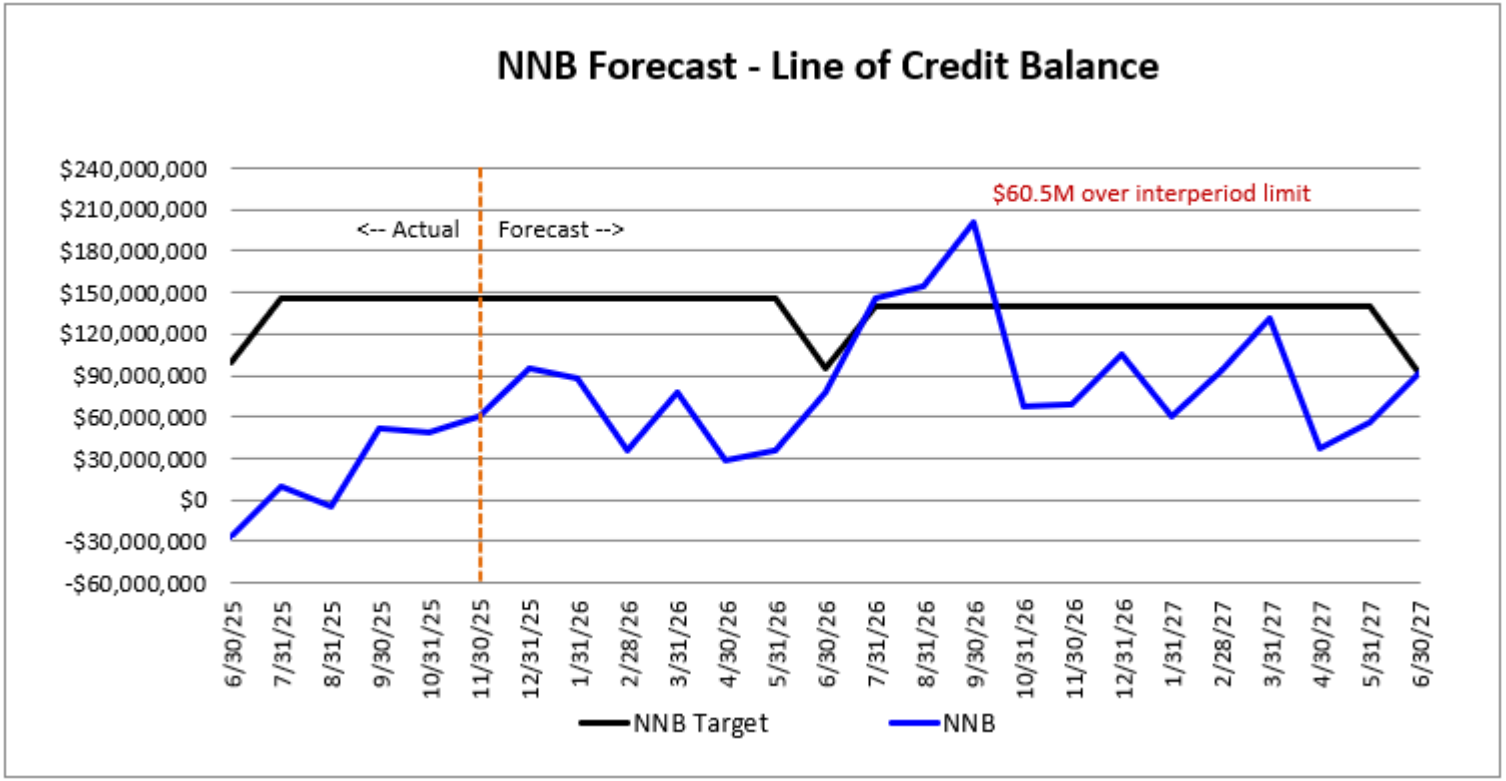
**FY2022 - Includes Donation of Radiation Oncology Building to SRH (based on VMG appraisal) - $3.1M*
**FY2023 - Includes Donation of Bay Valley Building to SRH (based on appraised value) - $1.8M*
**FY2025 - Includes capitalized Sub Acute project - $5.4M*

Fiscal Year 2026 Proposed Budget – Projected Cash Flow



- 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.



November 2025 Financial Report
Material Items Impacting NNB Forecast

- 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	-
	$ 30,641	$ 54,981	$ 54,884	$ 35,991	$ 111,915	$ 36,222	$ 195,202	$ 146,158	$ 146,210

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
	$ (52,931)	

Appendix : SRH Approved Budget

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

Fiscal Year 2026 Budget

Board of Directors

Fiscal Year 2026 Budget – Key Assumptions

- **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

Fiscal Year 2026 Budget – Key Assumptions

- **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.

Fiscal Year 2026 Budget – Key Assumptions

- **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 DHLP would be reduced by $3.5M and repayment period would begin July 1, 2027 on balance estimated at $14.1M.

Fiscal Year 2026 Budget – Key Assumptions (MOB & Foundation)

- **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.

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

Consolidated Financial Statement
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**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

Fiscal Year 2026 Proposed Budget – Patient Services Revenue (In Thousands)

	Projected 2025	Proposed 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.

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

Fiscal Year 2026 Proposed Budget – Supplemental Funding & Other Revenue (In Thousands)

	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

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

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 Administritive	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.

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

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

	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)

	Projected 2025	Proposed 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.

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

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*

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

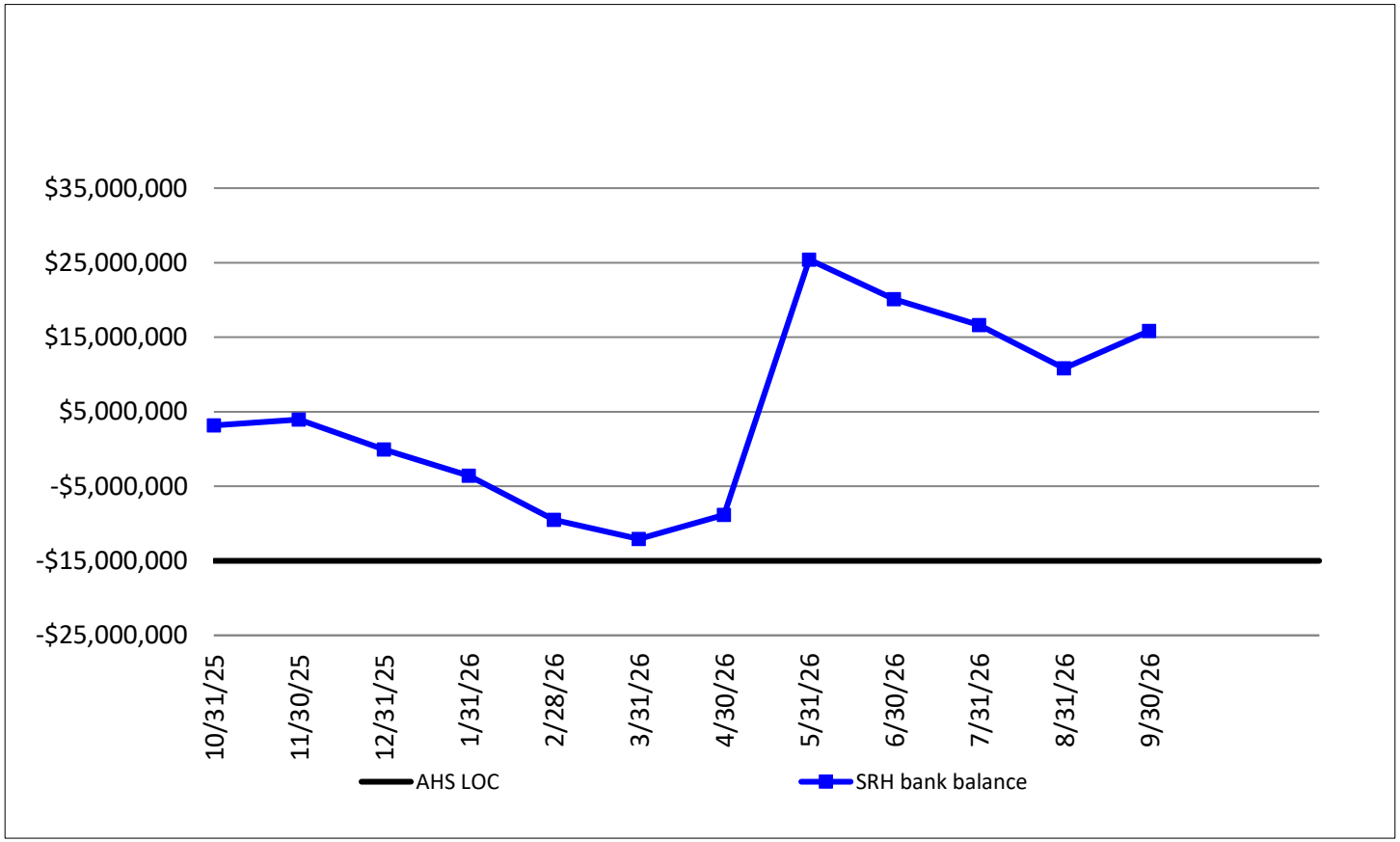
Fiscal Year 2026 Proposed Budget – Capital Expenditures

- **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**

**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*

Fiscal Year 2026 Proposed Budget – Projected Cash Flow



- 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.

DISCUSSION: Alameda Health System Governance Structure Update

No Written Materials

Agenda Item F4 AHS Governance Structure Update

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

Chief Financial Officer Report, September Financial Report

ALAMEDA HEALTH SYSTEM

November 2025 Financial Report
Finance Committee, January 7, 2026

October 2025 Highlights
Finance Committee dark in December.

- October revenue unfavorable $2.0M. Lower NPR ($2.3M) driven by volume offset by retail pharmacy.
- Favorable YTD revenue variance of $4.6M.
  - Net patient revenue below budget ($0.5M); collection percentage was 0.3% below budget.
  - SAC law settlement on older claims ($3.1M).
  - Alliance P4P ($1.2M).
- October expenses unfavorable $1.5M due to labor $1.8M (111 FTE variance and self funded heath plan), pharmaceuticals ($1.9M) partially offset by OMS ($1.0M), security ($0.3M) and facilities timing ($0.6M).
- YTD unfavorable expense variance of $5.0M.
  - Labor costs unfavorable by $8.9M from unfavorable staff wages and registry ($6.3M)/FTE variance of 78, employee benefits ($4.2M) offset by favorable provider wages and contracts ($1.6M).
  - Non-labor cost favorable by $3.9M with variances in outside medical services ($2.8) and software licenses/hosting fees ($0.9M).
    - Lower costs associated with fewer patient days/LOS and trauma cases.
    - OMS trending consistent with FY25 spend. Ambulance credit from FY25.

	October 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 137,263	$ 139,294	$ (2,031)	(1.5)%	$ 550,785	$ 546,177	$ 4,608	0.8%	$ 510,636	7.9%
Operating expense	138,020	136,556	(1,464)	(1.1)%	541,730	536,721	(5,009)	(0.9)%	512,703	(5.7)%
Operating income (loss)	**(757)**	**2,738**	**(3,495)**	**(127.6)%**	**9,055**	**9,456**	**(401)**	**(4.2)%**	**(2,067)**	**538.1%**
Other non-operating activity	(505)	(1,099)	594	54.0%	(1,444)	(1,456)	12	0.8%	(1,176)	(22.8)%
Net Income (loss)	**$ (1,262)**	**$ 1,639**	**$ (2,901)**	**(177.0)%**	**$ 7,611**	**$ 8,000**	**$ (389)**	**(4.9)%**	**$ (3,243)**	**334.7%**
EBIDA adjustments	2,920	3,587	(667)		10,904	11,650	(746)		15,444	
EBIDA	**$ 1,658**	**$ 5,226**	**$ (3,568)**		**$ 18,515**	**$ 19,650**	**$ (1,135)**		**$ 12,201**	
Operating Margin	(0.6)%	2.0%	(2.6)%		1.6%	1.7%	(0.1)%		(0.4)%	
EBIDA Margin	1.2%	3.8%	(2.6)%		3.4%	3.6%	(0.2)%		2.4%	

November 2025 Financial Report
Finance Dashboard

November-2025

	Metric	FY2026 Goal YTD	Actual YTD	YTD	Trend Lines
Volume					
	Total Adjusted Discharges	13,133	13,658		
	Total Adjusted Patient Days	151,696	152,954		
Revenue Cycle					
	Collection Ratio	19.5%	19.3%		
	Cash as % of Net Revenue	100.0%	105.7%		
	Gross Days in Patient Receivables	62.0	62.7		
Labor					
	Productivity %	100.0%	98.4%		
	Registry as % of Total FTEs	4.2%	4.0%		
	Overtime % excl Company 30	4.5%	5.6%		
	Total FTEs	5,125	5,193		
	FTE per Adjusted Discharge	0.96	0.93		
	*Labor Cost/FTE w/o GASB	$236,093	$231,838		
Profitability					
	Total Cost per Adjusted Discharge	$50,590	$49,165		
	Total Cost per Adjusted Patient Days	$4,380	$4,390		
	Net Income	$8,048	$5,534		
	EBIDA Margin	3.3%	2.8%		
	NNB (Net Negative Balance)	<$95M	-$60,007		
	Net Position	>$0	-$56,096		
Capital					
	Capital Spent	$12,196	$8,658		
	% of Capital Spent		71.0%		

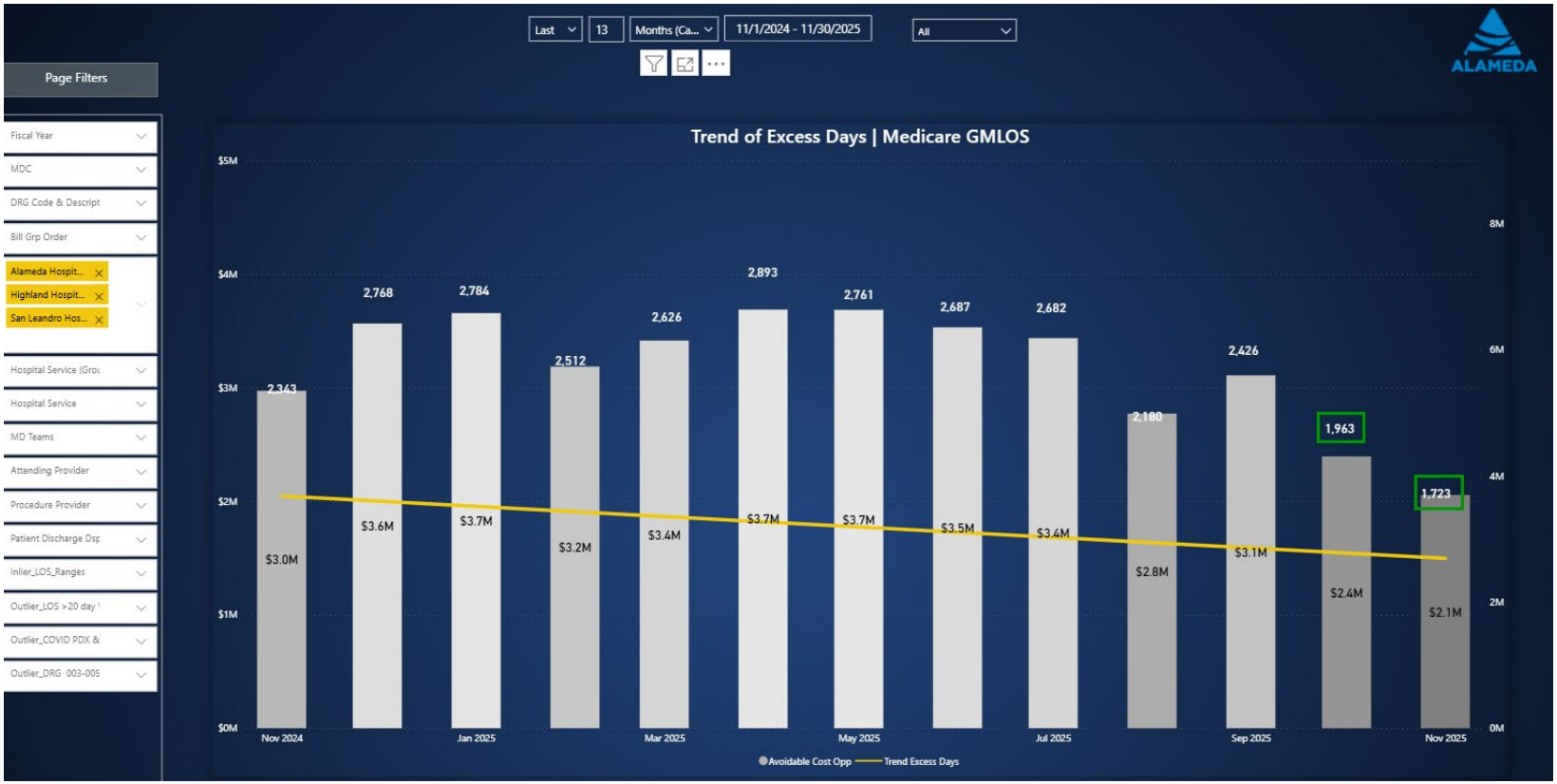
*Labor costs excludes contracted physicians; Includes Registry travel & housing costs

November 2025 Financial Report
Volume Highlights – Part 1

	November 2025				FY2026 year-to-date				FY2025 year-to-date		
	Actual	Budget	Var	% Var	Actual	Budget	Var	% Var	Actual	Var	% Var
Campus: AHS ALL CAMPUS											
Total Adjusted Patient Days	29,831	28,840	991	3.4%	152,954	151,696	1,258	0.8%	150,276	2,678	1.8%
Total Adjusted Discharges	2,584	2,494	90	3.6%	13,658	13,133	525	4.0%	13,115	543	4.1%
Physician wRVU	124,465	144,578	-20,113	-13.9%	666,350	631,322	35,028	5.5%	652,487	13,863	2.1% #
FQHC & Other Clinic Visits	31,045	33,099	-2,054	-6.2%	177,560	184,328	-6,768	-3.7%	172,685	4,875	2.8%
GENERAL ACUTE											
Patient Days	5,699	6,088	-389	-6.4%	29,241	31,300	-2,059	-6.6%	30,911	-1,670	-5.4%
Discharges	1,168	1,178	-10	-0.9%	6,193	6,037	156	2.6%	6,064	129	2.1%
Average Length of Stay	4.9	5.2	0.3	5.6%	4.7	5.2	0.5	8.9%	5.1	0.4	7.4%
CMI	1.639	1.598	0.041	2.6%	1.602	1.656	-0.054	-3.3%	1.656	-0.054	-3.3%
Emergency Visits	8,925	8,309	616	7.4%	46,903	43,821	3,082	7.0%	44,965	1,938	4.3%
Trauma Cases	328	260	68	26.4%	1,570	1,577	-7	-0.4%	1,620	-50	-3.1%
Observation Equivalent Days	711	566	144	25.5%	3,415	3,409	6	0.2%	3,241	173	5.4%
Surgeries	601	522	79	15.2%	3,428	3,459	-31	-0.9%	3,803	-375	-9.9%
PSYCH											
Psych Patient Days	1,979	1,904	75	4.0%	10,187	9,959	228	2.3%	9,860	327	3.3%
Psych Discharges	203	211	-8	-4.0%	1,069	1,106	-37	-3.3%	1,094	-25	-2.3%
Average Length of Stay	9.7	9.0	-0.7	-8.3%	9.5	9.0	-0.5	-5.8%	9.0	-0.5	-5.7%
PES Equivalent Days	644	493	151	30.6%	3,741	3,404	337	9.9%	3,404	337	9.9%

November 2025 Financial Report
Medicare GMLOS Benchmark – Trend of Excess Days

Acute Care Hospitals: HGH, SLH, AH (excludes any rehab)



- <u>LOS Variance Days | November:</u> There were 1,723 excess days which is a decrease. This reflects the total # of actual days in a bed in excess of the allowed # of days compared to the Medicare acuity model benchmark.
- <u>Medicare GMLOS Benchmark:</u> Compares the total AHS patient population against the Federal regulatory guidelines (Medicare), regardless if the patient is a non-Medicare State (APR) payer or a Medicare Federal (MSDRG) payer.

November 2025 Financial Report
Volume Highlights – Part 2

	November 2025				FY2026 year-to-date				FY2025 year-to-date		
	Actual	Budget	Var	% Var	Actual	Budget	Var	% Var	Actual	Var	% Var
Campus: AHS ALL CAMPUS											
REHAB											
Rehab Patient Days	686	625	61	9.8%	3,498	3,553	-55	-1.5%	3,387	111	3.3%
Rehab Discharges	52	47	5	10.0%	272	269	3	1.2%	256	16	6.3%
Average Length of Stay	13.2	13.2	0	0.2%	12.9	13.2	0.4	2.7%	13.2	0.4	2.8%
SNF with Sub-Acute											
SNF Patient Days	8,269	8,270	-1	0.0%	42,422	42,177	245	0.6%	41,895	527	1.3%
Average Daily Census	275.6	275.7	0.0	0.0%	277.3	275.7	1.6	0.6%	273.8	3.4	1.3%
Occupancy %	95.0%	95.0%	0.0%	0.0%	96.0%	95.0%	0.0%	0.0%	94.0%	0.0%	0.0%
Bed Holds	61	72	-11	-15.1%	299	404	-105	-26.1%	402	-103	-25.6%
PAYOR MIX											
Insurance %	6.0%	6.0%	0.1%		6.6%	7.2%	-0.6%		7.1%	-0.5%	
Medi-Cal %	58.7%	60.0%	-1.3%		60.1%	61.3%	-1.2%		61.5%	-1.4%	
Medicare %	30.4%	28.1%	2.3%		28.9%	26.4%	2.5%		27.1%	1.8%	
Other Govt %	1.2%	2.4%	-1.2%		1.4%	1.8%	-0.4%		1.7%	-0.3%	
Self-Pay %	3.7%	3.5%	0.2%		3.0%	3.3%	-0.3%		2.7%	0.3%	
Total Payor Mix %	100.0%	100.0%	0.0%		100.0%	100.0%	0.0%		100.0%	0.0%	

November 2025 Financial Report
YTD Highlights

- Favorable YTD revenue variance of $4.6M.
  - Net patient revenue above budget ($2.1M), collection percentage was 0.1% below budget.
  - Other government programs below budget ($2.9M) from Measure A adjustment.
  - Other operating income above budget ($5.0M) from SAC law settlement on older claims ($3.1M) and Alliance P4P ($1.2M).

- Unfavorable YTD expense variance of $7.1M.
  - Labor costs unfavorable by $12.5M from unfavorable staff wages and registry ($8.7M), employee benefits ($5.2M) offset by favorable provider wages and contracts ($1.4M).
  - Non-labor cost favorable by $5.4M with the largest positive variances in outside medical services ($2.9) and software licenses/hosting fees ($1.4M).
    - Overall, lower costs associated with fewer patient days/LOS and trauma cases.

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 128,113	$ 128,121	$ (8)	(0.0)%	$ 678,898	$ 674,301	$ 4,597	0.7%	$ 632,290	7.4%
Operating expense	129,766	127,683	(2,083)	(1.6)%	671,495	664,405	(7,090)	(1.1)%	635,830	(5.6)%
Operating income (loss)	**(1,653)**	**438**	**(2,091)**	**(477.4)%**	**7,403**	**9,896**	**(2,493)**	**(25.2)%**	**(3,540)**	**309.1%**
Other non-operating activity	(426)	(392)	(34)	(8.7)%	(1,869)	(1,848)	(21)	(1.1)%	(1,498)	(24.8)%
Net Income (loss)	**$ (2,079)**	**$ 46**	**$ (2,125)**	**(4619.6)%**	**$ 5,534**	**$ 8,048**	**$ (2,514)**	**(31.2)%**	**$ (5,038)**	**209.9%**
EBIDA adjustments	2,694	2,868	(174)		13,599	14,518	(919)		18,860	
EBIDA	**$ 615**	**$ 2,914**	**$ (2,299)**		**$ 19,133**	**$ 22,566**	**$ (3,433)**		**$ 13,822**	
Operating Margin	(1.3)%	0.3%	(1.6)%		1.1%	1.5%	(0.4)%		(0.6)%	
EBIDA Margin	0.5%	2.3%	(1.8)%		2.8%	3.3%	(0.5)%		2.2%	

November 2025 Financial Report
Net Patient Services Revenue Highlights

- Gross patient service revenue is favorable driven by outpatient services.
  - General Acute inpatient days and discharges below budget and Length of Stay improving.
  - High acuity month with CMI 2.6% above budget and Trauma cases up 26.4%. YTD CMI below budget and trauma approximates budget.
    - Inpatient surgery above budget 5.1% and YTD below budget 6.3%.
  - ED visits 7.4% above budget and 7.0% YTD and Outpatient surgery above budget 23.3% and 3.8% YTD.
  - Clinic visits below budget 8.5% and 4.1% YTD.
  - SNF average daily census on target and favorable 0.6% YTD.
  - JGP days 4.0% above budget and 2.3% YTD; PES busy month and YTD up 9.9%.

- NPSR Collection ratio YTD was 19.4% and slightly below target.
  - Rate increases for government and Managed Medi-Cal were included in budget evenly and have not been realized.
  - Favorable settlement for Highland FY26 Medicare cost report ($1.9M).

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 206,890	$ 204,756	$ 2,134	1.0%	$ 1,087,162	$ 1,092,544	$ (5,383)	(0.5)%	$ 1,049,764	3.6%
Outpatient service revenue	147,726	130,174	17,552	13.5%	783,234	730,652	52,583	7.2%	709,851	10.3%
Professional service revenue	37,830	40,988	(3,158)	(7.7)%	204,878	215,341	(10,462)	(4.9)%	206,537	(0.8)%
Gross patient service revenue	392,446	375,918	16,528	4.4%	2,075,275	2,038,537	36,737	1.8%	1,966,151	5.6%
Deductions from revenue	(316,442)	(302,434)	(14,008)	(4.6)%	(1,674,723)	(1,640,044)	(34,679)	(2.1)%	(1,584,162)	5.7%
Net patient service revenue	**76,004**	**73,484**	**2,520**	**3.4%**	**400,551**	**398,493**	**2,058**	**0.5%**	**381,989**	**(4.9)%**
Collection % - NPSR	19.4%	19.5%	(0.1)%		19.3%	19.5%	(0.2)%		19.4%	
Capitation and HPAC	4,470	4,540	(70)	(1.5)%	22,387	22,729	(342)	(1.5)%	23,016	(2.7)%
Other government programs	42,493	45,415	(2,922)	(6.4)%	225,003	227,075	(2,072)	(0.9)%	201,576	11.6%
Other operating revenue	5,146	4,682	464	9.9%	30,957	26,004	4,954	19.1%	25,709	20.4%
Total operating revenue	**$ 128,113**	**$ 128,122**	**$ (9)**	**(0.0)%**	**$ 678,898**	**$ 674,300**	**$ 4,598**	**0.7%**	**$ 632,290**	**7.4%**

November 2025 Financial Report
Governmental and Other Revenue Highlights

- Other government programs unfavorable from Measure A adjustment ($2.5M) and Prop 56 ($0.4M). YTD unfavorable from Measure A FY2026 Q1 adjustment ($2.5M) and Prop56 ($1.0M) offset by favorable variance for Alameda Alliance P4P ($1.2M) and FEMA ($0.2M).
- Other operating revenue favorable from higher retail pharmacy ($0.1M) and SRH management fee ($0.3M). YTD, favorable driven by the settlement on low pay patient accounts ($3.1M), SRH management fee excluded from the budget ($1.7M) and higher retail pharmacy ($1.1M) offset by unfavorable grant activity ($1.2M).

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Net patient service revenue	76,004	73,484	2,520	3.4%	400,551	398,493	2,058	0.5%	381,989	(4.9)%
Capitation and HPAC	4,470	4,540	(70)	(1.5)%	22,387	22,729	(342)	(1.5)%	23,016	(2.7)%
Medi-Cal Waiver	8,475	8,474	1	0.0%	42,473	42,368	105	0.2%	46,349	(8.4)%
Measure A and parcel tax	10,288	12,760	(2,472)	(19.4)%	61,326	63,798	(2,472)	(3.9)%	63,927	(4.1)%
Supplemental Programs	23,730	24,182	(452)	(1.9)%	121,203	120,910	294	0.2%	91,301	32.8%
Other government programs	**42,493**	**45,415**	**(2,922)**	**(6.4)%**	**225,002**	**227,075**	**(2,073)**	**(0.9)%**	**201,576**	**11.6%**
Grant Revenue	1,405	1,376	29	2.1%	5,374	6,582	(1,209)	(18.4)%	6,288	(14.5)%
Other Operating Revenue	3,741	3,306	434	13.1%	25,584	19,421	6,163	31.7%	19,420	31.7%
Other operating revenue	**5,146**	**4,682**	**464**	**9.9%**	**30,957**	**26,004**	**4,954**	**19.1%**	**25,709**	**20.4%**
Total operating revenue	**$ 128,113**	**$ 128,122**	**$ (9)**	**(0.0)%**	**$ 678,898**	**$ 674,300**	**$ 4,598**	**0.7%**	**$ 632,290**	**7.4%**

November 2025 Financial Report
Expense Highlights excluding Labor

- Purchased services favorable from software licensing ($0.5M), clinical services ($0.5M), emergency food/shelter ($0.3M), security ($0.2M), and other purchased services ($0.4M) spread across various departments. YTD, favorable from outside medical services ($2.9M), software licenses/hosting fees ($1.4M), security services ($0.8M) and emergency food/shelter ($0.2M).
  - The favorable variance in outside medical services is expected to continue for the remainder of the fiscal year. The budget was based on higher ambulance services which were the result of duplicate invoices between sister companies. A refund of $1.2 million was received in June 2025.
- Material and supplies unfavorable from pharmaceuticals ($0.7M). Medical and surgical supplies approximated budget for the month. YTD unfavorable due to pharmaceuticals ($1.5M) offset by favorable medical supplies ($0.8M) and non-medical supplies ($0.2M).

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 101,238	$ 97,634	$ (3,604)	(3.7)%	$ 520,415	$ 507,877	$ (12,538)	(2.5)%	$ 485,721	(7.1)%
Purchased services	7,651	9,542	1,891	19.8%	42,415	47,790	5,375	11.2%	41,935	(1.1)%
Materials and supplies	12,652	12,082	(570)	(4.7)%	66,362	65,850	(512)	(0.8)%	63,175	(5.0)%
Facilities	3,405	3,213	(192)	(6.0)%	17,913	17,139	(774)	(4.5)%	15,601	(14.8)%
Depreciation and amortization	2,336	2,463	127	5.2%	11,755	12,605	850	6.7%	17,297	32.0%
General and administrative	2,484	2,749	265	9.6%	12,635	13,144	509	3.9%	12,101	(4.4)%
Total operating expense	**$ 129,766**	**$ 127,683**	**$ (2,083)**	**(1.6)%**	**$ 671,495**	**$ 664,405**	**$ (7,090)**	**(1.1)%**	**$ 635,830**	**(5.6)%**

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

- Facilities unfavorable from facility repairs ($0.5M) offset by favorable utilities ($0.3M). YTD, unfavorable from facility repairs ($2.2M) offset by favorable utilities ($1.1M) and rental equipment ($0.3M). Facility repairs occurred at Highland Hospital ($1.2M), Alameda Hospital ($0.8M), and San Leandro Hospital ($0.3M).
- Depreciation and amortization favorable from lower equipment depreciation ($0.4M) offset by higher lease and software amortization ($0.3M). YTD, favorable from lower equipment depreciation ($2.1M) offset by higher lease and software amortization ($1.3M).
- General and administrative favorable from recruitment expense ($0.2M). YTD, favorable from timing of recruitment expense ($0.4M).

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 101,238	$ 97,634	$ (3,604)	(3.7)%	$ 520,415	$ 507,877	$ (12,538)	(2.5)%	$ 485,721	(7.1)%
Purchased services	7,651	9,542	1,891	19.8%	42,415	47,790	5,375	11.2%	41,935	(1.1)%
Materials and supplies	12,652	12,082	(570)	(4.7)%	66,362	65,850	(512)	(0.8)%	63,175	(5.0)%
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Total operating expense	**$ 129,766**	**$ 127,683**	**$ (2,083)**	**(1.6)%**	**$ 671,495**	**$ 664,405**	**$ (7,090)**	**(1.1)%**	**$ 635,830**	**(5.6)%**

November 2025 Financial Report
Expense Highlights – Labor

- Staff wage and registry unfavorable from higher FTEs (180 FTEs/$2.3M) and higher rate ($0.7M). YTD, higher FTE (96 FTEs/$6.2M) and higher rate ($2.4M).
- Providers are favorable for the month and YTD. AHMG and other providers, such as midwives and CRRTs are included as provider within AHS entity.
  - Provider salaries favorable from lower FTEs (17 FTEs/$0.6M) and favorable rate ($0.2M). YTD, lower FTEs (18 FTEs/$3.1M) offset by higher rate ($0.7M). Recruitment unrealized.
  - Physician contract services unfavorable for month and YTD. See subsequent slide for detail.
- Employee Benefits unfavorable from higher self-funded health ($1.5M) offset by lower other benefits ($0.3M) and Kaiser premium ($0.2M). YTD, unfavorable from higher self-funded health ($7.6M) offset by lower Kaiser premium ($1.4M), FICA ($1.1M), and other benefits ($0.3M).
- Retirement approximates budget. YTD, unfavorable from ACERA ($0.9M) and union plans ($0.2M) offset by favorable variance from AHMG retirement plan ($0.7M).

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 60,007	$ 56,025	$ (3,982)	(7.1)%	$ 301,791	$ 289,306	$ (12,485)	(4.3)%	$ 275,060	(9.7)%
Salaries and wages (providers)	12,061	12,847	786	6.1%	63,082	65,346	2,264	3.5%	61,520	(2.5)%
Registry	3,026	4,012	986	24.6%	17,291	21,066	3,775	17.9%	21,315	18.9%
Physician contract services	3,980	3,574	(406)	(11.4)%	18,806	17,924	(882)	(4.9)%	18,295	0.0%
Employee benefits (taxes, insurance)	15,521	14,528	(993)	(6.8)%	81,086	76,251	(4,835)	(6.3)%	73,396	(10.5)%
Retirement	6,643	6,648	5	0.1%	38,359	37,984	(375)	(1.0)%	36,136	(6.2)%
Total labor costs	**$ 101,238**	**$ 97,634**	**$ (3,604)**	**(3.7)%**	**$ 520,415**	**$ 507,877**	**$ (12,538)**	**(2.5)%**	**$ 485,721**	**(7.1)%**
Compensation ratio	79.0%	76.2%	-2.8%		76.7%	75.3%	-1.4%		76.8%	
Paid FTEs - staff	4,665	4,479	(186)	(4.2)%	4,650	4,545	(105)	(2.3)%		
Paid FTEs - providers	376	393	17	4.3%	347	365	18	4.9%		
Paid FTEs - registry	203	209	6	2.6%	206	215	9	4.1%		
Total FTEs	5,244	5,081	(163)	(3.2)%	5,203	5,125	(78)	(1.5)%	5,093	

November 2025 Financial Report
Provider Expenses Variance

November 2025 YTD				
		Provider Dollars		
	Service Type	YTD Actual	YTD Budget	Variance
Salaries	AHMG/SEIU	42,546	44,317	1,771
	UAPD Dental	853	1,322	469
	UAPD Primary Care	3,728	4,578	850
	UAPD Psych	5,147	5,255	108
	GME	178	56	(121)
	APPs	10,631	9,818	(813)
	Total Salaries	**63,082**	**65,346**	**2,264**
Contracts	Locums/Registry	1,712	1,095	(618)
	UCSF Contracts	7,944	7,534	(411)
	GME Contracts	1,633	1,563	(70)
	Other Physician Contracts	7,517	7,733	216
	Total Contracts	**18,806**	**17,924**	**(882)**
Total Physician Expense		**81,888**	**83,270**	**1,382**

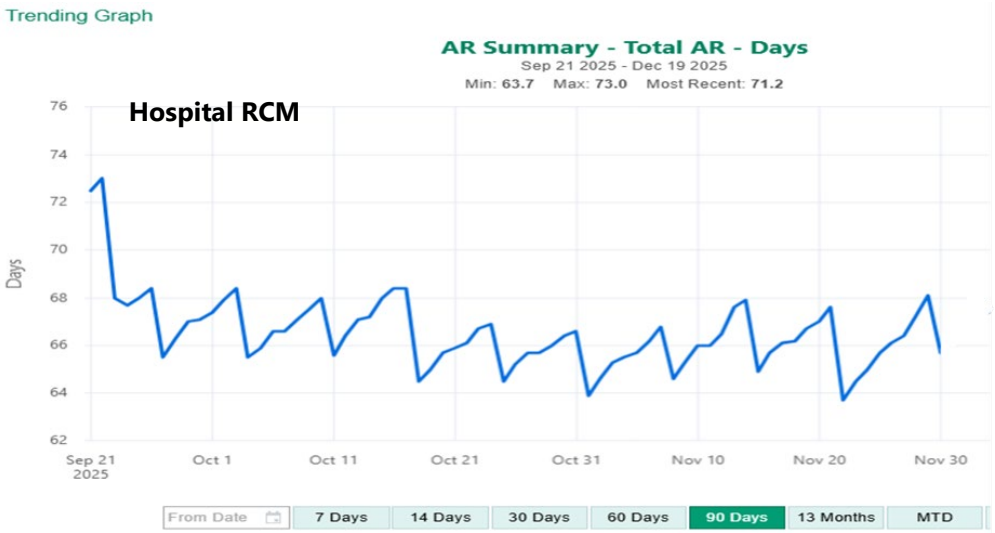
- New format for reporting, consistent with AHMG fully consolidated within AHS financial entity.
- Major variance in provider salaries from unrealized recruitment in the FY2026 budget.
- Major variance for contracts is locums.

November 2025 Financial Report
Balance Sheet Key Metrics

- Days in Cash are 5.1 days and higher than year-end; typically, below 5.0 days.
- Gross AR Days increased 3.0 days and Net AR Days increased 0.1 days. See next slide for additional detail.
- Days in Accounts Payable decreased due to timing of the check run and implementation of Hyland/Onbase (automation of AP processes). The target is 30 days.
- Net Position is negative $56.1M and decreased $5.7M from June 30, 2025 reflecting YTD Net Income.
- Net Negative Balance is a payable of $60.0M. NNB consists of the liquidity facility (loan) of $88.1M offset by the restricted cash of $28.1M; and is expected to be below the June 30, 2026 credit ceiling of $95.0M at the end of the fiscal year.

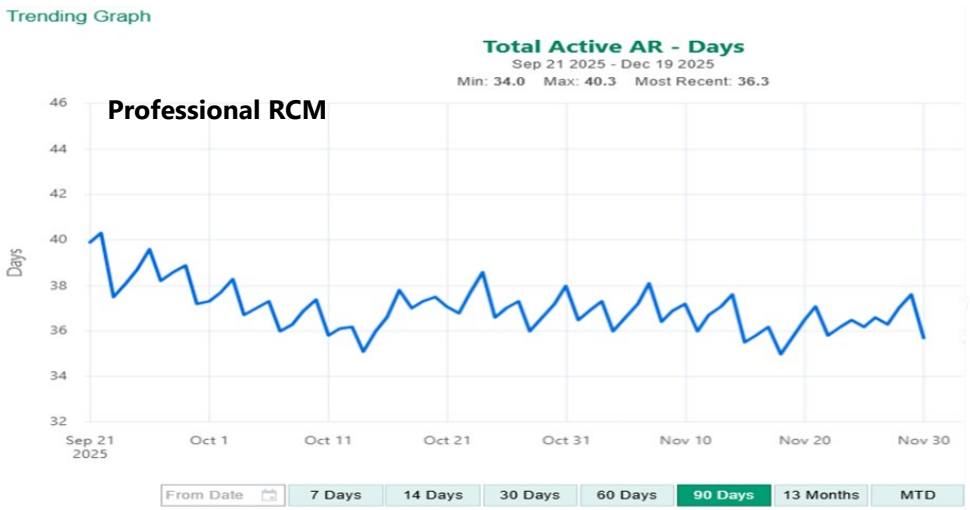
	Nov-25	Oct-25	FY 2025
Days in cash	5.1	1.7	2.9
Gross days in patient receivable	62.7	59.7	62.4
Net days in patient receivable	45.1	45.0	43.8
Due from/(to) third-party payors	$ 328,889	$ 228,706	$ 158,555
Due from/(to) County	$ (57,420)	$ 36,559	$ 49,680
Days in accounts payable	27.0	30.1	38.3
% of AP over 60 days	0.8%	0.7%	4.0%
Net position - fund balance/(deficit)	$ (56,096)	$ (54,019)	$ (61,798)
Net negative balance - receivable/(payable)	$ (60,007)	$ (48,605)	$ 26,949

November 2025 Financial Report
AR Trending



Hospital Revenue Cycle Key Indicators

- HB AR Days increased by 2.5 days compared to prior month.
  - HB AR Days target is 57.0
  - November AR Days 66.4, October AR Days 63.9
- November collections were $59.3M. Lower than the average of the prior twelve months at $62.4M.
- An AR Reduction Task Force will be launched in January 2026 to bring in more cash quickly.
- Inpatient CDI is under review to determine improvements for specific DRGs that may not capture all complication or comorbidity.



Professional Revenue Cycle Key Indicators

- PB AR Days decreased by 0.5 days compared to prior month.
  - PB AR Days target is 33.0
  - November AR Days 36.0, October AR Days 36.5
- November collections were $12.1M. Higher than average of the prior twelve months at $11.4M.
- Enterprise CI launched to address provider clinical documentation along with charge automation and usage of Epic tools.

November 2025 Financial Report
Patient Collections

- FY26 patient collections approximately 12.1 % higher than the same period in FY25.
- Received payments for JGP in November is $11.6M for the FY26 contract executed for $81.4M.
  - JGP FY25 contract with the County was amended from $49.2M to $74.2M. The maximum contract has been paid.
  - Since the conversion to SmartCare/CALAIM in July 2023, the County began withholding approximately 20% of AHS invoices for provided services.

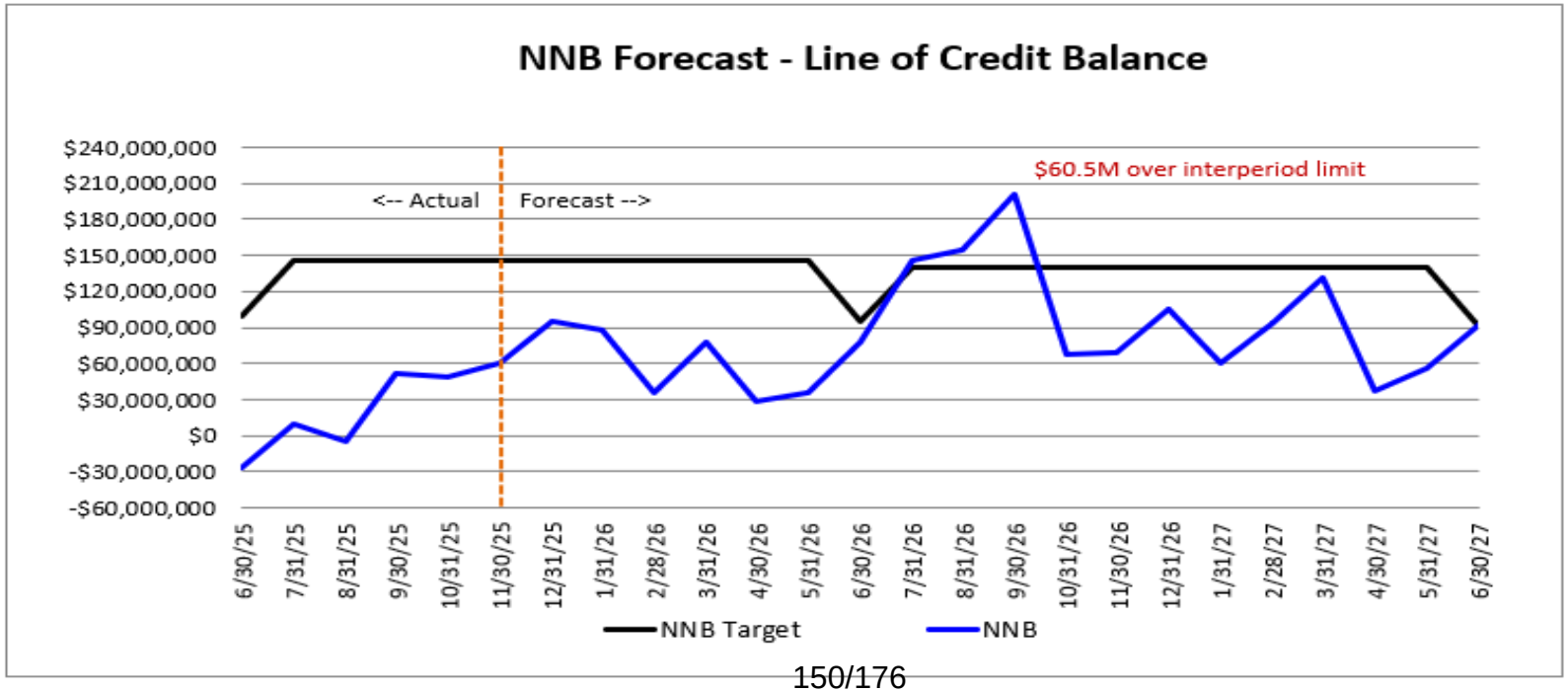
PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2026	FY 2025	FY 2024	FY 2023	FY 2022
Jul	11,928	67,883	79,811	72,694	79,592	74,260	59,732
Aug	28,651	82,136	110,787	79,768	69,313	58,590	57,374
Sep	-	66,819	66,819	69,741	63,322	76,063	61,968
Oct	868	82,323	83,191	76,783	63,122	59,796	49,923
Nov	11,569	71,370	82,939	78,747	57,781	56,939	52,057
Dec	-	-	-	94,631	63,867	67,018	68,121
Jan	-	-	-	89,014	68,757	71,452	62,292
Feb	-	-	-	68,511	75,852	57,886	52,269
Mar	-	-	-	91,851	54,720	65,320	62,888
Apr	-	-	-	74,892	61,895	55,307	56,235
May	-	-	-	74,339	102,015	63,795	69,591
Jun	-	-	-	72,211	71,208	70,027	53,187
Total	**53,016**	**370,531**	**423,547**	**943,182**	**831,444**	**776,453**	**705,637**
% change between fiscal years			12.1%	13.4%	7.1%	10.0%	

November 2025 Financial Report
Line of Credit (NNB) Forecast through 6/30/26

- FY2026 forecast reflects AHS operations consistent with the approved budget and is expected to be compliant at 6/30/26 below $95M and 6/30/27 below $90M. AHS is expected to exceed the inter-period limit by $60.5M early next FY. Forecast shows increased debt for the entire fiscal year if immediate action is not taken. H1 and other state impacts are not included in the forecast model which projects based on current cashflow. LRSP is underway.
  - The NNB improved by $11.6M over last report.
  - Patient receipts continue to be strong offset by a delay in receiving CY2025 Hospital Fee receipts.

- Items that are included in forecast.
  - St. Rose funding for IGT contribution of $10.5M for FY2025 and FY2026 pending Trustees' approval.
  - St. Rose expected to access the line of credit starting in January 2026 and repaid in full by June 2026.



November 2025 Financial Report
Material Items Impacting NNB Forecast

- GPP CY2025 Q3B (in December) for $18.5M was moved from February 2026 to December 2025 based on DHCS notification.
- 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 was delayed and 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	-
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	-
	$ 30,641	$ 54,981	$ 54,884	$ 35,991	$ 111,915	$ 36,222	$ 195,202	$ 146,158	$ 146,210

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
	$ (52,931)	

September 2025 FYE Consolidated Results Financial Summary & YTD Highlights

- SRH's YTD net income is $1.4M, $21.7M favorable to budget
  - The budget did not include the full donation of the local share for the IGT; receipt of IGT funding in May 2025 ($30.3M), exceeding budget by $23.2M.
  - Net patient service revenue variance, favorable 3.4%, driven by timing of supplemental revenue (DSH payments).
  - Expenses unfavorable overall ($1.2M), driven by high health benefits and three expected settlement claims partially offset by Sub Acute delays opening/lower census.

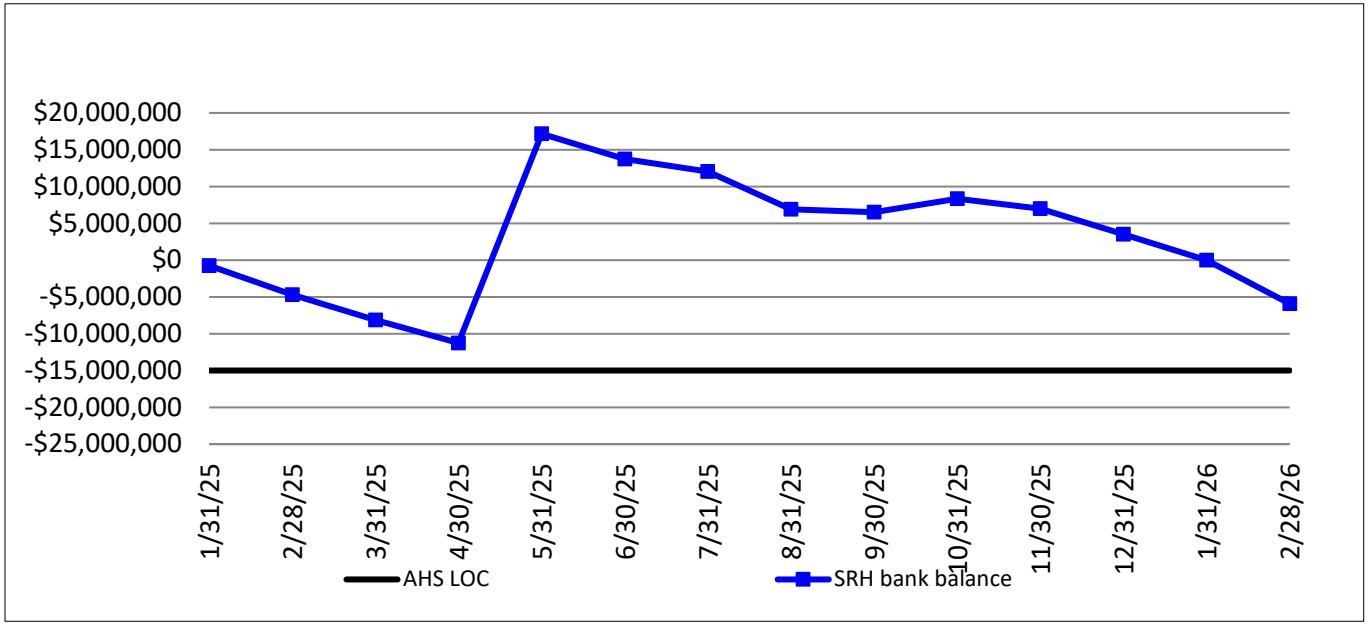
- MOB's YTD net income is $0.6M, exceeding budget by $0.2M
  - Rent revenue higher than budget from additional tenant (LaFamilia).
  - Still deferring repairs.

- Foundation's YTD net loss is $0.6M, unfavorable by $0.7M driven by the $1M donation to St. Rose Hospital, partially offset by The Dee Jordan Trust ($0.3M) and another donation/grant of $0.05M from DAFgiving360 in honor of Victor Verbinski.

	September 30,2025				Year-To-Date			
	Actual	**Budget**	**Var ($)**	**Var (%)**	**Actual**	**Budget**	**Var ($)**	**Var (%)**
Total Net Patient Service Revenue	$9,944	$8,742	$1,202	13.7%	$104,878	$101,450	$3,428	3.4%
Total Other Revenue	$346	$922	($576)	-62.5%	$40,967	$18,255	22,712	124.4%
TOTAL OPERATING REVENUE	**$10,291**	**$9,665**	**$626**	**6.5%**	**$145,846**	**$119,706**	**$26,140**	**21.8%**
Less: Operating Expenses	$13,567	$11,522	($2,045)	-17.7%	$139,470	$138,286	($1,184)	-0.9%
EBITDA	**($3,276)**	**($1,858)**	**($1,418)**	**76.4%**	**$6,375**	**($18,581)**	**$24,956**	**-134.3%**
Total Non-Operating Exp/(Income)	$399	$386	$13	3.3%	$4,983	$4,707	$276	5.9%
Restr Donation - (AA Geropscych)	$0	$292	($292)	-100.0%	$0	$3,500	($3,500)	-100.0%
NET INCOME/(LOSS)	**($3,675)**	**($1,952)**	**($1,723)**	**88.3%**	**$1,392**	**($19,788)**	**$21,180**	**-107.0%**

September 2025 Cash Flow Projection

- SRH started drawing down from AHS LOC in January 2025 and has borrowed $11M through May 6, 2025. Interest was accrued on the County's cost of fund rate. Total amount drawn, along with the interest incurred to date ($109K), was paid off on June 12, 2025.
- SRF donated $1M to SRH on April 16, 2025.
- IGT funding received on May 28, 2025 - $30.3M
  - Paid in full AHS LOC ($11M)
  - Continue catching up on paying vendors especially health benefit-related invoices
- The cash situation has improved driven by donation by Stanford in November ($1M). SRH expects to draw from the LOC in January 2026. We are still awaiting information regarding the new QAF program, which typically provides supplemental funding during the first quarter of the new fiscal year.



MEMORANDUM

ALAMEDA HEALTH SYSTEM

1411 East 31st Street
Oakland, CA 94602

TO: AHS Finance Committee
FROM: Kim Miranda, CFO
DATE: December 31 , 2025
SUBJECT: November 2025 Financial Report

Financial Summary

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Operating revenue	$ 128,113	$ 128,121	$ (8)	(0.0)%	$ 678,898	$ 674,301	$ 4,597	0.7%	$ 632,290	7.4%
Operating expense	129,766	127,683	(2,083)	(1.6)%	671,495	664,405	(7,090)	(1.1)%	635,830	(5.6)%
Operating income (loss)	**(1,653)**	**438**	**(2,091)**	**(477.4)%**	**7,403**	**9,896**	**(2,493)**	**(25.2)%**	**(3,540)**	**309.1%**
Other non-operating activity	(426)	(392)	(34)	(8.7)%	(1,869)	(1,848)	(21)	(1.1)%	(1,498)	(24.8)%
Net Income (loss)	**$ (2,079)**	**$ 46**	**$ (2,125)**	**(4619.6)%**	**$ 5,534**	**$ 8,048**	**$ (2,514)**	**(31.2)%**	**$ (5,038)**	**209.9%**
EBIDA adjustments	2,694	2,868	(174)		13,599	14,518	(919)		18,860	
EBIDA	**$ 615**	**$ 2,914**	**$ (2,299)**		**$ 19,133**	**$ 22,566**	**$ (3,433)**		**$ 13,822**	
Operating Margin	(1.3)%	0.3%	(1.6)%		1.1%	1.5%	(0.4)%		(0.6)%	
EBIDA Margin	0.5%	2.3%	(1.8)%		2.8%	3.3%	(0.5)%		2.2%	

Net Income for the month was a loss of $2.1 million compared to a breakeven budget and unfavorable to budget $2.1 million and 4619.6%. Operating Revenue was $128.1 million and approximates budget. Operating Expense was $129.8 million and unfavorable to budget by $2.1 million and 1.6%. Earnings before interest, depreciation, and amortization (EBIDA) were $0.6 million and the EBIDA Margin was 0.5% compared to a budget EBIDA of $2.9 million and a budget EBIDA Margin of 2.3%. For the month, EBIDA was unfavorable to budget by $2.3 million.

Net Income year-to-date (YTD) was $5.5 million compared to a budget of $8.0 million and unfavorable to budget by $2.5 million and 31.2%. Operating Revenue was $678.9 million and favorable to budget by $4.6 million and 0.7%. Operating Expense was $671.5 million and unfavorable to budget by $7.1 million and 1.1%. EBIDA was $19.1 million and the EBIDA Margin was 2.8% compared to the budget EBIDA of $22.6 million and a budget EBIDA Margin of 3.3%. For the year, EBIDA is unfavorable to budget $3.4 million.

Operating Revenue

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Inpatient service revenue	$ 206,890	$ 204,756	$ 2,134	1.0%	$ 1,087,162	$ 1,092,544	$ (5,383)	(0.5)%	$ 1,049,764	3.6%
Outpatient service revenue	147,726	130,174	17,552	13.5%	783,234	730,652	52,583	7.2%	709,851	10.3%
Professional service revenue	37,830	40,988	(3,158)	(7.7)%	204,878	215,341	(10,462)	(4.9)%	206,537	(0.8)%
Gross patient service revenue	392,446	375,918	16,528	4.4%	2,075,275	2,038,537	36,737	1.8%	1,966,151	5.6%
Deductions from revenue	(316,442)	(302,434)	(14,008)	(4.6)%	(1,674,723)	(1,640,044)	(34,679)	(2.1)%	(1,584,162)	5.7%
Net patient service revenue	**76,004**	**73,484**	**2,520**	**3.4%**	**400,551**	**398,493**	**2,058**	**0.5%**	**381,989**	**(4.9)%**
Collection % - NPSR	19.4%	19.5%	(0.1)%		19.3%	19.5%	(0.2)%		19.4%	
Capitation and HPAC	4,470	4,540	(70)	(1.5)%	22,387	22,729	(342)	(1.5)%	23,016	(2.7)%
Other government programs	42,493	45,415	(2,922)	(6.4)%	225,003	227,075	(2,072)	(0.9)%	201,576	11.6%
Other operating revenue	5,146	4,682	464	9.9%	30,957	26,004	4,954	19.1%	25,709	20.4%
Total operating revenue	**$ 128,113**	**$ 128,122**	**$ (9)**	**(0.0)%**	**$ 678,898**	**$ 674,300**	**$ 4,598**	**0.7%**	**$ 632,290**	**7.4%**

Gross Patient Revenue

Gross Patient Service Revenue (patient charges) was $392.4 million for the month and favorable to budget by $16.5 million and 4.4%. Inpatient and Outpatient charges were above budget by 1.0% and 13.5%, respectively. Professional fees were below budget by 7.7%. For the year, Gross Patient Service Revenue was $2.1 billion and favorable to budget by $36.7 million and 1.8%. Outpatient charges were above budget by 7.2%. Inpatient and Professional Fee charges were below budget by 0.5% and 4.9%, respectively. Inpatient charges were slightly higher than budget for the month driven by volume of trauma cases, inpatient surgeries, and the resulting higher case mix index (CMI) offset by lower patient days and discharges. The CMI was above budget for the month and is below budget YTD. CMI is an indicator of the overall complexity of inpatient illness and services being provided. General Acute Length of Stay (LOS) increased 0.2 to 4.9 for the month, trending consistently with the CMI. Noteworthy, LOS is trending better than the budget and prior year which indicates patients are staying fewer days than the expected LOS. Favorable outpatient charge variance for the month and YTD were driven by Emergency Room visits which exceeded budget by 7.4% and 7.0%, respectively. Outpatient surgeries also exceeded budget for the month and YTD by 23.3% and 3.8%, respectively. Professional Fees were unfavorable for the month and YTD due to lower clinic visits, which missed budget by 2,054 and 6.2% and 4,875 and 2.8%, respectively. Volumes were lower in November due to holidays. The largest variances were Eastmont dental (606 visits) and Highland OB Clinc (526 visits). Physician wRVU were below budget by 13.9% for the month due to fewer visits and above budget by 5.5% for the year driven by hospital services. Overall, adjusted patient days were higher than budget for the month and year. Adjusted discharges exceed budget by 3.6% for the month and 4.0% for the year; positively impacted by lower LOS.

Net Patient Revenue

Net Patient Service Revenue (NPSR) was $76.0 million and favorable to budget by $2.5 million and 3.4%. YTD, NPSR was $400.6 million favorable compared to budget $2.1 million and 0.5%. The collection ratio was 19.4% for the month and unfavorable to budget by 0.1%, which was slightly higher than the 19.3% YTD. Improving the collection percentage this month was a favorable settlement for the FY2025 AHS Medicare cost report of $1.9 million. Trauma cases tend to drive a higher commercial mix; however, the commercial payer mix was 6.0% and at budget for the month. YTD, commercial payor mix was 6.6% and unfavorable to budget by 0.6%. Trauma cases were above budget for the month and below YTD by 26.4% and 0.4%, respectively. Rate increases for Government and Alliance contracts have not occurred and were spread evenly in the budget. Collections on fully reserved accounts (over 270 days) were consistent with the trend.

Other Government Program Revenue

Other Government Program Revenue for the month was $42.5 million and unfavorable to budget by $2.9 million and 6.4% based on the transactions below.

- Measure A FY2026 Q1 decreased based on receipts by $2.5 million.
- Prop 56 was lower than budget by $0.4 million.

For the year, the Other Government Program Revenue is $225.0 million and unfavorable to budget by $2.1 million and 0.9% based on the transactions below.

- Measure A FY2026 Q1 decreased based on receipts by $2.5 million.
- Pay-for-Performance (P4P) revenue increased from successfully meeting CY2024 Alameda Alliance quality metrics for additional payment of $1.2 million.
- FEMA revenue received for successful filing of Covid-related expenditure was $0.2 million. Total FEMA receipts, starting in FY2024, are $7.1 million.
- Prop 56 was lower than budget by $1.0 million. The budget was based on FY25 receipts that included an overpayment from Alameda Alliance. It is anticipated that this unfavorable variance will continue for the remainder of the fiscal year.

Other Operating Revenue

Other Operating Revenue for the month was $5.1 million and favorable to budget by $0.5 million and 9.9% based on the transactions below.

- Retail pharmacy revenue was favorable by $0.1 million.
- St. Rose Hospital management fee favorable by $0.3 million, which was not included in the budget.
- The remaining variance, netting to a positive $0.1 million, is spread across many programs.

For the year, Other Operating Revenue was $31.0 million and favorable by $5.0 million and 19.1% based on the transactions below.

- Payor settlement received on older patient accounts of $3.1 million.
- Retail pharmacy revenue favorable by $1.1 million.
- St. Rose Hospital management fee $1.7 million, which was not included in the budget.
- Offset by unfavorable grant revenue from timing differences of $1.2 million.

Operating Expense

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Labor costs	$ 101,238	$ 97,634	$ (3,604)	(3.7)%	$ 520,415	$ 507,877	$ (12,538)	(2.5)%	$ 485,721	(7.1)%
Purchased services	7,651	9,542	1,891	19.8%	42,415	47,790	5,375	11.2%	41,935	(1.1)%
Materials and supplies	12,652	12,082	(570)	(4.7)%	66,362	65,850	(512)	(0.8)%	63,175	(5.0)%
Facilities	3,405	3,213	(192)	(6.0)%	17,913	17,139	(774)	(4.5)%	15,601	(14.8)%
Depreciation and amortization	2,336	2,463	127	5.2%	11,755	12,605	850	6.7%	17,297	32.0%
General and administrative	2,484	2,749	265	9.6%	12,635	13,144	509	3.9%	12,101	(4.4)%
Total operating expense	**$ 129,766**	**$ 127,683**	**$ (2,083)**	**(1.6)%**	**$ 671,495**	**$ 664,405**	**$ (7,090)**	**(1.1)%**	**$ 635,830**	**(5.6)%**

Operating Expense was $129.8 million for the month and unfavorable to budget by $2.1 million and 1.6%. Non-labor expense variances net to a favorable variance of $1.5 million for the month as follows (Labor costs are discussed in a subsequent section):

- Purchased services for the month were favorable to budget by $1.9 million and 19.8% driven by favorable variances in software licenses ($0.5 million), clinical services ($0.5 million), emergency food/shelter ($0.3 million), security ($0.2 million) and other favorable variances across various categories ($0.4 million).
- Materials and supplies were unfavorable to budget of $0.6 million and 4.7% driven by unfavorable variances in pharmaceutical ($0.7 million) offset by a favorable variance in non-medical supplies ($0.1 million). Medical and surgical supplies were on budget for the month.
- Facilities for the month were unfavorable to budget by $0.2 million and 6.0% driven by unfavorable variance in building repairs ($0.5 million) offset by favorable variance in utilities ($0.3 million). Most of the facility variance was for Highland Hospital.
- Depreciation and amortization were favorable to budget by $0.1 million and 5.2% driven by a favorable variance for equipment depreciation ($0.4 million) offset by higher lease/software amortization ($0.3 million).
- General and administrative costs were favorable to budget by $0.3 million and 9.6% driven by favorable timing variance for recruitment ($0.2 million) and remaining variance ($0.1 million) spread across various categories.

For the year, Operating Expense was $671.5 million and unfavorable to budget by $7.1 million and 1.1%. Non-labor expense variances net to a favorable variance of $5.4 million as follows (Labor costs are discussed in a subsequent section).

- Purchased services were favorable to budget by $5.4 million and 11.2% driven by favorable variances in outside medical services ($2.9 million), software licensing ($1.4 million), security ($0.8 million), and emergency food/shelter ($0.2 million). The favorable variance in outside medical services is expected to continue for the remainder of the fiscal year. The budget was based on higher ambulance services which were the result of duplicate invoices between sister companies. A refund of $1.2 million was received in June 2025.
- Materials and supplies were unfavorable to budget by $0.5 million and 0.8% driven by unfavorable variance in pharmaceuticals ($1.5 million) offset by favorable variances in other medical supplies ($0.8 million) and computer equipment ($0.2 million).
- Facilities were unfavorable to budget by $0.8 million and 4.5% driven by unfavorable variance in facility repairs ($2.2 million) offset by a favorable variance for utilities ($1.1 million) and rental equipment ($0.3 million). The facility repairs occurred at Highland Hospital ($1.1 million), Alameda Hospital ($0.8 million), and San Leandro Hospital ($0.3 million).
- Depreciation and amortization were favorable to budget by $0.9 million and 6.7% driven by favorable variance from timing of equipment depreciation ($2.2 million) and offset by higher than anticipated amortization of leases and software agreements ($1.3 million).
- General and administrative costs were favorable to budget $0.5 million and 3.9% driven by favorable variance for timing of recruitment ($0.4 million) and the remaining variance ($0.1 million) spread across various categories.

Labor Costs

	November 2025				Year-To-Date				FY 2025	
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var	YTD	% Var
Salaries and wages (staff)	$ 60,007	$ 56,025	$ (3,982)	(7.1)%	$ 301,791	$ 289,306	$ (12,485)	(4.3)%	$ 275,060	(9.7)%
Salaries and wages (providers)	12,061	12,847	786	6.1%	63,082	65,346	2,264	3.5%	61,520	(2.5)%
Registry	3,026	4,012	986	24.6%	17,291	21,066	3,775	17.9%	21,315	18.9%
Physician contract services	3,980	3,574	(406)	(11.4)%	18,806	17,924	(882)	(4.9)%	18,295	0.0%
Employee benefits (taxes, insurance)	15,521	14,528	(993)	(6.8)%	81,086	76,251	(4,835)	(6.3)%	73,396	(10.5)%
Retirement	6,643	6,648	5	0.1%	38,359	37,984	(375)	(1.0)%	36,136	(6.2)%
Total labor costs	**$ 101,238**	**$ 97,634**	**$ (3,604)**	**(3.7)%**	**$ 520,415**	**$ 507,877**	**$ (12,538)**	**(2.5)%**	**$ 485,721**	**(7.1)%**
Compensation ratio	79.0%	76.2%	-2.8%		76.7%	75.3%	-1.4%		76.8%	
Paid FTEs - staff	4,665	4,479	(186)	(4.2)%	4,650	4,545	(105)	(2.3)%		
Paid FTEs - providers	376	393	17	4.3%	347	365	18	4.9%		
Paid FTEs - registry	203	209	6	2.6%	206	215	9	4.1%		
Total FTEs	5,244	5,081	(163)	(3.2)%	5,203	5,125	(78)	(1.5)%	5,093	

Labor costs for the month were $101.2 million and unfavorable to budget by $3.6 million and 3.7%. YTD, labor costs were $520.4 million and unfavorable to budget by $12.5 million and 2.5%. Starting in September 2025, physician contract services were moved to the labor cost section to show a complete picture of staffing.

Total staff wages and registry costs for the month were $63.0 million and unfavorable to budget by $3.0 million and 5.0% driven by higher volume (180 FTEs/$2.3 million) and higher rates ($0.7 million). YTD, this category was $319.1 million and unfavorable by $8.7 million and 2.8% driven by higher volume (96 FTEs/$6.2 million) and higher rates ($2.4 million). AHS is using UKG timekeeping to track registry utilization. At this point, timing differences occur between when registry invoices are paid, and the hours included to calculate FTE, causing variances for the month. This category exceeded budget by 186 as follows:

- Sub-acute registry catch up – 58 FTEs
- GRIT initiative not realized – 45 FTEs
- Volume driven based on current labor standards – 41 FTEs
- Departments exceeding labor standards - 35 FTEs
- New FTE, not included in the budget - 7 FTEs

Total provider wages and physician contract services for the month were $16.0 million and favorable to budget by $0.4 million and 2.3%. YTD, this category was $81.9 million and favorable to budget by $1.4 million and 1.7%. The positive variance is driven by unrealized recruitment that was included in the budget. Contract physician was driven by locum usage. As a reminder, contract providers do not provide hours to calculate an FTE.

Employee benefits were unfavorable for the month by $1.0 million and 6.8% driven by self-funded health insurance ($1.5 million) offset by positive variances in Kaiser insurance plan ($0.2 million), other benefits ($0.2 million), and worker compensation ($0.1 million). YTD, employee benefits were unfavorable to budget by $4.8 million and 6.3% driven by self-funded health ($7.6 million) offset by positive variances for Kaiser insurance plan ($1.4 million), FICA ($1.1 million), and other benefits ($0.3 million).

Retirement approximate budget for the month. YTD, retirement expense was unfavorable $0.4 million and 1.2% from ACERA ($0.9 million), union plans ($0.2 million) offset by positive variance for AHMG plan ($0.7 million).

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

	Nov-25	Oct-25	FY 2025
Days in cash	5.1	1.7	2.9
Gross days in patient receivable	62.7	59.7	62.4
Net days in patient receivable	45.1	45.0	43.8
Due from/(to) third-party payors	$ 328,889	$ 228,706	$ 158,555
Due from/(to) County	$ (57,420)	$ 36,559	$ 49,680
Days in accounts payable	27.0	30.1	38.3
% of AP over 60 days	0.8%	0.7%	4.0%
Net position - fund balance/(deficit)	$ (56,096)	$ (54,019)	$ (61,798)
Net negative balance - receivable/(payable)	$ (60,007)	$ (48,605)	$ 26,949

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

Accounts Receivable (AR)
The Gross Days in AR were 62.7 days and 3.0 days higher than last month due to lower gross revenue per calendar day of 2.0%. Net Days in AR were 45.1 and consistent with the previous month. The calculation reflects 90 days versus actual days for the quarter to standardize the calculation. Utilizing a 90-day period does lead to more fluctuations. Key updates on work in progress within Revenue Cycle are noted below:

- Settlements through arbitration using Sac Law continue to support GRIT. In August, a settlement of $3.1 million was received and recorded as other operating income due to the age of the patient accounts.
- Enterprise CI launched to address providers' clinical documentation along with charge automation and usage of Epic tools. Inpatient CDI is under review to determine improvements for specific DRGs that may not be coded to include complication or comorbidity.
- Inpatient charge reconciliation is in process for women's services, bedside procedures, implants, and Code Blue.
- An AR Reduction Task Force will be launched in January 2026 to bring in more cash quickly.
- EPIC posted collections were lower in November due to holiday.

Patient collections are reflected in the table below. Behavioral Health represents the County receipts under contract for JGP services which total $53.0 million. AHS and the County executed the 2nd amendment in May 2025 increasing the FY2024 contract total from $61.2 million to $73.6 million. All remaining funds were paid in August 2025. Payments under the FY2025 contract which was also amended to increase the maximum from $49.2 million to $74.2 million. All remaining funds were paid in October 2025. As a reminder the FY2023 contract was $72.1 million, and AHS accrued at this higher level of reimbursement, which is now supported by the recent amendments. The FY2026 interim contract was signed for $81.4 million on October 13, 2025. Payments on the FY2026 contract total $11.6 million through November 2025. AHS has not received information on how the maximum contract amount was determined and the County is unable to provide reports

from their new billing system, SmartCare. AHS is unable to trend, research or follow up on payment denials or other discrepancies leading to underpayment. The County continues to withhold approximately 20 percent of the amount due on the invoices submitted for payment.

PATIENT COLLECTIONS
(in thousands)

	Behavioral Health	Epic	Total FY 2026	FY 2025	FY 2024	FY 2023	FY 2022
Jul	11,928	67,883	79,811	72,694	79,592	74,260	59,732
Aug	28,651	82,136	110,787	79,768	69,313	58,590	57,374
Sep	-	66,819	66,819	69,741	63,322	76,063	61,968
Oct	868	82,323	83,191	76,783	63,122	59,796	49,923
Nov	11,569	71,370	82,939	78,747	57,781	56,939	52,057
Dec	-	-	-	94,631	63,867	67,018	68,121
Jan	-	-	-	89,014	68,757	71,452	62,292
Feb	-	-	-	68,511	75,852	57,886	52,269
Mar	-	-	-	91,851	54,720	65,320	62,888
Apr	-	-	-	74,892	61,895	55,307	56,235
May	-	-	-	74,339	102,015	63,795	69,591
Jun	-	-	-	72,211	71,208	70,027	53,187
Total	**53,016**	**370,531**	**423,547**	**943,182**	**831,444**	**776,453**	**705,637**
% change between fiscal years			12.1%	13.4%	7.1%	10.0%	

Accounts Payable
Days in Accounts Payable are 27.0 at the end of the month and were 3.1 days lower than the prior month from timing of recurring check runs versus the last day of the calendar month and resolution of ongoing implementation issues with OnBase. The Percent over 60 Days is 0.8% and is below the 5% target. Purchasing and Accounts Payable teams are making positive progress resolving older invoices held in work queues.

Supplemental Program Revenue Receivable/Payable
The information presented in the table below provides subsidiary information for Supplemental Program receivables and payables on the Balance Sheet. The net receivable balance for Supplemental Programs is $328.9 million, which increased $100.2 million over last month. Key items are noted below.

- Payment received for Old Waiver FY2012 IGT ($2.0 million).
- IGT funded for GPP CY2025 Q3B ($26.9 million).
- IGT funded for Voluntary Rate Range CY2024 ($41.9 million).
- Recognized revenue for FY2025 Medicare cost reports based on filed reports ($2.8 million).
- Minor cost report adjustments and monthly accruals ($30.6 million).

Estimates are necessary to record supplemental income because the ultimate amount that may be collected under the program is uncertain, dependent on costs for services that were ultimately provided, quality metrics achieved, Medi-Cal enrollment, and our ability to identify and claim related costs.

AHS has significant liability estimates dating back more than 5 years as reflected at the bottom of the schedule. They include the old Medi-Cal Waiver, AB915, Physician SPA and Highland FQHC. Notification of FY2011Waiver settlement was received in June 2025 from DHCS and adjustments were booked in June to eliminate the reserves ($4.8 million) and recognize receivable ($27.6 million). The result was a favorable pick up of $32.4 million. The preliminary settlement schedule varied from trend which warranted the reserve. However, when the pool finally settled among all the public hospital systems, the preliminary data proved to be valid. Also, AB915 was added to the section for FY2014 through FY2020 as the program audits are delayed by the State. The total estimated amount due is $54.4 million.

Net Reimbursement Supplemental Programs

as of 11/30/2025

Programs	FY97-20	FY21-25	FY26	Net Balance	Comments
Medicare Cost Report	(1,617)	(1,780)	(277)	(3,674)	Older years pending disputed SSI ratio and outlier holds for both OPPS/IPPS services from CMS.
Medi-Cal P14 Waiver	4,225	(1,780)	(3,692)	(1,246)	P14 audits are in various stages of completion. Currently DHCS has finalized up to FY19.
Current Waiver (GPP & CalAIM)	-	13,212	53,370	66,581	Global Payment Program (GPP) subsidizing remaining uninsured. GPP extended to 2026 as CalAIM.
AB85 Realignment	0	(45,311)	-	(45,311)	Realignment reserves for HPAC amendment passing through the County for physical health for Medi-Cal and Indigent populations.
Physician SPA	(6,000)	1,160	4,725	(115)	Reconciliation based on P14 utilization file with the State. FY14-FY16 Finalized. Catch-up ACA interim payments began during FY22.
FQHC	(7,922)	(15,405)	(2,084)	(25,411)	Negotiating settlement for a new FQ rate. The difference between the new FQ rate and FFS rate will determine the settlement for the impacted years. AHS started FQ billing in March 2022.
Medi-Cal Managed Care EPP	0	88,215	28,221	116,435	EPP (Enhanced Payment Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care QIP	0	72,826	33,209	106,035	QIP (Quality Incentive Program). New supplemental program for services provided to Medi-Cal Managed Care.
Medi-Cal Managed Care Rate Range	(0)	111,717	21,583	133,300	Subsidize rates for Medi-Cal Managed Care members in Alameda County.
Medi-Cal Managed Care GME	0	5,935	6,179	12,114	CMS approved in March 2020. GME is paying concurrently with fiscal year.
Medi-Cal Managed Care DP-NF Pass-Through	-	10,749	-	10,749	New payment program assisting AHS with LTC carve-in from FFS to managed care, time-limited CY2023 through CY2025. CY2023 disclosed and received Jan 2025.
Medi-Cal SNF Cost Settlement	0	926	175	1,101	The State began their reconciliation.
AB915	-	2,353	3,670	6,023	AB915/Medi-Cal Hospital OP cost settlement. DHCS began reconciling older years during FY23.
All Other Supplemental Programs	0	3,643	3,100	6,743	Hospital Fee, NDPH & P4P programs
Subtotal	**$ (11,313)**	**$246,460**	**$148,178**	**$ 383,325**	
Old Waiver (FY11 & FY12)	27,565	0	0	27,565	FY11 & FY12 will be finalized by Feb 2026.
AB915 (FY14-FY20)	(17,000)	0	0	(17,000)	FY14-FY20 Reserve pending on audits.
Physician SPA (FY08-12)	(25,000)	0	0	(25,000)	FY13 final settled.
FQHC (FY12-18)	(40,000)	0	0	(40,000)	Negotiating settlement for Highland FQ clinics is pending for HGH K-6 clinic.
Subtotal	**$ (54,435)**	**$ -**	**$ -**	**$ (54,435)**	
Grand Total	**$ (65,749)**	**$246,460**	**$148,178**	**$ 328,889**	

Net County Receivable and Payable

Due To/From County of Alameda	Nov-25	Oct-25	FY 2025
Due from County of Alameda	$ 24,188	$ 49,617	$ 54,713
Capital designation receivable	7,000	7,000	7,000
Due from County of Alameda	**31,188**	**56,617**	**61,713**
Due to County of Alameda	(2,002)	(2,263)	(1,153)
County IGT funding	(80,009)	(11,199)	-
Capital cost payable	(6,597)	(6,597)	(10,880)
Due to County of Alameda	**(88,608)**	**(20,059)**	**(12,033)**
Net due from/(to) County	**$ (57,420)**	**$ 36,558**	**$ 49,680**

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

- The County receivable includes the HPAC contract, John George Pavilion (JGP) services agreement and grants.
- The Capital Designation receivable reflects reimbursement expected from the County ($7 million per year) to help fund the Sapphire project. An annual invoice is sent to the County after AHS transfers the funds, and certain contractual requirements are met at the end of the fiscal year. The FY2025 invoice was submitted to the County in June 2025.
- Inter-government transfers (IGT) are ongoing to draw down federal supplemental funding and once they have received the funds are returned to the County. Two large IGTs were funded in November 2025 for GPP FY2025 Q3B ($26.9 million) and Voluntary Rate Range CY2024 ($41.9 million)
- The Capital Cost Transfer reflects a payable based on the balance remaining on open cost report settlements associated with County owned buildings ($6.6 million). AHS transfers cost reimbursement estimates to the County each year and AHS has the contractual ability to benefit from these funds to help maintain and invest in County owned facilities. AHS paid 90% for the FY2023 filing ($4.3 million) in September 2025. In May 2024, the County spent $1.2 million to pay for an emergency transformer on the Fairmont campus. AHS is working with the County to develop a workflow to allow AHS to capture costs for future cost reimbursement. AHS is not aware of any additional expenditures made by the County.

Net Position

The Net Position or Fund Balance of AHS as of November 30, 2025, is negative $56.1 million, which improved $5.5 million over last fiscal year on June 30, 2025 reflecting the YTD net income.

Net Negative Balance

The Net Negative Balance (NNB) or Line of Credit with the County is $60.0 million payable on November 30, 2025, and remains compliant with the terms of the Permanent Agreement. The Working Capital Loan is

reported on the Balance Sheet as a long-term liability labeled "Liquidity Facility – County of Alameda." To calculate the NNB, the Liquidity Facility ($88.1 million payable) decreased by the County Restricted Cash Fund ($28.1 million) which is included in Cash.

Contingencies

John George Pavilion (JGP)

The County continues to struggle with the implementation of new software, SmartCare, for claims beginning in July, 2023 under Cal Aim. JGP technical and professional services have been input into SmartCare to be billed and paid for by the State although AHS has not received any information from the County on denials or payments they have received. There is a twelve-month timely filing requirement to submit claims and the County struggled to meet this billing window, primarily for professional fees. The County has indicated it will ensure claims are paid even if the timely filing deadline means they cannot be federally matched. The County is paying claims up to the annual maximum contract amount; however, they are withholding approximately 20% pending resolution with the State. AHS has no information on how the maximum contract amounts were determined or the status of claims or if more adequate funding will happen.

Highland Federally Qualified Healthcare Center (FQHC) Settlement

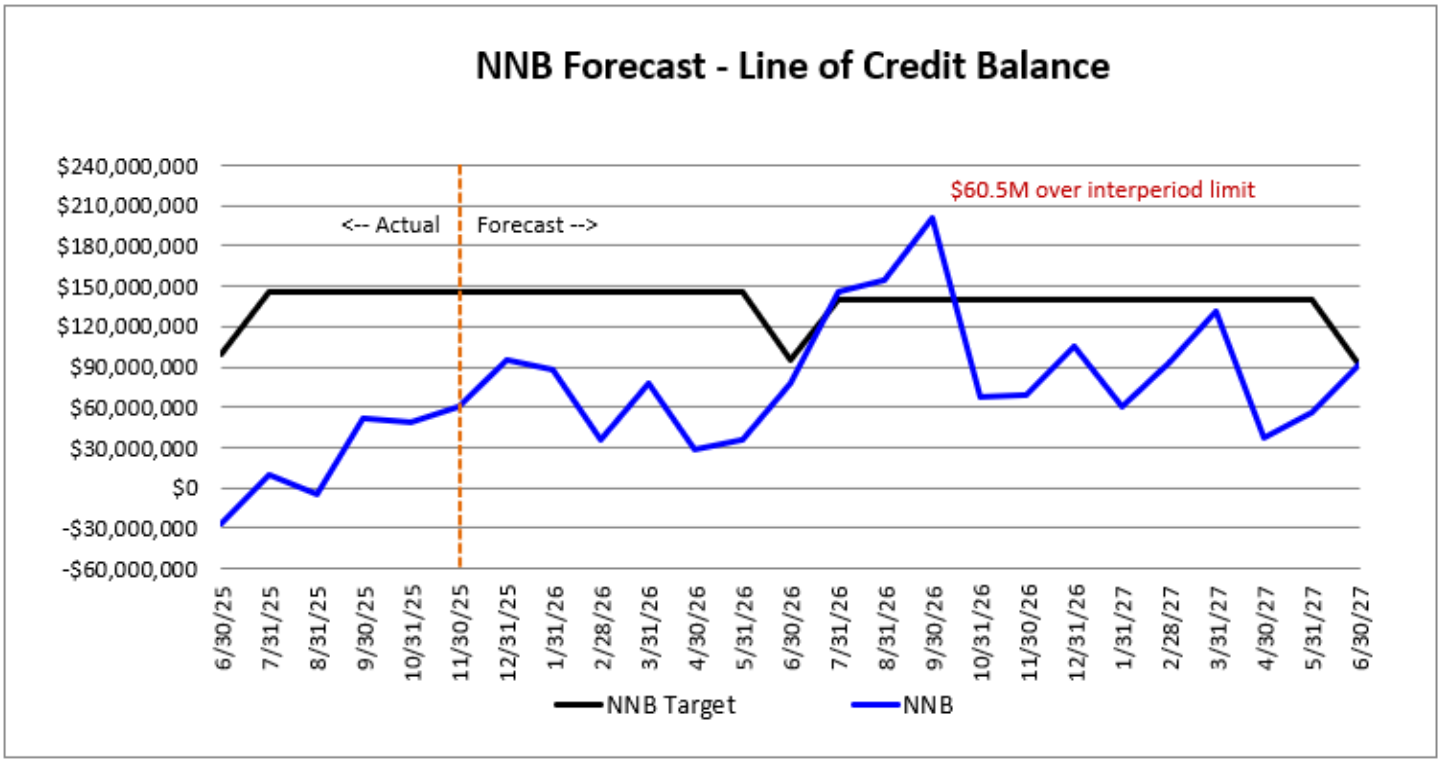
The State reached out to AHS inquiring about a new application that AHS submitted to establish the dental clinic located at Highland as a new FQHC. The State wanted to understand the new application request which started a conversation that ultimately resulted in the State verbally agreeing AHS could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

Line of Credit (Net Negative Balance) Forecast

The Line of Credit Balance or the Net Negative Balance (NNB) held with the County is forecasted in the line graph below through June 30, 2027 for planning purposes. AHS is currently forecasting that the NNB will be compliant with the terms of the agreement with the County which limits the NNB to $95.0 million on June 30, 2026 and to $90.0 million on June 30, 2027. The forecast indicates AHS will exceed the inter-period limit by up to $60.5 million during the first quarter of fiscal year 2027 if actions are not taken to improve performance. The forecast reflects AHS operations consistent with the approved budget; however, the forecast updates as actual activity is reflected in the cashflow model. The approved FY2026 budget required cashflow in excess of operations which is causing the organization to incur nearly $100 million in debt by year-end. As a reminder, the BOT approved the FY2026 budget with the understanding that administration would take immediate action to prevent AHS from maximizing the NNB as projected and to work with the County to modify the existing NNB agreement.

The forecast NNB for June 30, 2026 improved by $11.6 million compared to the September financial report. The key factors were as follows:

- Continued strong patient receipts offset by a delay in receiving CY2025 Hospital Fee receipts ($7.4 million) from FY2026 to FY2027.



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

- GPP CY2025 Q3B for $18.5 million was moved from February 2026 to December 2025.
- All other activity remained constant with the prior forecast.
- H1 and other State changes are expected to have a material and significant impact on AHS and Medi-Cal funding. Models are too fluid and are not included in the forecast, which primarily relies on current cashflow to project future cashflows.

The bottom portion of the table below reflects older year's liability estimates which are not included in the forecast (blue line) due to unknown timing for resolution. However, notice was received from DHCS that the FY11 Waiver settlement would be favorable resulting in a pickup of $29.2 million or $38.9M expected in November which is incorporated in the cashflow forecast. AB915 for FY2014 through FY2020 was added to the schedule because program review for these fiscal years was delayed by the State ($17.0 million). The Federal Qualified Health Center (FQHC) recoupment is a conservative settlement estimate based on the difference between reimbursement rates for services provided at Highland campus locations that were considered qualified and subsequently denied by the State. AHS is in current discussions with the State and once an agreement is reached with the State the FQHC liability will be adjusted Lastly, Physician SPA reconciliations are delayed because the State is having difficulty obtaining claim data.

Material Items Included in NNB Forecast
(in thousands)

	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	-
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	-
	$ 30,641	$ 54,981	$ 54,884	$ 35,991	$ 111,915	$ 36,222	$ 195,202	$ 146,158	$ 146,210

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
	$ (52,931)	

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Revenues and Expenses
For the Period Ended November 30, 2025
(In Thousands)

	November 2025				Year-To-Date				FY 2025		
	Actual	Budget	Variance	% Variance	Actual	Budget	Variance	% Variance	YTD	Variance	% Variance
Operating revenue											
Net patient service revenue	$ 76,004	$ 73,484	$ 2,520	3.4%	$ 400,551	$ 398,493	$ 2,058	0.5%	$ 381,989	$ 18,562	4.9%
Capitation revenue	4,470	4,540	(70)	(1.5)%	22,387	22,729	(342)	(1.5)%	23,016	(629)	(2.7)%
Other government programs	42,493	45,415	(2,922)	(6.4)%	225,003	227,075	(2,072)	(0.9)%	201,576	23,427	11.6%
Other operating revenue	5,146	4,682	464	9.9%	30,957	26,004	4,953	19.0%	25,709	5,248	20.4%
Total operating revenue	**128,113**	**128,121**	**(8)**	**(0.0)%**	**678,898**	**674,301**	**4,597**	**0.7%**	**632,290**	**46,608**	**7.4%**
Operating expense											
Labor costs	101,238	97,634	(3,604)	(3.7)%	520,415	507,877	(12,538)	(2.5)%	485,721	(34,694)	(7.1)%
Purchased services	7,651	9,542	1,891	19.8%	42,415	47,790	5,375	11.2%	41,935	(480)	(1.1)%
Materials and supplies	12,652	12,082	(570)	(4.7)%	66,362	65,850	(512)	(0.8)%	63,175	(3,187)	(5.0)%
Facilities	3,405	3,213	(192)	(6.0)%	17,913	17,139	(774)	(4.5)%	15,601	(2,312)	(14.8)%
Depreciation and amortization	2,336	2,463	127	5.2%	11,755	12,605	850	6.7%	17,297	5,542	32.0%
General and administrative	2,484	2,749	265	9.6%	12,635	13,144	509	3.9%	12,101	(534)	(4.4)%
Total operating expense	**129,766**	**127,683**	**(2,083)**	**(1.6)%**	**671,495**	**664,405**	**(7,090)**	**(1.1)%**	**635,830**	**(35,665)**	**(5.6)%**
Operating income (loss)	**(1,653)**	**438**	**(2,091)**	**(477.4)%**	**7,403**	**9,896**	**(2,493)**	**(25.2)%**	**(3,540)**	**10,943**	**309.1%**
Non-operating activity											
Interest income (expense)	(358)	(405)	47	11.6%	(1,844)	(1,913)	69	3.6%	(1,563)	(281)	(18.0)%
Other nonoperating revenue	(68)	13	(81)	(623.1)%	(25)	65	(90)	(138.5)%	65	(90)	(138.4)%
Total non-operating activity	**(426)**	**(392)**	**(34)**	**(8.7)%**	**(1,869)**	**(1,848)**	**(21)**	**(1.1)%**	**(1,498)**	**(371)**	**(24.8)%**
Net income (loss)	**$ (2,079)**	**$ 46**	**$ (2,125)**	**(4619.6)%**	**$ 5,534**	**$ 8,048**	**$ (2,514)**	**(31.2)%**	**$ (5,038)**	**$ 10,572**	**209.9%**
EBIDA adjustments											
Interest income (expense)	358	405	(47)		1,844	1,913	(69)		1,563	281	
Depreciation and amortization	2,336	2,463	(127)		11,755	12,605	(850)		17,297	(5,542)	
Total EBIDA adjustments	2,694	2,868	(174)		13,599	14,518	(919)		18,860	(5,261)	
EBIDA	**$ 615**	**$ 2,914**	**$ (2,299)**		**$ 19,133**	**$ 22,566**	**$ (3,433)**		**$ 13,822**	**$ 5,311**	

ALAMEDA HEALTH SYSTEM (consolidated)
Balance Sheet
As of November 30, 2025
(In Thousands)

	Current Month	Prior Month	FYE 2025
ASSETS			
Cash & cash equivalents	$ 21,522	$ 7,515	$ 14,556
Patient account receivables, net	103,031	105,568	101,401
Due from third-party payors	475,247	377,693	338,189
Due from County of Alameda	31,188	56,617	61,713
Due from State of California	27,028	28,262	25,635
Inventories	12,631	12,644	12,267
Other current assets	23,741	24,919	20,054
TOTAL CURRENT ASSETS	**694,388**	**613,218**	**573,815**
Restricted cash equivalents	28,099	28,099	27,781
Right-to-use lease assets, net	28,615	30,690	31,604
Right-of-use subscription assets, net	10,896	9,290	8,190
Capital assets - nondepreciable	9,021	9,021	9,021
Capital assets - depreciable, net	130,851	130,768	129,675
TOTAL NONCURRENT ASSETS	**207,482**	**207,868**	**206,271**
DEFERRED OUTFLOWS OF RESOURCES	**105,570**	**105,570**	**105,570**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$ 1,007,440**	**$ 926,656**	**$ 885,656**
LIABILITIES & NET ASSETS			
Accounts payable and accrued expenses	$ 78,759	$ 78,841	$ 89,527
Accrued compensation	61,328	56,399	65,654
Due to third-party payors	146,358	148,987	179,634
Due to County of Alameda	88,608	20,058	12,033
Other Payables	51,065	50,160	43,509
TOTAL CURRENT LIABILITIES	**426,118**	**354,445**	**390,357**
Liquidity facility - County of Alameda	88,106	76,704	832
Net pension obligation	369,632	369,632	370,400
Post employment benefit asset	43,255	43,255	43,255
Accrued compensated absences, net of current portion	22,604	22,604	26,667
Self-insurance liabilities, net of current portion	41,231	41,231	41,231
Lease obligations, net of current portion	27,111	27,549	29,739
Subscription obligations, net of current portion	4,277	4,053	3,771
Other long-term liabilities	0	0	0
TOTAL LONG TERM LIABILITIES	**596,216**	**585,028**	**515,895**
DEFERRED INFLOWS OF RESOURCES	**41,202**	**41,202**	**41,202**
Fund balance - capital contribution	86,653	86,653	86,484
Fund balance - prior years	(148,283)	(148,283)	(166,072)
Current year income/(loss)	5,534	7,611	17,790
FUND BALANCE	**(56,096)**	**(54,019)**	**(61,798)**
TOTAL LIABILITIES, DEFERRED INFLOWS, & FUND BALANCE	**$ 1,007,440**	**$ 926,656**	**$ 885,656**

ALAMEDA HEALTH SYSTEM (consolidated)
Statement of Cash Flows
For the Period Ended November 30, 2025
(in thousands)

	Current Month	Year-to Date	FYE 2025
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating income (loss)	$ (1,653)	$ 7,403	$ 20,942
Depreciation and amortization	2,336	11,755	37,542
Net changes in operating assets and liabilities:			
Patient account receivables, net	2,537	(1,630)	4,695
Due from/to third-party payors	(100,183)	(170,334)	(13,222)
Due from/to County	93,979	107,100	(24,880)
Due from State	1,234	(1,393)	(1,371)
Inventory	13	(364)	(280)
Other current assets	1,178	(3,687)	(2,432)
Accounts payable and accrued expenses	(82)	(10,769)	4,040
Accrued compensation	4,931	(4,326)	9,387
Other current payables	905	7,556	10,867
Net pension liability	-	(768)	(55,607)
Other postemployment benefits obligations	-	-	4,881
Other long-term liabilities	-	(4,063)	7,347
Deferred outflows/inflows	-	-	50,894
Net cash provided by (used in) operating activities	**5,195**	**(63,520)**	**52,803**
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES			
Change in liquidity facility	11,402	87,274	(4,269)
Interest payments on working capital loan	370	2,053	3,604
Proceeds from grants for COVID-19 pandemic	-	-	-
Receipts of rental income	(68)	(25)	(253)
Net cash provided by (used in) noncapital financing activities	**11,704**	**89,302**	**(918)**
CASH FLOWS FROM CAPITAL AND FINANCING ACTIVITIES			
Purchase and construction of capital assets	(1,391)	(7,981)	(19,936)
Proceeds from disposals of capital assets	0	0	0
Repayment of other long-term liabilities	0	0	(2,783)
Payments of lease liabilies	1,036	(2,747)	(6,730)
Interest payments on lease liabilities	89	456	1,232
Payments of subscription obligations	(1,809)	(4,042)	(6,587)
Interest payments on subscription obligations	10	78	131
Capital contributions and transfers	-	169	1,033
Net cash provided by (used in) capital and financing activities	**(2,065)**	**(14,067)**	**(33,640)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest and investment income	(827)	(4,431)	(7,866)
Net cash provided by (used in) investing activities	**(827)**	**(4,431)**	**(7,866)**
CHANGES IN CASH AND CASH EQUIVALENTS	**14,007**	**7,284**	**10,379**
CASH AND CASH EQUIVALENTS, beginning of period	35,614	42,337	31,958
CASH AND CASH EQUIVALENTS, end of period	**$ 49,621**	**$ 49,621**	**$ 42,337**

ALAMEDA HEALTH SYSTEMS Volume Reports

ALAMEDA HEALTH SYSTEM

Month: November

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: AHS ALL CAMPUS											
Total Adjusted Patient Days	29,831	28,840	991	3.4%	152,954	151,696	1,258	0.8%	150,276	2,678	1.8%
Total Adjusted Discharges	2,584	2,494	90	3.6%	13,658	13,133	525	4.0%	13,115	543	4.1%
GENERAL ACUTE											
Patient Days	5,699	6,088	-389	-6.4%	29,241	31,300	-2,059	-6.6%	30,911	-1,670	-5.4%
Discharges	1,168	1,178	-10	-0.9%	6,193	6,037	156	2.6%	6,064	129	2.1%
Average Daily Census	190	202.9	-13	-6.4%	191.1	204.6	-13.5	-6.6%	202	-10.9	-5.4%
Average Length of Stay	4.9	5.2	0.3	5.6%	4.7	5.2	0.5	8.9%	5.1	0.4	7.4%
Adjusted Patient Days	10,909	10,996	-88	-0.8%	56,013	57,650	-1,636	-2.8%	57,165	-1,151	-2.0%
Adjusted Discharges	2,236	2,128	107	5.0%	11,863	11,120	743	6.7%	11,214	649	5.8%
Occupancy %	64%	68%	-4%	-6.4%	64%	69%	-5%	-6.6%	68%	-4%	-5.4%
CMI	1.639	1.598	0.041	2.6%	1.602	1.656	-0.054	-3.3%	1.656	-0.054	-3.3%
Emergency Visits	8,925	8,309	616	7.4%	46,903	43,821	3,082	7.0%	44,965	1,938	4.3%
Left Without Being Seen (LWBS)	338	400	62	18.3%	2,217	2,609	392	17.7%	3,034	817	36.9%
Trauma Cases	328	260	68	26.4%	1,570	1,577	-7	-0.4%	1,620	-50	-3.1%
Observation Equivalent Days	711	566	144	25.5%	3,415	3,409	6	0.2%	3,241	173	5.4%
IP Surgeries	246	234	12	5.1%	1,505	1,606	-101	-6.3%	1,539	-34	-2.2%
OP Surgeries	355	288	67	23.3%	1,923	1,853	70	3.8%	2,264	-341	-15.1%
Total Surgeries	601	522	79	15.2%	3,428	3,459	-31	-0.9%	3,803	-375	-9.9%
Deliveries	121	139	-18	-12.8%	725	722	3	0.4%	678	47	6.9%
PSYCH											
Psych Patient Days	1,979	1,904	75	4.0%	10,187	9,959	228	2.3%	9,860	327	3.3%
Psych Discharges	203	211	-8	-4.0%	1,069	1,106	-37	-3.3%	1,094	-25	-2.3%
Psych OP Factor	1.1998	1.1778	-0.022	-1.9%	1.2328	1.2207	-0.0121	-1.0%	1.229	-0.0038	-0.3%
Average Daily Census	66	63.5	2.5	4.0%	66.6	65.1	1.5	2.3%	64.4	2.1	3.3%
Average Length of Stay	9.7	9	-0.7	-8.3%	9.5	9	-0.5	-5.8%	9	-0.5	-5.7%
Adjusted Patient Days	2,374	2,242	132	5.9%	12,559	12,157	402	3.3%	12,118	441	3.6%
Adjusted Discharges	244	249	-5	-2.2%	1,318	1,350	-32	-2.4%	1,345	-27	-2.0%
PES Equivalent Days	644	493	151	30.6%	3,741	3,404	337	9.9%	3,404	337	9.9%
PES Visits	801	711	90	12.7%	4,050	4,063	-13	-0.3%	4,056	-6	-0.1%
PES Hours	15,446	12,207	3,239	26.5%	89,794	79,250	10,544	13.3%	81,695	8,099	9.9%
PES Hours per Visit	19	17	-2	-12.3%	22	20	-3	-13.7%	20	-2	-10.1%
REHAB											
Rehab Patient Days	686	625	61	9.8%	3,498	3,553	-55	-1.5%	3,387	111	3.3%
Rehab Discharges	52	47	5	10.0%	272	269	3	1.2%	256	16	6.3%
Rehab OP Factor	1	1	0	0.0%	1	1	0	0.0%	1	0	0.0%
Average Daily Census	22.9	20.8	2	9.8%	22.9	23.2	-0.4	-1.5%	22.1	0.7	3.3%
Average Length of Stay	13.2	13.2	0	0.2%	12.9	13.2	0.4	2.7%	13.2	0.4	2.8%
Adjusted Patient Days	686	625	61	9.8%	3,498	3,553	-55	-1.5%	3,387	111	3.3%

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: November

Adjusted Discharges	52	47	5	10.0%	272	269	3	1.2%	256	16	6.3%
Occupancy %	82%	74%	0%	0.0%	82%	83%	0%	0.0%	79%	0%	0.0%
Bed Holds	2	0	2	0.0%	5	0	5	0.0%	0	5	0.0%
Paid FTE	71	66	-6	-8.7%	71	73	2	2.4%	70	-1	-0.8%
Productive FTE	63	53	-9	-17.4%	61	62	1	1.3%	60	-1	-0.9%
Paid FTE per AOB	3.11	3.14	0.03	1.0%	3.1	3.13	0.03	0.8%	3.17	0.08	2.4%
Worked Hours per APD	15.7	14.6	-1	-7.0%	15.2	15.1	0	-0.3%	15.6	0.4	2.3%
Worked Hours per AD	207	194	-13	-6.7%	195	200	5	2.5%	206	10	5.1%
SNF with Sub-Acute											
SNF Patient Days	8,269	8,270	-1	0.0%	42,422	42,177	245	0.6%	41,895	527	1.3%
SNF Discharges	18	23	-5	-22.8%	87	119	-32	-26.8%	96	-9	-9.4%
SNF OP Factor	1.0326	1.0015	-0.0311	-3.1%	1.0343	1.0017	-0.0325	-3.2%	1.0301	-0.0041	-0.4%
Average Daily Census	275.6	275.7	0	0.0%	277.3	275.7	1.6	0.6%	273.8	3.4	1.3%
Average Length of Stay	459.4	354.6	-104.8	-29.5%	487.6	354.9	-132.7	-37.4%	436.4	-51.2	-11.7%
Adjusted Patient Days	8,539	8,283	256	3.1%	43,875	42,250	1,625	3.8%	43,158	718	1.7%
Adjusted Discharges	19	23	-5	-20.4%	90	119	-29	-24.4%	99	-9	-9.0%
Occupancy %	95%	95%	0%	0.0%	96%	95%	0%	0.0%	94%	0%	0.0%
Bed Holds	61	72	-11	-15.1%	299	404	-105	-26.1%	402	-103	-25.6%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	5,245	5,080	-165	-3.3%	5,204	5,125	-78	-1.5%	5,087	-116	-2.3%
Total Productive FTE	4,461	4,288	-173	-4.0%	4,517	4,425	-92	-2.1%	4,390	-127	-2.9%
Total Paid FTE per AOB	5.27	5.28	0.01	0.2%	5.21	5.17	-0.04	-0.7%	5.18	-0.03	-0.5%
Worked Hours Per APD	25.6	25.5	-0.1	-0.6%	25.8	25.5	-0.3	-1.2%	25.5	-0.3	-1.1%
Worked Hours Per AD	296	295	-1	-0.4%	289	295	5	1.9%	293	4	1.2%
Physician wRVU	124,465	144,578	-20,113	-13.9%	666,350	631,322	35,028	5.5%	652,487	13,863	2.1%
TOTAL CLINIC VISITS	31,045	33,099	-2,054	-6.2%	177,560	184,328	-6,768	-3.7%	172,685	4,875	2.8%
FQHC Visits	26,057	28,264	-2,207	-7.8%	149,624	155,756	-6,132	-3.9%	144,577	5,047	3.5%
Non-FQHC Visits	4,988	4,835	153	3.2%	27,936	28,572	-636	-2.2%	28,108	-172	-0.6%
PAYOR MIX											
Insurance %	6.04%	5.99%	0.05%		6.61%	7.17%	-0.56%		7.07%	-0.45%	
Medi-Cal %	58.71%	60.02%	-1.31%		60.13%	61.30%	-1.17%		61.49%	-1.36%	
Medicare %	30.38%	28.12%	2.26%		28.86%	26.38%	2.48%		27.07%	1.79%	
Other Govt %	1.17%	2.38%	-1.21%		1.39%	1.83%	-0.43%		1.70%	-0.30%	
Self-Pay %	3.70%	3.49%	0.21%		3.01%	3.33%	-0.32%		2.68%	0.33%	
Total Payor Mix %	100.00%	100.00%	0.00%		100.00%	100.00%	0.00%		100.00%	0.00%	
CAMPUS CMI											
CMI Alameda	1.453	1.454	-0.001	-0.1%	1.394	1.449	-0.054	-3.7%	1.447	-0.052	-3.6%
CMI Highland	1.735	1.667	0.069	4.1%	1.691	1.75	-0.058	-3.3%	1.75	-0.059	-3.4%
CMI San Leandro	1.458	1.472	-0.014	-1.0%	1.449	1.493	-0.044	-2.9%	1.492	-0.043	-2.9%
CMI Behavioral Health	1.31	1.367	-0.057	-4.2%	1.362	1.341	0.021	1.6%	1.34	0.021	1.6%

ALAMEDA HEALTH SYSTEMS Volume Reports

ALAMEDA HEALTH SYSTEM

Month: November

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: HIGHLAND											
Total Patient Days	3,883	4,152	-269	-6.5%	20,582	21,663	-1,081	-5.0%	21,401	-819	-3.8%
Total Discharges	740	721	19	2.7%	3,930	3,759	171	4.5%	3,751	179	4.8%
Total Adjusted Patient Days	7,056	7,252	-196	-2.7%	37,160	38,096	-937	-2.5%	37,498	-339	-0.9%
Total Adjusted Discharges	1,345	1,258	86	6.9%	7,095	6,611	484	7.3%	6,572	523	8.0%
GENERAL ACUTE											
Patient Days	3,883	4,152	-269	-6.5%	20,582	21,663	-1,081	-5.0%	21,401	-819	-3.8%
Discharges	740	721	19	2.7%	3,930	3,759	171	4.5%	3,751	179	4.8%
OP Factor	1.8231	1.7529	-0.0701	-4.0%	1.8117	1.7648	-0.0469	-2.7%	1.7581	-0.0536	-3.1%
Average Daily Census	129.4	138.4	-9	-6.5%	134.5	141.6	-7.1	-5.0%	139.9	-5.4	-3.8%
Average Length of Stay	5.2	5.8	0.5	8.9%	5.2	5.8	0.5	9.1%	5.7	0.5	8.2%
Adjusted Patient Days	7,079	7,279	-199	-2.7%	37,289	38,231	-942	-2.5%	37,625	-336	-0.9%
Adjusted Discharges	1,349	1,263	86	6.8%	7,120	6,634	486	7.3%	6,595	525	8.0%
Occupancy %	77%	82%	-5%	-6.5%	80%	84%	-4%	-5.0%	83%	-3%	-3.8%
Emergency Visits	4,696	4,253	443	10.4%	24,198	22,027	2,171	9.9%	22,588	1,610	7.1%
Left Without Being Seen (LWBS)	199	380	181	91.2%	1,431	2,405	974	68.0%	2,364	933	65.2%
Trauma Cases	328	260	68	26.4%	1,570	1,577	-7	-0.4%	1,620	-50	-3.1%
Observation Equivalent Days	245	268	-23	-8.7%	1,194	1,553	-359	-23.1%	1,334	-140	-10.5%
IP Surgeries	203	173	30	17.3%	1,237	1,244	-7	-0.5%	1,220	17	1.4%
OP Surgeries	203	154	49	32.2%	1,107	947	160	16.9%	985	122	12.4%
Total Surgeries	406	327	79	24.3%	2,344	2,191	153	7.0%	2,205	139	6.3%
Deliveries	121	139	-18	-12.8%	725	722	3	0.4%	678	47	6.9%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	2,045	1,798	-247	-13.7%	1,925	1,804	-122	-6.7%	1,815	-110	-6.1%
Total Productive FTE	1,735	1,506	-229	-15.2%	1,669	1,552	-117	-7.6%	1,558	-112	-7.2%
Total Paid FTE per AOB	8.69	7.44	-1.26	-16.9%	7.93	7.24	-0.68	-9.4%	7.4	-0.52	-7.0%
Worked Hours Per APD	42.1	35.6	-6.5	-18.4%	39.3	35.6	-3.7	-10.3%	36.3	-3	-8.2%
Worked Hours Per AD	221	205	-16	-7.8%	206	205	0	-0.2%	207	1	0.7%
Physician wRVU	7	3	5	175.6%	32	29	3	10.8%	29	4	13.0%
OTHER STATS											
GI Procedures	573	252	321	127.3%	1,972	1,561	411	26.3%	1,530	442	28.9%
Cardiac Procedures	65	51	14	28.1%	644	287	357	124.1%	319	325	101.9%
HGH Cath Lab and IR Procedures	469	408	61	14.9%	3,786	2,351	1,435	61.0%	3,632	154	4.2%
TOTAL CLINIC VISITS											
Specialty	1413	1059	354	33.4%	7,794	6,018	1,776	29.5%	6,547	1,247	19.0%
Behavioral Health	761	682	79	11.6%	3.978	4.768	-790	-16.6%	4,351	-373	-8.6%
PAYOR MIX											
Insurance %	6.02%	7.48%	-1.46%		7.09%	8.45%	-1.37%		8.21%	-1.12%	
Medi-Cal %	56.80%	57.97%	-1.18%		58.96%	61.12%	-2.16%		61.41%	-2.45%	
Medicare %	31.20%	27.47%	3.73%		28.80%	24.44%	4.37%		25.14%	3.66%	
Other Govt %	1.57%	2.48%	-0.91%		1.57%	2.16%	-0.58%		1.99%	-0.41%	
Self-Pay %	4.42%	4.61%	-0.19%		3.58%	3.83%	-0.26%		3.25%	0.32%	
Total Payor Mix %	100.00%	100.00%	0.00%		100.00%	100.00%	0.00%		100.00%	0.00%	
CAMPUS CMI											
CMI Highland	1.735	1.667	0.069	4.1%	1.691	1.75	-0.058	-3.3%	1.75	-0.059	-3.4%

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: ALAMEDA											
Total Patient Days	5,962	6,073	-111	-1.8%	30,516	30,883	-367	-1.2%	30,521	-5	0.0%
Total Discharges	205	224	-19	-8.4%	1,162	1,121	41	3.6%	1,119	43	3.8%
Total Adjusted Patient Days	8,964	8,588	375	4.4%	46,523	45,014	1,510	3.4%	45,762	761	1.7%
Total Adjusted Discharges	308	316	-8	-2.6%	1,772	1,634	137	8.4%	1,678	94	5.6%
GENERAL ACUTE											
Patient Days	902	953	-51	-5.4%	4,437	4,772	-335	-7.0%	4,823	-386	-8.0%
Discharges	192	212	-20	-9.4%	1,110	1,061	49	4.6%	1,071	39	3.6%
OP Factor	1.8334	1.7072	-0.1262	-7.4%	1.8879	1.7741	-0.1137	-6.4%	1.837	-0.0508	-2.8%
Average Daily Census	30.1	31.8	-1.7	-5.4%	29	31.2	-2.2	-7.0%	31.5	-2.5	-8.0%
Average Length of Stay	4.7	4.5	-0.2	-4.4%	4	4.5	0.5	11.1%	4.5	0.5	11.2%
Adjusted Patient Days	1,654	1,627	27	1.6%	8,376	8,465	-89	-1.0%	8,860	-483	-5.5%
Adjusted Discharges	352	362	-10	-2.7%	2,096	1,882	213	11.3%	1,967	128	6.5%
Occupancy %	46%	48%	-3%	-5.4%	44%	47%	-3%	-7.0%	48%	-4%	-8.0%
Emergency Visits	1,580	1,408	172	12.2%	8,533	7,822	711	9.1%	8,123	410	5.0%
Left Without Being Seen (LWBS)	39	0	-39	-100.0%	283	0	-283	-100.0%	217	-66	-23.3%
Observation Equivalent Days	262	129	133	103.0%	1,175	911	264	29.0%	975	200	20.5%
IP Surgeries	15	21	-6	-27.4%	68	96	-28	-28.8%	84	-16	-19.0%
OP Surgeries	2	0	2	0.0%	21	0	21	0.0%	380	-359	-94.5%
Total Surgeries	17	21	-4	-17.7%	89	96	-7	-6.8%	464	-375	-80.8%
SNF with Sub-Acute											
SNF Patient Days	5,060	5,120	-60	-1.2%	26,079	26,111	-32	-0.1%	25,698	381	1.5%
SNF Discharges	13	12	1	10.1%	52	60	-8	-13.7%	48	4	8.3%
SNF OP Factor	1.0076	1.0015	-0.0061	-0.6%	1.0079	1.0017	-0.0062	-0.6%	1.0053	-0.0026	-0.3%
Average Daily Census	168.7	170.7	-2	-1.2%	170.5	170.7	-0.2	-0.1%	168	2.5	1.5%
Average Length of Stay	389.2	433.5	44.3	10.2%	501.5	433.4	-68.1	-15.7%	535.4	33.9	6.3%
Adjusted Patient Days	5,098	5,127	-29	-0.6%	26,284	26,155	129	0.5%	25,833	451	1.7%
Adjusted Discharges	13	12	1	10.7%	52	60	-8	-13.2%	48	4	8.6%
Occupancy %	93%	94%	0%	0.0%	94%	94%	0%	0.0%	93%	0%	0.0%
Bed Holds	42	29	13	42.4%	155	235	-80	-34.0%	230	-75	-32.6%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	658	615	-42	-6.8%	641	616	-25	-4.1%	596	-45	-7.5%
Total Productive FTE	584	528	-56	-10.5%	563	535	-28	-5.3%	518	-45	-8.7%
Total Paid FTE per AOB	2.2	2.15	-0.05	-2.4%	2.11	2.09	-0.02	-0.7%	1.99	-0.12	-5.8%
Worked Hours Per APD	11.2	10.5	-0.6	-5.9%	10.6	10.4	-0.2	-1.9%	9.9	-0.7	-6.9%
Worked Hours Per AD	325	286	-39	-13.5%	278	286	8	2.9%	270	-8	-2.9%
TOTAL CLINIC VISITS	1,238	1,133	105	9.2%	6,903	6,203	700	11.3%	6,444	459	7.1%
Specialty	1,238	1,133	105	9.2%	6,903	6,203	700	11.3%	6,444	459	7.1%
PAYOR MIX											
Insurance %	6.32%	5.25%	1.07%		7.19%	7.11%	0.08%		7.53%	-0.34%	-4.5%
Medi-Cal %	59.42%	57.99%	1.43%		58.12%	56.57%	1.56%		57.56%	0.56%	1.0%
Medicare %	32.32%	33.89%	-1.58%		31.98%	32.82%	-0.83%		33.12%	-1.13%	-3.4%
Other Govt %	0.22%	1.98%	-1.76%		1.03%	1.68%	-0.65%		1.41%	-0.38%	-26.9%
Self-Pay %	1.71%	0.88%	0.83%		1.67%	1.83%	-0.16%		0.38%	1.29%	342.1%
Total Payor Mix %	100.00%	100.00%	0.00%		100.00%	100.00%	0.00%		100.00%	0.00%	0.0%
CAMPUS CMI											
CMI Alameda	1.453	1.454	-0.001	-0.1%	1.394	1.449	-0.054	-3.7%	1.447	-0.052	-3.6%

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: SAN LEANDRO											
Total Patient Days	1,600	1,608	-8	-0.5%	7,720	8,418	-698	-8.3%	8,074	-354	-4.4%
Total Discharges	288	293	-5	-1.8%	1,425	1,486	-61	-4.1%	1,498	-73	-4.9%
Total Adjusted Patient Days	3,380	3,055	325	10.6%	16,546	16,753	-207	-1.2%	16,317	229	1.4%
Total Adjusted Discharges	608	557	51	9.2%	3,054	2,957	97	3.3%	3,027	27	0.9%
GENERAL ACUTE											
Patient Days	914	983	-69	-7.0%	4,222	4,865	-643	-13.2%	4,687	-465	-9.9%
Discharges	236	246	-10	-4.0%	1,153	1,217	-64	-5.3%	1,242	-89	-7.2%
OP Factor	2.468	2.1358	-0.3323	-15.6%	2.5206	2.2946	-0.226	-9.8%	2.3282	-0.1924	-8.3%
Average Daily Census	30.5	32.8	-2.3	-7.0%	27.6	31.8	-4.2	-13.2%	30.6	-3	-9.9%
Average Length of Stay	3.9	4	0.1	3.1%	3.7	4	0.3	8.4%	3.8	0.1	3.0%
Adjusted Patient Days	2,256	2,099	157	7.5%	10,642	11,163	-521	-4.7%	10,912	-270	-2.5%
Adjusted Discharges	582	525	57	10.9%	2,906	2,793	113	4.1%	2,892	15	0.5%
Occupancy %	48%	52%	-4%	-7.0%	44%	50%	-7%	-13.2%	49%	-5%	-9.9%
Emergency Visits	2,649	2,648	1	0.0%	14,172	13,972	200	1.4%	14,254	-82	-0.6%
Left Without Being Seen (LWBS)	34	20	-14	-42.4%	169	204	35	20.7%	453	284	168.0%
Observation Equivalent Days	204	169	35	20.6%	1,046	946	101	10.6%	933	114	12.2%
IP Surgeries	28	40	-12	-30.4%	200	267	-67	-25.1%	235	-35	-14.9%
OP Surgeries	150	134	16	11.6%	795	906	-111	-12.2%	899	-104	-11.6%
Total Surgeries	178	175	3	1.9%	995	1,173	-178	-15.2%	1,134	-139	-12.3%
REHAB											
Rehab Patient Days	686	625	61	9.8%	3,498	3,553	-55	-1.5%	3,387	111	3.3%
Rehab Discharges	52	47	5	10.0%	272	269	3	1.2%	256	16	6.3%
Rehab OP Factor	1	1	0	0.0%	1	1	0	0.0%	1	0	0.0%
Average Daily Census	22.9	20.8	2	9.8%	22.9	23.2	-0.4	-1.5%	22.1	0.7	3.3%
Average Length of Stay	13.2	13.2	0	0.2%	12.9	13.2	0.4	2.7%	13.2	0.4	2.8%
Adjusted Patient Days	686	625	61	9.8%	3,498	3,553	-55	-1.5%	3,387	111	3.3%
Adjusted Discharges	52	47	5	10.0%	272	269	3	1.2%	256	16	6.3%
Occupancy %	82%	74%	0%	0.0%	82%	83%	0%	0.0%	79%	0%	0.0%
Bed Holds	2	0	2	0.0%	5	0	5	0.0%	0	5	0.0%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	518	461	-57	-12.4%	490	469	-21	-4.5%	469	-21	-4.4%
Total Productive FTE	450	390	-60	-15.3%	420	400	-20	-5.0%	399	-21	-5.2%
Total Paid FTE per AOB	4.6	4.52	-0.07	-1.6%	4.53	4.28	-0.25	-5.9%	4.4	-0.13	-3.0%
Worked Hours Per APD	22.8	21.9	-0.9	-4.2%	22.2	20.9	-1.3	-6.4%	21.4	-0.8	-3.7%
Worked Hours Per AD	127	120	-7	-5.6%	120	118	-2	-1.7%	115	-5	-4.2%
PAYOR MIX											
Insurance %	7.61%	3.31%	4.31%		6.35%	6.03%	0.32%		5.78%	0.56%	
Medi-Cal %	52.77%	57.57%	-4.80%		55.61%	57.22%	-1.60%		56.99%	-1.38%	
Medicare %	34.49%	34.57%	-0.08%		33.45%	32.34%	1.11%		33.06%	0.39%	
Other Govt %	1.60%	1.74%	-0.15%		1.77%	1.29%	0.47%		1.37%	0.39%	
Self-Pay %	3.53%	2.81%	0.72%		2.82%	3.13%	-0.30%		2.79%	0.03%	
Total Payor Mix %	100.00%	100.00%	0.00%		100.00%	100.00%	0.00%		100.00%	0.00%	
CAMPUS CMI											
CMI San Leandro	1.458	1.472	-0.014	-1.0%	1.449	1.493	-0.044	-2.9%	1.492	-0.043	-2.9%

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	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: JOHN GEORGE											
Total Patient Days	1,979	1,904	75	4.0%	10,187	9,959	228	2.3%	9,860	327	3.3%
Total Discharges	203	211	-8	-4.0%	1,069	1,106	-37	-3.3%	1,094	-25	-2.3%
OP Factor	1.1679	1.156	-0.0119	-1.0%	1.1931	1.1882	-0.005	-0.4%	1.1928	-0.0003	0.0%
Total Adjusted Patient Days	2,311	2,201	111	5.0%	12,154	11,832	322	2.7%	11,761	393	3.3%
Total Adjusted Discharges	237	244	-7	-3.0%	1,275	1,314	-39	-2.9%	1,305	-29	-2.3%
PSYCH											
Psych Patient Days	1,979	1,904	75	4.0%	10,187	9,959	228	2.3%	9,860	327	3.3%
Psych Discharges	203	211	-8	-4.0%	1,069	1,106	-37	-3.3%	1,094	-25	-2.3%
Psych OP Factor	1.1998	1.1778	-0.022	-1.9%	1.2328	1.2207	-0.0121	-1.0%	1.229	-0.0038	-0.3%
Average Daily Census	66	63.5	2.5	4.0%	66.6	65.1	1.5	2.3%	64.4	2.1	3.3%
Average Length of Stay	9.7	9	-0.7	-8.3%	9.5	9	-0.5	-5.8%	9	-0.5	-5.7%
Adjusted Patient Days	2,374	2,242	132	5.9%	12,559	12,157	402	3.3%	12,118	441	3.6%
Adjusted Discharges	244	249	-5	-2.2%	1,318	1,350	-32	-2.4%	1,345	-27	-2.0%
PES Equivalent Days	644	493	151	30.6%	3,741	3,404	337	9.9%	3,404	337	9.9%
PES Visits	15,446	711	14,735	2072.4%	89,794	4,063	85,731	2110.0%	4,056	85,738	#######
PES Hours	15,446	12,207	3,239	26.5%	89,794	79,250	10,544	13.3%	81,695	8,099	9.9%
PES Hours per Visit	1	17	16	94.2%	1	20	19	94.9%	20	19	95.0%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	396	358	-38	-10.6%	397	369	-28	-7.6%	382	-15	-3.8%
Total Productive FTE	337	297	-41	-13.7%	343	316	-28	-8.8%	331	-12	-3.8%
Total Paid FTE per AOB	5.14	4.88	-0.26	-5.3%	5	4.77	-0.23	-4.8%	4.97	-0.02	-0.4%
Worked Hours Per APD	25	23.1	-1.9	-8.3%	24.7	23.3	-1.4	-5.9%	24.6	-0.1	-0.4%
Worked Hours Per AD	244	208	-36	-17.2%	235	210	-25	-12.1%	222	-14	-6.2%
Physician wRVU	4,456	7,444	-2,988	-40.1%	37,049	44,533	-7,484	-16.8%	44,335	-7,285	-16.4%
PAYOR MIX											
Insurance %	3.85%	6.40%	-2.55%		4.81%	5.27%	-0.46%		4.74%	0.07%	
Medi-Cal %	67.65%	66.34%	1.31%		65.90%	65.00%	0.90%		64.84%	1.06%	
Medicare %	27.56%	17.85%	9.71%		27.02%	24.20%	2.82%		26.06%	0.96%	
Other Govt %	-1.50%	5.67%	-7.17%		-0.14%	1.28%	-1.42%		0.67%	-0.81%	
Self-Pay %	2.44%	3.73%	-1.29%		2.41%	4.26%	-1.85%		3.69%	-1.28%	
Total Payor Mix %	100.00%	100.00%	0.00%		100.00%	100.00%	0.00%		100.00%	0.00%	
CAMPUS CMI											
CMI Behavioral Health	1.31	1.367	-0.057	-4.2%	1.362	1.341	0.021	1.6%	1.34	0.021	1.6%

ALAMEDA HEALTH SYSTEMS Volume Reports

ALAMEDA HEALTH SYSTEM

Month: November

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: FAIRMONT											
Total Patient Days	3,209	3,150	59	1.9%	16,343	16,066	277	1.7%	16,197	146	0.9%
Total Discharges	7	12	-5	-39.2%	36	59	-23	-38.5%	48	-12	-25.0%
OP Factor	1.2723	1.3255	0.0533	4.0%	1.3049	1.3604	0.0555	4.1%	1.3458	0.0409	3.0%
Total Adjusted Patient Days	4,083	4,176	-93	-2.2%	21,326	21,856	-531	-2.4%	21,798	-473	-2.2%
Total Adjusted Discharges	9	15	-6	-41.6%	47	80	-33	-41.1%	65	-18	-27.3%
SNF with Sub-Acute											
SNF Patient Days	3,209	3,150	59	1.9%	16,343	16,066	277	1.7%	16,197	146	0.9%
SNF Discharges	7	12	-5	-39.2%	36	59	-23	-38.5%	48	-12	-25.0%
SNF OP Factor	1.0742	1.0017	-0.0725	-7.2%	1.0783	1.0018	-0.0765	-7.6%	1.0711	-0.0072	-0.7%
Average Daily Census	107	105	2	1.9%	106.8	105	1.8	1.7%	105.9	1	0.9%
Average Length of Stay	458.4	273.7	-184.7	-67.5%	454	274.3	-179.7	-65.5%	337.4	-116.5	-34.5%
Adjusted Patient Days	3,447	3,155	292	9.2%	17,623	16,095	1,528	9.5%	17,349	274	1.6%
Adjusted Discharges	8	12	-4	-34.8%	39	59	-20	-33.9%	51	-13	-24.5%
Occupancy %	98%	96%	0%	0.0%	98%	96%	0%	0.0%	97%	0%	0.0%
Bed Holds	19	42	-23	-55.2%	144	170	-26	-15.0%	172	-28	-16.3%
Paid FTE	277	277	0	-0.1%	281	274	-7	-2.7%	288	7	2.3%
TOTAL FTE, HOURS, WRVU											
Total Paid FTE	300	295	-5	-1.6%	299	293	-6	-2.0%	296	-3	-0.8%
Total Productive FTE	254	249	-5	-1.9%	258	253	-5	-2.1%	257	-1	-0.5%
Total Paid FTE per AOB	2.2	2.12	-0.08	-3.9%	2.14	2.05	-0.09	-4.5%	2.08	-0.06	-3.1%
Worked Hours Per APD	10.7	10.2	-0.4	-4.2%	10.6	10.1	-0.5	-4.7%	10.3	-0.3	-2.7%
Worked Hours Per AD	4890	2801	-2089	-74.6%	4806	2774	-2032	-73.3%	3478	-1328	-38.2%
CLINIC / TELEHEALTH VISITS --											
Behavioral Health	1,477	1,894	-417	-22.0%	8,719	11,210	-2,491	-22.2%	10,435	-1,716	-16.4%
Rehab	8	15	-7	-46.4%	60	49	11	23.7%	58	2	3.4%
Clinic Visits	1,485	1,909	-424	-22.2%	8,779	11,258	-2,479	-22.0%	10,493	-1,714	-16.3%
Telehealth Behavioral Health	91	53	38	72.8%	482	325	157	48.3%	273	209	76.6%
Telehealth Visits	91	53	38	72.8%	482	325	157	48.3%	273	209	76.6%
TOTAL CLINIC VISITS	1,576	1,961	-385	-19.6%	9,261	11,583	-2,322	-20.0%	10,766	-1,505	-14.0%
PAYOR MIX											
Insurance %	0.95%	0.82%	0.13%		1.45%	0.88%	0.57%		1.07%	0.38%	
Medi-Cal %	75.18%	77.83%	-2.65%		79.50%	76.00%	3.50%		77.51%	1.99%	
Medicare %	17.18%	19.92%	-2.74%		18.02%	22.23%	-4.22%		21.54%	-3.53%	
Other Govt %	0.54%	0.31%	0.23%		0.27%	0.27%	-0.01%		0.22%	0.05%	
Self-Pay %	6.15%	1.13%	5.02%		0.77%	0.61%	0.16%		-0.33%	1.10%	
Total Payor Mix %	100.00%	100.00%	0.00%		100.00%	100.00%	0.00%		100.00%	0.00%	

ALAMEDA HEALTH SYSTEMS Volume Reports

Month: November

	MONTH				YEAR-TO-DATE				PRIOR YEAR-TO-DATE		
	MTD Actual	MTD Budget	Var	% Var	YTD Actual	YTD Budget	Var	% Var	YTD PY Actual	Var	% Var
Campus: FQ CLINIC											
CLINIC VISITS											
Total by Site	26,057	28,264	-2,207	-7.8%	149,624	155,756	-6,132	-3.9%	144,577	5,047	3.5%
Highland FQHC	14,341	15,457	14,341	-7.2%	83,128	86,666	-3,538	-4.1%	83,608	-480	-0.6%
Eastmont Wellness Center	6,296	7,147	-851	-11.9%	36,743	39,596	-2,853	-7.2%	31,661	5,082	16.1%
Hayward Wellness Center	3,394	3,572	-178	-5.0%	18,336	18,087	249	1.4%	18,331	5	0.0%
Newark Wellness Center	2,026	2,088	-62	-3.0%	11,417	11,407	10	0.1%	10,977	440	4.0%
Total by Specialty	26,057	28,264	-2,207	-7.8%	149,624	155,756	-6,132	1.4%	144,577	5,047	3.5%
Primary Care	13,692	14,542	-850	-5.8%	77,138	77,769	-631	1.4%	77,285	-147	-0.2%
Behavioral Health	41	17	24	141.2%	243	137	106	1.4%	90	153	170.0%
Dental	2,905	3,393	-488	-14.4%	16473	19794	-3,321	1.4%	12142	4,331	35.7%
Specialty	9,419	10,312	-893	-8.7%	55,770	58,056	-2,286	1.4%	55,060	710	1.3%
PAYOR MIX											
Insurance %	3.03%	2.49%	0.54%		2.86%	2.47%	0.39%		2.55%	0.31%	
Medi-Cal %	76.81%	80.23%	-3.43%		77.95%	80.02%	-2.08%		78.39%	-0.44%	
Medicare %	15.40%	12.63%	2.77%		14.42%	12.89%	1.54%		14.31%	0.12%	
Other Govt %	1.89%	1.69%	0.20%		1.64%	1.70%	-0.05%		1.94%	-0.30%	
Self-Pay %	2.88%	2.96%	-0.08%		3.13%	2.93%	0.20%		2.82%	0.32%	
Total Payor Mix %	100.00%	100.00%	0.00%		100.00%	100.00%	0.00%		100.00%	0.00%	