Joint Planning Committee

AHS - City of Alameda Health Care District

Date: July 31, 2023

Time: 4 - 6 p.m.

LOCATION:
Alameda Health Hospital, 2070 Clinton Street, Alameda CA, Conference Room A

Join Zoom Meeting
Meeting ID: 875 8691 5000 Passcode: 930334
Dial by your location
+1 669 444 9171 US
+1 669 900 6833 US

District Board	District Board / AHS Liaison	Alameda Hospital Medical Staff	AHS	Others
Robert Deutsch M.D., President Gayle Codiga, Vice President Debi Stebbins Executive Director	David Sayen	Dr. Nikita Joshi - Chief of Staff and Medical Director of AH ED Dr. Pirnia – Orthopedic Surgeon and AH Vice Chief of Staff Dr. Tamina Isolani- Nagarvala AH Hospitalist Medical Director	Jeanette Dong - Chief Strategy Officer Richard Espinoza – CAO Post Acute Services Mark Fratzke – COO Mark Friedman – Board of Trustees Eric Gully – Director of Business Intelligence Mario Harding – CAO Community Hospitals James Helena – Director of Facilities Kimberly Miranda – Chief Financial Officer Grace Mesina – Director of Financial Planning Christy Tho Vo – Manger of Strategic Planning and Business Development Ethan Torrence – Fellow	Katy Ford – Ratcliff Architects Madelyn McClellan – Smith-Kargn Architecture Rowena Manlapaz – Alameda Community Member

1. Call to Order — Dr. Robert Deutsch, Mark Fratzke
2. Approval of Meeting Minutes from June 26, 2023, ENCLOSURE — Dr. Robert Deutsch
3. Review of Financial Implications of Option 3 for AHS — Kimberly Miranda
4. Update on Alameda Hospital Infrastructure — Mark Fratzke
5. Sterile Processing Department (SPD) — Dr. Robert Deutsch
6. Update on AB 869: Legislation extending 2030 Seismic Standards Deadline — Debi Stebbins
7. Update on Financing Strategy — Debi Stebbins

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8. New Program Updates	
A. Dementia Unit	Richard Espinoza
B. Mental Health Rehabilitation Center (MHRC)	Patricia Espeseth
9. Next Meeting Date	Dr. Robert Deutsch Mark Fratzke
10. Adjournment	Dr. Robert Deutsch

Joint Planning Committee Minutes

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Time: 4 - 6 p.m.

District Board	District Board / AHS Liaison	Alameda Hospital Medical Staff	AHS	Others
Robert Deutsch M.D., President Gayle Codiga, Vice President Debi Stebbins - Executive Director	David Sayen - Absent	Dr. Nikita Joshi - Chief of Staff and Medical Director of AH ED Dr. Pirnia – Orthopedic Surgeon and AH Vice Chief of Staff Dr. Tamina Isolani- Nagarvala AH Hospitalist Medical Director Dr. Laura Lang – Chair of Anesthesia / Perioperative Medical Director	Jeanette Dong - Chief Strategy Officer Richard Espinoza – CAO Post Acute Services Mark Fratzke – COO Mark Friedman – Board of Trustees Eric Gully – Absent Director of Business Intelligence Mario Harding – Absent CAO Community Hospitals James Helena – Director of Facilities Kimberly Miranda – Absent Chief Financial Officer Grace Mesina – Director of Financial Planning Christy Tho Vo – Manger of Strategic Planning and Business Development Ethan Torrence – Fellow	Katy Ford – Ratcliff Architects Madelyn McClellan – Absent Smith Karng Architects Rowena Manlapaz – Alameda Community Member

Agenda Item/Topic	Presentation and Discussion Notes	Action Items/ Follow-Up
Call to Order	The meeting was called to order at 4 p.m. by Dr. Robert Deutsch.	
Update on AB - 869	Dr. Deutsch briefly reviewed the minutes from March 23, 2023.	A motion to accept the March 23rd meeting minutes was made by Ms. Codiga and Seconded by Mr. Friedman. The motion was unanimously

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		carried.
Update on AB - 869	Ms. Stebbins informed the group that Assemblyman Wood sponsored a bill AB 869 which provides an extension of the seismic deadline to 2035. Under the bill hospitals must meet the criteria in one of four areas. 1. Being a rural hospital, which is not relevant to AH 2. Being within a 30-minute drive to the next hospital 3. A hospital has a higher-than-average level of revenue from Medi-Cal patients 4. A hospital attempted to float a revenue bond unsuccessfully. Alameda Hospital does not fit any of the criteria right now. Ms. Stebbins noted that the bill has passed the Assembly without opposition, including from SEIU. It is now with the California Senate and is subject to additional amendments. Ms. Stebbins added that she is working with ACHD, and a lobbyist named Dennis Cardoza, who works with CHA. Ms. Stebbins added that Mr. Cardoza had a possible conflict of interest due to his work with CHA. Ms. Stebbins did not feel that would be a problem if we decided to engage him. Ms. Stebbins also noted that Mr. Cardoza has particularly good ties with Assemblyman Wood's staff. The attempt is going to be to add Alameda Hospital under a new category of exceptions for the extension. Additionally, under AB 869 if a hospital can show continued financial distress that extension could be rolled over to subsequent years beyond 2035. Mr. Fratzke asked if we do not meet any of the four criteria now, what are we hoping to introduce into the bill that will allow us to influence or change the bill's language. Ms. Stebbins noted that it could have something to do with financial hardship. Ms. Stebbins also noted that even though a similar bill failed last year, it could focus on the unique geographic challenges of Alameda being cut off from the mainland in the event of an earthquake. One of these two options could be a potential language change for the bill. Mr. Fratzke asked what are the chances, or what are the odds of us being able to either alter back the bills language, or introduce a separate bill? Ms. Dong noted that since Mr. Wood is the chair of the Health Committee, she is positive that the speaker would support his bill and not welcome new legislation. Additionally, we are beyond the deadlines of introduction of a new bill. Ms. Stebbins added that she sent an email to ACHD on June 26, 2023, to see if the bill as been set for the Senate Health Committee. Ms. Dong added that we would have to shop amendments in the building around to members of the committee, and particularly the chair and the staff of the committee to see whether the language change is a doable amendment. Ms. Stebbins noted that this year the District Board has tried to avoid having separate lobbyists and	Ms. Stebbins will make the connection in Sacramento and with Mr. Cardoza to come up with specifics that would be helpful. Ms. Stebbins will set up another meeting with Lena Tam's office following the Board of Supervisors meeting on 06-27-23 to discuss the possibility for the 10.5 revenue bond along with AHS.

	instead coordinated with ACHD's advocacy efforts. Alameda is one of the highest-risk seismic areas in the State due to liquefaction risk and where it is on the fault. For that reason, certain groups may oppose an extension of the seismic retrofit. Mr. Fratzke asked Ms. Dong if a bill like this flew through and wasn't it covered by any revisions how long before it would be approved? Additionally, if it takes the journey of being revised and negotiated, how long would that take. Ms. Dong informed the group that negotiations continue until it gets to the Senate floor. Ms. Dong added that if you amend the bill hopefully before Senate Health Committee, and it is heard at Senate House with the amendment it then goes to the Senate floor. During that time the author can amend the bill, or another member can offer friendly amendments to the original sponsored author. When an amended bill is passed it goes back for concurrence on both sides. Ms. Dong added to also focus on the signature from Governor Newsom to a bill with an amendment. Ms. Dong noted this bill could be passed by the fall. There has been no indication this would be a two-year bill at this time. Ms. Dong added that we should develop a few options now that are doable and make Alameda Hospital eligible for the bill should it be codified. Ms. Dong also suggested retaining someone that has a relationship with Governor Newsome and his staff such as Dr. Galley, his Cabinet secretary. and others. Dr. Deutsch noted that the first step is, is specifically designing what amendments would be most viable. Ms. Dong added that the Governor is eyeing the bill now and the Democratic party analysis happens all at once when you get to the floor. So, everything should be done together. Ms. Stebbins added that Mr. Cardoza was informed the governor wants to get the seismic retrofit in place first. There has been no mention of funding from the state level, however there are a lot of hospitals in the same situation. Ms. Stebbins noted that she has had conversations with two lawyers from the Foley firm. Mark Shiabela and Brian Quint, both of whom are bond counsel. Mr. Quint also referred Ms. Stebbins to a financial advisor Gary Hicks. Both Mr. Quint and Mr. Hicks have participated in about 300 bond offerings. who has done about 300 financial analyses, supporting bond measures, feel that we could go out for a hospital revenue bond. This bond would be contingent on using the 6-million-dollar parcel tax to secure the bond. Often hospital revenue bonds are supposed to be paid back out of the proceeds of revenue coming from capital improvements. In this case, because the bond would be secured by 6 million dollars coming from the parcel tax, it is not considered as high risk for investors. Both Mr. Quint and Mr. Hicks felt that from their experience with bond measures, this would be a straightforward bond structure. Ms. Stebbins also noted that in order to be ready, we have to go back and revisit which option for seismic retrofit to pursue and develop definitive cost projections. Mr. Fratzke noted that Ms. Miranda will be able to provide financial options within the next 30 days. Dr. Deutsch added that after we decide on	

	to be the best option then we could see the feasibility of this hospital revenue bond using the parcel tax security. Dr. Deutsch also added if we fail, that might be sufficient to then tell Assemblyman Wood's Committee that we pursued bond financing unsuccessfully. Mr. Fratzke asked Ms. Stebbins if she had been informed how much could be borrowed against 6-million-dollar parcel tax? Ms. Stebbins noted she had not received that information but would like to provide a specific option to Mr. Hicks and Mr. Quint. Ms. Stebbins also noted that there could be a maximum bond of 75 to 100 million with a 5% interest rate over 20-30 years. Dr. Deutsch asked could part of the bond be considered to update the HVAC at AH. Ms. Stebbins noted that the bond money would not be available in time for replacement of the HVAC system. Ms. Stebbins also noted she received a call from Lena Tam's chief of staff, Jamie Yee, today and was asked to write a summary of the HVAC system for tomorrow morning's agenda for the Board of Supervisors to ask for consideration for the 10.5 million dollars. Ms. Stebbins added that Ms. Yee though the money would come from the Measure A roll over money. However, Ms. Stebbins has been informed by others there is not unspent Measure A rollover money this year. Mr. Freidman noted that he has worked with Mr. Hicks and Mr. Quint at the Eden Health District. Mr. Freidman added that one issue that always comes up is when refinancing or taking on debt is what the debt service coverage ratio is . Ms. Dong noted that it may be too late to get on the agenda for tomorrow's Board of Supervisors meeting. However, the Board of Supervisors meet at least twice a month so this issue could be placed on a future agenda. Ms. Stebbins noted that the Board of Supervisors meeting is open to the public and she will be in attendance. Mr. Friedman added that there is an item on the agenda to approve the rollover for measure A.	

Infrastructure Renovation update	Mr. Fratzke noted that next Wednesday, July 5, 2023, he will be presenting a plan to the AHS Finance Committee to replace the infrastructure. Mr. Fratzke added that the project will not be completed in one year but in increments over 4-5 years. Mr. Fratzke also added that we can secure a couple million dollars this year, however, it is not yet budgeted, and we would use about 50% of the emergency capital to be able to start funding something this year.	

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New Programs	Dr. Deutsch informed the groups that this committee is also looking at AHS programs that could be housed at Alameda Hospital. Mr. Espinoza presented the possibility of a Secure Dementia Unit. There are two secure dementia facilities in Alameda County. Mr. Espinoza added that most SNFs have moved away from secured units for residents who have advanced dementia. There is approximately 20 unused beds at Alameda Hospital on two-south. Mr. Espinoza noted that would require bringing up the space to SNF regulatory compliance. This would be for residents that have advanced dementia, special needs and wandering behavior. Mr. Espinoza added that many SNFs in our community deny admissions to such residents, because extra staff is needed to avoid patients eloping. Mr. Espinoza added that community SNFs are reimbursed at a Medi-Cal per diem rate. Most SNFs reimbursement rate is about $240, and if a CNA cost $200 a day, and another sitter is needed then they automatically lose money. AHS does admit these patients into their facilities, but it does potentially cause length of stay issues. As Distinct Part SNF's, we do receive more than double the free-standing rate. Ms. Stebbins asked Mr. Espinoza if they would lose any beds when upgrading the units to comply with the SNF regulations. An analysis done about 3 years ago projected 20 beds would be a good size. Mr. Espinoza added that a reevaluation may be needed because the regulations have changed recently and there can be no more than 2 beds per room. Mr. Fratzke added that Mr. Espinoza has been looking into two programs, the secure dementia unit and a Medi SNF unit. Between the two. Mr. Fratzke noted a Medi SNF Unit would be the better route. Mr. Espinoza added that a Medi SNF unit would handle clinically complex residents and might be more profitable due to a potential higher reimbursement. <u>Mental Health Rehab Center</u> Ms. Espeseth outlined an option for a Mental Health Rehab center. This would be a sub-acute psychiatric setting that is a locked. In Alameda County there are many families, advocates, care providers who are always looking for these facilities. Ms. Espeseth noted that many patients in the mental health setting become stable but still need to have their symptoms managed. Many of these patients do not do well in the community and end up returning to the hospital. There is a great need for this level of care. For example, there are patients at John, George ready to be placed in a lower level of care facility but are staying for up to 6 to 8 weeks because there are not any open beds. One example of a sub-acute facility in our community is Villa Fairmont, which is about 100 bed facility. In Alameda County, we get about 13 of those beds' patients a month. Ms. Espeseth noted there are several people that that get placed on the Admin days. An admin day means that somebody's reached medical stability for the acute setting, they are stabilized on their meds, and they are ready to step down to a lower facility. However, there are about 24% to 35% of these patients waiting to get a lower level bed without	Mr. Espinoza will continue to investigate both the programs. The Medi SNF and a Secure Dementia facility and run a parallel cost analysis to be presented during the July meeting.

	anywhere to go. Ms. Espeseth added in a sub-acute facility, everyone who goes there has been put on a temporary LPS as a site conservatorship. The legal system and conservators assess that this person really is not safe to step back to the community. They to be placed in another locked setting that focuses more on the patient's own self-care skills. There are also more rehab services that are geared towards reentry so the patients can get back to independent living. Ms. Espeseth noted the length of stay is 3-6 months and the demand would be high. People could stay up to a year but to be more realistic and meet the needs of the community it is best to stay within the 3–6-month period. Dr. Deutsch noted that right now there is a unit at Alameda Hospital that could support any one of these programs with about 20 beds. Dr. Deutsch suggested AHS evaluate what they feel to be the most important need and coming back to the committee with recommendations. Mr. Fratzke suggested taking each one of the scenarios and the bed compliments they have and figuring out the financial aspects based on the program(s).Dr. Joshi added it would be helpful to see the programs broken down into the number of beds and comparing the programs to see which one could take advantage of the preexisting resources of doctors, hospitals, etc. Dr. Joshi asked what the timeline is we are looking at for how this decision would get made. Mr. Fratzke noted that it would be best to understand each scenario and the profitability of each of them. For example, if we were to convert the Fairmount campus to a Medi Psych unit it would cost about 8 million dollars. Mr. Fratzke also noted that the SNF codes are outside of the seismic upgrades. Dr. Deutsch added that all of these proposals are very preliminary and once we see them broken down there may be some programs that can take place in the near term and dovetail into the 2030 requirements. Mr. Fratzke noted that it seems the most important thing to be would be to understand how much financial capital we need. Dr. Deutsch suggested taking option 3 as a starting point and figuring out which program could fit into this option. Ms. Ford noted that Option 3 would convert Stephens Wing's 3rd floor from Med Surg to SNF. Keeping 35 sub-acute beds, 31 acute and an additional 16 SNF beds. Ms. Stebbins noted that the 3rd floor is the biggest space in the Stephens Wing at Alameda Hospital. Mr. Fratzke also added that AHS is currently working on the profitability of all these scenarios. Ms. Stebbins suggested overlaying the programs on top of option three. Mr. Fratzke suggested just looking at option 3 next month and the other options the following month.	

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Financial Presentation	Ms. Mesina presented the current financial statement for Alameda with actual 2022 finances and projected 2023 finances. Alameda's patient population has a net revenue collection that is higher than we had allocated to AH in the past. The collection percentage has been updated to 16.2% for 2022 and, and 16.4 % for 2023.The collection percentage is based on actual patient collection for all Alameda patients. The pro fees and expense revenues and expenses allocated are based on gross charges. Ms. Mesina and her team are still confirming some of the pro fee expenses and will provide that at next meeting. The HPAC revenue is allocated, based on the percent of all of the hospital to total HPAC charges. Ms. Mesina noted that South Shore moved to the Fairmont campus in November 2022 so, this is not in the projected 2023 financials yet. Other government programs. You can see a 5.6-million-dollar reduction due to payback from SNF supplemental for prior years. The total amount in feedback is about $4.8 to 5 million dollars. There is also an AB85 realignment reserves for potential feedback. This will change because we have reevaluated the analysis on the AB realignment reserve and will not have to pay back as much as planned, therefore releasing mor reserves that will increase revenue. Ms. Mesina also noted the collection percentage improved by .2 % and there has been a decrease in surgeries by 20% from the current year to prior year due to Orthopedic Surgeries moving to San Leandro. There has also been a decrease in SNF days due to South Shore moving to Fairmont. Ms. Mesina noted there is a higher labor cost from 2022-2023 because of the volume in acute patient days. Labor shortages have resulted in more overtime and registry use. Mr. Fratzke asked if the projected54,000 SNF days for 2023 is lower than the 57,000 SNF days from 2022 due to the move of South Shore to Fairmont. Ms. Mesina confirmed this is accurate. Ms. Stebbins also asked if there was an ETA on when South Shore would move back to its facility and Mr. Espinoza confirmed it move back in October 2023. Ms. Mesina and her team will build South Shore into the future financial models to be presented at the next meeting(s). Ms. Mesina presented the 5 areas of service at Alameda Hospital. <u>Emergency Room</u> – Ms. Mesina noted that the community includes anyone that comes in through the community while transfers are anyone who is sent from San Leandro and Highland. The payor mix for this area consist of Medicare, Medi-Cal, and private insurance, which is around 10% and is down from last year. Ms. Mesina also noted that 50% of patients being admitted to the ED come from the City of Alameda. Ms. Mesina added that common DRGs of patients admitted through the ED are sepsis heart failure, cellulitis, and respiratory infections.	Ms. Mesina and her team will provide all of the pro fee expenses at the July JPC meeting. Ms. Mesina and her team will build South Shore into future financial models to be presented at the July meeting.

	Non- Emergency Room – Ms. Mesina noted that majority of the transfers come from Highland Hospital, and they are directly admitted into the unit. There are about 1,300 days being transferred into Alameda. Ms. Stebbins asked if there is a good gauge on Observation Days. Mr. Fratzke noted that Observation Days are not always used appropriately across our whole system. This is a part of a new initiative starting at Highland. The transfer in DRGs are mostly heart failure, hemorrhage, and some sepsis. Ms. Mesina noted the "other" category is so large because it is a lot of little things that add up as there are over 800 DRGs. Sub- Acute – There is a negative operating margin for the subacute unit due to higher expenses. Mr. Espinoza noted that the direct overhead increased due to union contracts. Ms. Mesina noted that the Direct overhead includes any cost center such as nursing administration and case management, that is housed at Alameda Hospital. Most of the patients are coming from Oakland and Alameda. Ms. Mesina also noted that the payor mix is predominantly Medi-Cal. Wound Care – Ms. Mesina noted the volume has gone up by 750 patient visits. The net revenue collection has decreased due to because the payor mix shift from insurance to Medicare.46% of the patients are from Oakland , 11 % are from Alameda and the payor mix went down by 2% in insurance and increase in Medi-Cal managed care at 2.9%. SNF- Ms. Mesina noted that the SNF includes South Shore for 5 months and Park Bridge. Patients were transferred to Fairmont starting in November 2022 . 43% of the patients are from Alameda, 27% are from Oakland. Ms. Mesina noted that she and her team are working on the current next steps for the July meeting including validating the professional fee allocations, carving out the ICU and impact of not ICU, how many beds should be converted to the SNF. Ms. Mesina noted that each one of these options will be built out with financials, and as we discussed earlier, and option 3 will be provided first at the July meeting with the others to follow for future meetings.	
Adjournment	Dr. Deutsch adjourned the meeting at 5:45 pm	

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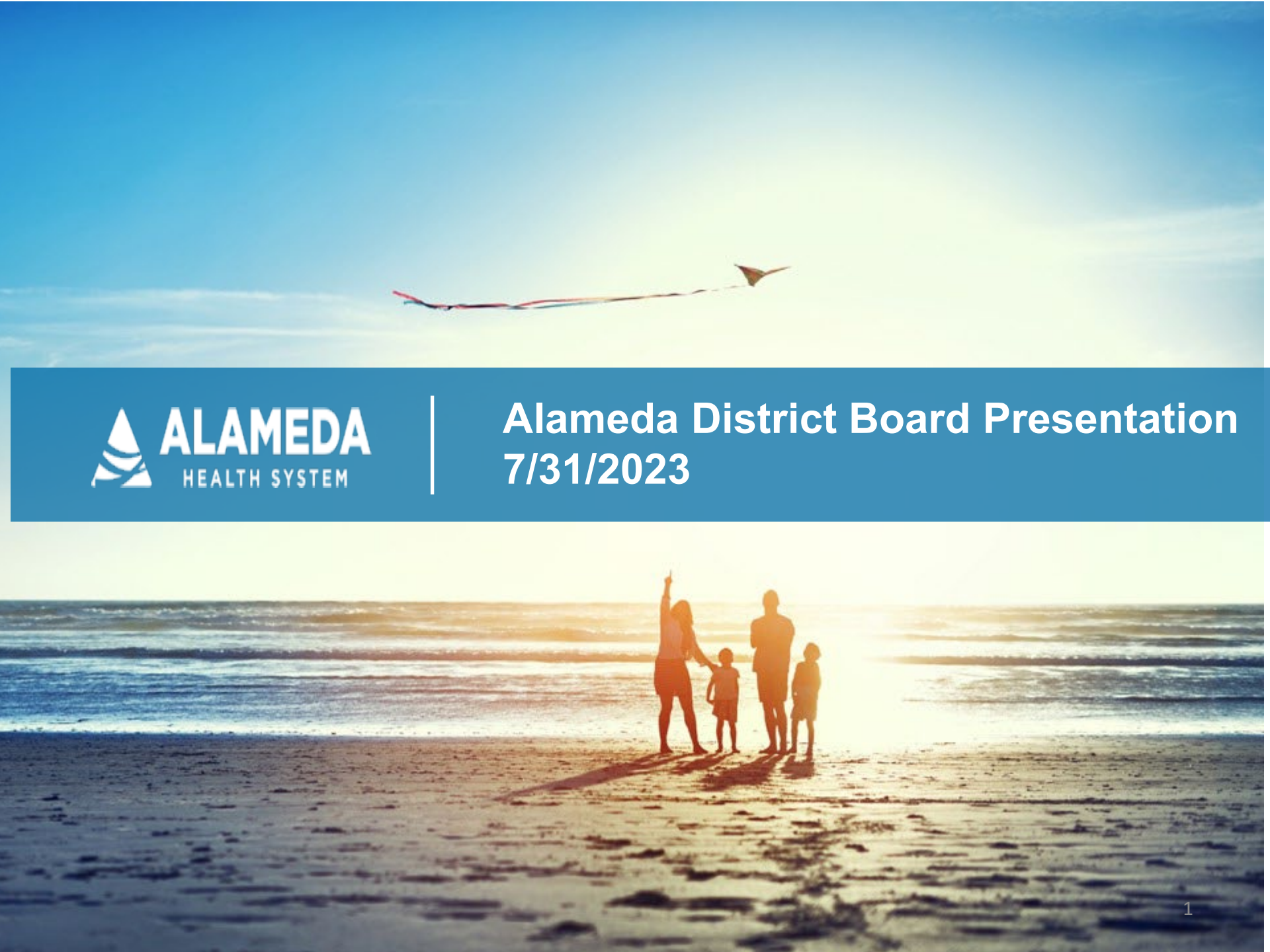
Minutes submitted by: Alixandria Williams, Executive Assistant

Approved: _____



ALAMEDA HEALTH SYSTEM

Alameda District Board Presentation 7/31/2023

Agenda

- Current state financial review for six service areas:
  - ❑ Emergency Room Activity
  - ❑ Electives
  - ❑ Sub-Acute
  - ❑ Wound care
  - ❑ SNF (Park Bridge & South Shore)
  - ❑ Other (lab and other ancillary services from other AHS facilities)
- Option 1 - No Stephens upgrade, relocate kitchen, IT. Total cost $102M . Convert 29 med/surg beds to SNF beds.
- Option 3 - Stephens upgrade; Total cost $75M . Convert 29 med/surg beds to SNF beds

Alameda Hospital: Baseline is FY23 (May 23 Annualized)

In Thousands	ER Room Activity	Electives	Sub-Acute	Wound Care	SNF	Other (Lab)	Total
	CURRENT STATE ACT FY2023 (11 months Annualized)						
Operating Revenue ----------							
Net Patient Revenue	57,424	19,570	14,881	4,106	22,170	1,474	119,626
County HPAC	911	3,229	52	1		95	4,288
Other Government Programs	9,599	3,033	2,224	612	3,181	198	18,847
Parcel tax Revenue	2,854	902	661	182	946	59	5,603
Other Revenues	227	72	52	14	75	5	445
Total Revenue - All Sources	**71,015**	**26,805**	**17,871**	**4,915**	**26,371**	**1,831**	**148,808**
Collection %	**16.3%**	**15.2%**	**18.6%**	**17.1%**	**19.4%**	**20.7%**	**16.9%**
Operating Expenses ----------							
Labor costs	52,440	17,631	14,383	1,486	14,424	636	101,000
Physician contract services	4,986	1,575	230	36			6,828
Purchased services	2,717	1,805	786	516	1,248	244	7,315
Materials and supplies	5,827	3,738	1,476	645	1,581	180	13,448
Facilities	2,223	711	735	150	71	45	3,935
Depreciation and amortization	2,195	777	407	396	982	47	4,803
General and administrative	145	46	33	1	68	4	297
Estimated call fee	2,914						2,914
Allocate Professional Services	2,849	7,960	6	813	29		11,656
Total Operating Expenses	**76,294**	**34,244**	**18,056**	**4,043**	**18,403**	**1,155**	**152,195**
Operating Income (Loss)	**-5,279**	**-7,439**	**-184**	**872**	**7,968**	**675**	**-3,387**
Operating Margin	**-7.4%**	**-27.8%**	**-1.0%**	**17.7%**	**30.2%**	**36.9%**	**-2.3%**
Total Paid FTEs	252.51	89.32	83.47	10.57	161.70	4.30	601.87

Assumptions:

- Collection % based on actual closed patient accounts and varies slightly from entity financial stmt.
- Pro-fees revenue is actual payments for patient.
- Allocated 20% of AHMG expenses to ED. The rest is allocated based on Pro-fee gross charges.
- HPAC revenue is allocated based on percent of Alameda hospital HPAC charges against AHS HPAC total charges
- South Shore moved to Fairmont campus in November 2022. *Fairmont excluded from proforma.*
- System overhead & Suppl. funding not allocated. Net is negative on entity financials based on WIPFLI allocation.

Alameda Hospital: Statistics (May 23 Annualized)

In Thousands	CURRENT STATE ACT FY2023 (11 months Annualized) ER Room Activity	Electives	Sub-Acute	Wound Care	SNF	Other (Lab)	Total
Acute Care							
Acute Patient Days	11,706	3,596	-	-	-	-	15,303
Acute Discharges	-	-	-	-	-	-	2,706.45
Observation Equiv Days	956	744	-	-	-	1,700	1,700
Avg. Daily Census (ADC)	32.07	9.85	-	-	-	-	41.92
Avg. Lengh of Stay (LOS)	5.1	5.8	-	-	-	-	5.3
Expected Lengh of Stay (LOS)	3.9	3.1					3.7
Occupancy							64%
Surgeries	*490*	*1,113*	-	-	-	-	*1,603*
Emergency Visits	*16,836*	-	-	-	-	-	*16,836*
Transfers in from Highland ED	-	-	-	-	-	-	*435*
Wound Care visits	-	-	-	*8,223*	-	-	*8,223*
SNF							
SNF Patient days	-	-	*12,287*	-	*41,688*	-	*53,975*
Discharges	-	-	-	-	-	-	*135*
Average Daily Census	-	-	33.66	-	114.21	-	147.88
Occupancy			96%		87%		
Payor Mix							
Insurance	11%	7%	2%	11%	1%	3%	7%
Medi-Cal	7%	8%	94%	0%	68%	22%	27%
Medi-Cal MC	27%	48%	0%	31%	25%	46%	27%
Medicare	40%	22%	1%	42%	1%	16%	26%
Medicare MC	12%	4%	0%	16%	3%	6%	8%
Other Govt	2%	8%	0%	0%	2%	4%	2%
Self Pay	2%	1%	3%	0%	100%	2%	2%

Alameda Hospital – Option 1
No Stephens upgrade, relocate Kitchen & IT

In Thousands	ER Room Activity	Electives	Sub-Acute	Wound Care	SNF	Other (Lab)	Total
	Option 1 - No Stephens upgrade, relocate kitchen, IT. Convert 29 med/surg beds to SNF beds						
Operating Revenue ----------							
Net Patient Revenue	56,735	4,288	14,881	4,106	25,131	1,474	106,616
County HPAC	911	1,172	52	1		95	2,231
Other Government Programs	$9,284	$751	$2,224	$612	$3,603	$198	$16,672
Parcel tax Revenue	$2,854	$902	$661	$182	$946	$59	$5,603
Other Revenues	$227	-$51	$52	$14	$85	$5	$332
Total Revenue - All Sources	**70,011**	**7,062**	**17,871**	**4,915**	**29,764**	**1,831**	**131,455**
Collection %	**16.6%**	**12.5%**	**18.6%**	**17.1%**	**19.4%**	**20.7%**	**17.3%**
Operating Expenses ----------							
Labor costs	50,902	3,968	14,383	1,486	16,357	636	87,731
Physician contract services	4,855	390	230	36			5,511
Purchased services	2,641	561	786	516	1,410	244	6,158
Materials and supplies	5,656	1,175	1,476	645	1,799	180	10,931
Facilities	2,163	179	735	150	77	45	3,348
Depreciation and amortization	2,139	215	407	396	1,124	47	4,327
General and administrative	141	12	33	1	72	4	263
Estimated call fee	2,839						2,839
Allocate Professional Services	2,829	2,886	6	813	33		6,566
Total Operating Expenses	**74,164**	**9,385**	**18,056**	**4,043**	**20,872**	**1,155**	**127,675**
Operating Income (Loss)	**-4,153**	**-2,323**	**-184**	**872**	**8,893**	**675**	**3,780**
Operating Margin	**-5.9%**	**-32.9%**	**-1.0%**	**17.7%**	**29.9%**	**36.9%**	**2.9%**
Total Paid FTEs	239.89	21.04	83.47	10.57	181.68	4.30	540.94

Assumptions:

- Removed 100% of transfers and elective surgery to reduce acute beds to 31 at 82% occupancy.
- Park Bridge payer mix, revenue and labor rates used to open hospital SNF with 16 beds at 95% occupancy.
- Improvement in LOS of 5% or 0.26 day.
- $1.1M is the risk not achieving the LOS reduction.

Alameda Hospital – Option 3
Stephens upgrade

Option 3-Stephens upgrade; convert 29 med/surg beds to SNF beds							
In Thousands	ER Room Activity	Electives	Sub-Acute	Wound Care	SNF	Other (Lab)	Total
Operating Revenue ----------							
Net Patient Revenue	56,735	4,288	14,881	4,106	25,131	1,474	106,616
County HPAC	911	1,172	52	1		95	2,231
Other Government Programs	$9,284	$751	$2,224	$612	$3,603	$198	$16,672
Parcel tax Revenue	$2,854	$902	$661	$182	$946	$59	$5,603
Other Revenues	$227	-$51	$52	$14	$85	$5	$332
Total Revenue - All Sources	**70,011**	**7,062**	**17,871**	**4,915**	**29,764**	**1,831**	**131,455**
Collection %	**16.6%**	**12.5%**	**18.6%**	**17.1%**	**19.4%**	**20.7%**	**17.3%**
Operating Expenses ----------							
Labor costs	50,902	3,968	14,383	1,486	16,357	636	87,731
Physician contract services	4,855	390	230	36			5,511
Purchased services	2,641	561	786	516	1,410	244	6,158
Materials and supplies	5,656	1,175	1,476	645	1,799	180	10,931
Facilities	2,163	179	735	150	77	45	3,348
Depreciation and amortization	2,139	215	407	396	1,124	47	4,327
General and administrative	141	12	33	1	72	4	263
Estimated call fee	2,839						2,839
Allocate Professional Services	2,829	2,886	6	813	33		6,566
Total Operating Expenses	**74,164**	**9,385**	**18,056**	**4,043**	**20,872**	**1,155**	**127,675**
Operating Income (Loss)	**-4,153**	**-2,323**	**-184**	**872**	**8,893**	**675**	**3,780**
Operating Margin	**-5.9%**	**-32.9%**	**-1.0%**	**17.7%**	**29.9%**	**36.9%**	**2.9%**
Total Paid FTEs	239.89	21.04	83.47	10.57	181.68	4.30	540.94

Assumptions:

- Same assumptions as Option 1

Financial Report
Electives for FY23

Elective Groups	Net Patient Revenue
Elective procedures	$2,795,551
Elective surgery	3,991,398
HGH/SLH Transfer	8,282,805
Total	**$15,069,754**

- Elective Procedures (outpatient)

Cost Center	Unit	Charges
77500-AHD CLINICAL LABORATORY	10,959	$ 2,206,755
77501-AHD MICROBIOLOGY	529	$ 121,358
77590-AH CARDIOLOGY EKG	427	$ 1,502,679
77630-AHD DIAGNOSTIC IMAGING	4,345	$ 2,705,416
77660-AHD MAGNETIC RESONANCE MI	2,272	$ 10,436,611
77670-AHD ULTRASONOGRAPHY	1,487	$ 1,827,379
77675-AHD VASCULAR LAB	262	$ 745,581
77680-AHD CT SCANNER	489	$ 2,398,055
77770-AHD PHYSICAL THERAPY	10,043	$ 3,108,652
77790-AHD OCCUPATIONAL THERAPY	1,568	$ 426,701
Grand Total-	32,380	$ 25,479,188

- Elective Surgery

	Surgery Cases	% of cases
Orthopaedic Surgery	440	40%
Obstetrics and Gynecology	275	25%
Urogynecology	220	20%
Urology	91	8%
Gynecologic Oncology	50	5%
Gastroenterology	17	2%
Vascular Surgery	8	1%
General Surgery	2	0%
Grand Total	1,103	100%

Alameda Hospital: Statistics For Options 1 and 3

In Thousands	ER Room Activity	Electives	Sub-Acute	Wound Care	SNF	Other (Lab)	Total
	Options 1 and 3						
Acute Care							
Acute Patient Days	11,706	-					11,706
Acute Discharges	3,038	-					3,038
Observation Equiv Days							1,700
Avg. Daily Census (ADC)	32.07	-	-	-	-	-	32.07
Avg. Lengh of Stay (LOS)	4.99	-					4.99
Expected Lengh of Stay (LOS)	3.9	-					3.9
Occupancy	82%	-					82%
Surgeries	490	0					490
Emergency Visits	16,836	-					16,836
Transfers in from Highland ED							-
Wound Care visits				8,223	-	-	8,223
SNF							
SNF Patient days	-	-	12,287	-	47,236	-	59,523
Discharges	-	-	-	-	-	-	135
Average Daily Census	-	-	33.66	-	129.41	-	163.08
Occupancy			96%		88%		90%
Payor Mix							
Insurance	11%	7%	2%	11%	1%	3%	7%
Medi-Cal	7%	8%	94%	0%	68%	22%	27%
Medi-Cal MC	27%	48%	0%	31%	25%	46%	27%
Medicare	40%	22%	1%	42%	1%	16%	26%
Medicare MC	12%	4%	0%	16%	3%	6%	8%
Other Govt	2%	8%	0%	0%	2%	4%	2%
Self Pay	100%	1%	3%	0%	100%	2%	2%

Alameda Hospital – Summary option 1 & 3

	Current State - (Annualized from May23 YTD)			Option 1 - No Stephens upgrade, relocate kitchen, IT. Convert 29 med/surg beds to SNF beds			Option 3-Stephens upgrade; convert 29 med/surg beds to SNF beds		
CAPITAL COST						$102M			$75M
BED COUNTS	Available	Volume	Occupancy	Available	Volume	Occupancy	Available	Volume	Occupancy
ICU	8	6	72%	8	6	72%	8	6	72%
Tel	31	17	56%	31	26	85%	31	26	85%
Med/Surg	27	19	69%	-	-	0%	-		
Total Acute	**66**	**42**	**64%**	**39**	**32**	**82%**	**39**	**32**	**82%**
Sub-Acute	35	34	96%	35	34	96%	35	34	96%
New SNF	-	-	0%	16	15	0%	16	15	0%
Total	**167**	**118**	**70%**	**129**	**113**	**88%**	**129**	**113**	**88%**
Return on Investment (ROI)									
Operating Income (Loss)						$ 3,779,742			$ 3,779,742
Capital costs						(102,000,000)			(75,000,000)
# of years to payback						**27.0**			**19.8**

Notes:

- Bed counts for option 1 and 3 are the same.
- Assuming the inflation rates for revenues and expenses will be the same, payback for option 1 will be 27 years and 20 years for option 3.

Amortization of Bonds

		Option 1	Option 2	Option 3	Option 4
Loan Amount		$102,000,000	$60,000,000	$75,000,000	$120,000,000
Interest Rate	6.00%				
# Years	30				
Annual Payment		**$7,338,498**	**$4,316,764**	**$5,395,955**	**$8,633,528**

Notes:

- Assume an interest rate of 6% over 30-year loan.
- Does not include costs to issue bonds, need a better assumption
- $5.6M Parcel tax revenue may support a loan below $75M

Alameda Hospital Financial Report
Next Steps

Next Steps

- Complete options 2 and 4 which require assumptions?

Option 2: no change in acute bed types requires staffing for all licensed beds at 80-85% occupancy rate? Current acute occupancy rate for licensed beds is 62%.

  - Which services can grow volume?
    - Geri psych?
    - Detox Unit?
    - Other?
- Option 4: Convert all beds to SNF and close Hospital.
  - Future SNF reimbursement rate without Hospital. What is new lower rate?

- Other ideas:
- What are the regulatory requirements to reduce emergency services and ICU beds to lower costs. What are legal hospital licensing requirements?
- Is there options to better utilize surgical suites and manage patients better?
- Consider opening a medical SNF in hospital with more short term stays and improved blended payer mix to increase revenue?
- How do we handle cost covid will these go down? Need to identify fixed cost that do not flex with volume.
- Finalize FY23 and FY22 to provide some trend data.
- Finalize CCU costs
  - Smaller unit and transfer to Highland for certain patients.
  - Patient Management: possible opportunity to move to lower cost of care setting sooner

APPENDIX

Financial Report
AHD Key Facts

- Alameda District Hospital acute average daily census runs approximately 59% occupancy; mostly admissions coming through the ED. YTD census is 38.6.
  - Med surg, 27) and Tele, 31 (58 beds,)
  - ICU census (8 Beds)
  - Clinics include Wound Care Clinic

- Skilled Nursing runs at approximately 94% capacity; mostly admissions from AHS hospitals.
  - Hospital (Subacute 35 beds)
  - Park Bridge (120 beds) and
  - Fairmont South Shore (26 beds) moved to Fairmont campus in November 2022.

Alameda Hospital
Seismic Retrofit Options For Acute Compliance 2030

	OPTION 1 – NO STEPHENS UPGRADE; RELOCATE KITCHEN, IT	OPTION 2 – STEPHENS WING UPGRADE; KEEP EXISTING BED TYPE	OPTION 3 – STEPHENS UPGRADE; CONVERT 29 MED SURG BEDS TO SNF BEDS	OPTION 4 – MAX SNF LONG TERM CARE. DOWNSIZE ACUTE BEDS IN SOUTH WING TO HOLDING UNIT AND REPLACE WITH SNF BEDS
BASIC COMPONENTS	• Maintain Stephens Wing in current SPC 2 rating; Stephens 2nd Floor remains SubAcute. • Stephens Wing 3rd floor has to convert Med Surg beds to SubAcute (SNF) making Stephens Wing an OSHPD2 building, instead of OSHPD1 acute care • Upgrade West Wing SPC 4D • Upgrade West and South buildings to 2030 NPC4 • Upgrade campus to NPC5 (New 5000 gal water storage tank, generator and electrical upgrade, waste storage onsite.	• Upgrade Stephens Wing to SPC 4D (Stephens wing already retrofit for kitchen, IT and Geotech) • Upgrade West Wing SPC 4D • Upgrade all buildings to 2030 NPC4 • Upgrade campus to NPC5 (New 5000 gal water storage tank, generator and electrical upgrade, waste storage onsite.	• Upgrade Stephens Wing to SPC 4D (Stephens wing already retrofit for kitchen, IT and Geotech) • Upgrade West Wing SPC 4D • Upgrade all buildings to 2030 NPC4 • Upgrade campus to NPC5 (New 5000 gal water storage tank, generator and electrical upgrade, waste storage onsite).	• Upgrade Stephens Wing to SPC 4D (Stephens wing already retrofit for kitchen, IT and Geotech) • Upgrade West Wing SPC 4D • Upgrade all buildings to 2030 NPC4 • Upgrade campus to NPC5 (New 5000 gal water storage tank, generator and electrical upgrade, waste storage onsite.
COST ESTIMATES (in $ Millions) (Dollar amounts are Rough Orders of Magnitude and not vetted by Cost Estimating firm yet)	• **18 -20 M** - Relocation of Kitchen • **4 M** - IT Relocation • **5 M** - Stairway/Staff Elevator: Stephens to West Wing • **12 - 15 M** - Upgrade West Wing to SPC 4D; Seismic Upgrade • **3 - 4 M** - NPC 4 and 5 Upgrade • **7 - 10 M** - Convert 3rd Floor to 15 bed SNF • **10 - 15 M** - Re-skin exterior of South Wing (optional) • **12 M - 15 M** - Soft Costs (Geotech, Design, Permitting, Inspections) (+20%) • **12 M – 15 M** - Contingency, Escalation (+20%) **TOTAL: 82 - 102 M**	• **22 - 24 M** - Upgrade Stephens Wing to SPC 4D – Seismic Upgrade • **12 - 15 M** - Upgrade West Wing to SPC 4D - Seismic Upgrade • **3 - 4 M** NPC 4 and 5 Upgrade • **7- 19 M** - Soft Costs (Geotech, Design, Permitting, Inspections) (+20%) • **7 - 9 M** – Contingency and Escalation (+20%) **TOTAL: 52 - 60 M**	• **22 - 24 M** - Upgrade Stephens Wing to SPC 4D – Seismic Upgrade • **7 - 10 M** – Convert 3rd floor to 16 bed SNF • **12 - 15 M** - Upgrade West Wing to SPC 4D - Seismic Upgrade • **3 -14 M** NPC 4 and 5 Upgrade • **9 – 11 M** - Soft Costs (Geotech, Design, Permitting, Inspections) (+20%) • **9 - 11 M** – Contingency and Escalation (+20%) • **TOTAL: 62 - 75 M**	• **22 - 24 M** - Upgrade Stephens Wing to SPC 4D – Seismic Upgrade • **12 - 15 M** - Upgrade West Wing to SPC 4D - Seismic Upgrade • **3 - 4 M** NPC 4 and 5 Upgrade • **7- 19 M** - Soft Costs (Geotech, Design, Permitting, Inspections) (+20%) • **7 - 9 M** – Contingency and Escalation (+20%) **TOTAL: 100 - 120 M**
BED COUNTS	**BEDS:** **Lose 27 Med surg beds, gain 16 SNF for net loss of 11 beds. From 101 currently licensed beds to 90.**	**RESULTING BEDS:** **CCU: 8 beds remain** **Sub Acute: 12 +23 = 35 (could be less after seismic work)** **Acute: 58 Beds (could be less after seismic work)** **2nd floor beds tbd**	**RESULTING BEDS:** **CCU: 8 beds remain** **Sub Acute: 12+23 beds =35 (could be less after seismic work)** **Acute: 31 beds*** **SNF +16 beds** *** Lose 11 net beds** **2nd floor beds tbd**	**RESULTING BEDS:** **CCU: None** **Sub Acute: 26 to 35 bed range** **SNF: adds 35 beds** **2nd floor 8 acute holding**