DOCTORS MEDICAL CENTER

West Contra Costa Healthcare District
Doctors Medical Center
Governing Body
Board of Directors

Wednesday, March 28, 2012
4:30 PM
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA

DOCTORS MEDICAL CENTER

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER

GOVERNING BODY
BOARD OF DIRECTORS

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS
MARCH 28, 2012 - 4:30 P.M.
Doctors Medical Center - Auditorium
2000 Vale Road
San Pablo, CA 94806

Board of Directors
Eric Zell, Chair
Supervisor John Gioia, Vice Chair
Irma Anderson
Wendel Brunner, M.D.
Deborah Campbell
Nancy Casazza
Sharon Drager, M.D.
Pat Godley
Richard Stern, M.D.
William Walker, M.D.
Beverly Wallace

AGENDA

1. **CALL TO ORDER** — E. Zell
2. **ROLL CALL**
3. **APPROVAL OF FEBRUARY 22, 2012 MINUTES** — E. Zell
4. **PUBLIC COMMENTS** — E. Zell
   [At this time persons in the audience may speak on any items not on the agenda and any other matter within the jurisdiction of the of the Governing Body]
5. **MEDICAL EXECUTIVE REPORT** — L. Hodgson, M.D.
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION:*
      i. *Acceptance of Medical Staff Report*
      ii. *Approval of Appointments, Reappointments and Changes of Staff Status and Procedures*
      iii. *Approval of the Revised Policies:*
         1. Disclosure and Resolution Policy
         2. Honorarium and Reimbursement Policy

6. **MOSS ADAMS: FINAL DRAFT AUDIT FOR FISCAL 2011 ANNUAL REPORT** — Joelle Pulver/ Chris Pritchard
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the Final Draft Audit Fiscal 2011Audit Report*

7. **QUALITY REPORT** — K. Taylor
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: For Information Only*

8. **FINANCIALS –FEBRUARY 2012** — J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the February 2012 Financials*

9. **3rd FLOOR TELEMETRY EXPANSION** — B. Ellerston
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the 3rd Floor Telemetry Expansion proposal to add a new 1.4HGz wireless telemetry system*

10. **PEDIATRIC COLONSCOPE** — B. Ellerston
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: Approval of two Certified Pre-Owned Olympus Pediatric Colonoscopies.*

11. **POLICIES** — B. Ellerston/ D. Gideon
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION:*
       1. *Approval of the Plan for the Provision of Care Policy*
       2. *Physician Transaction and Arrangement Policy*

12. **CALIFORNIA EMERGENCY PHYSICIANS** D. Gideon
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: Approval of CEP Renewal Contract*

13. **CEO UPDATE** D. Gideon
    a. Presentation
    b. Discussion
    c. Public Comment
    d. *ACTION: For Information Only*

ADJOURN TO CLOSED SESSION

A. Reports of Medical Staff Audit and Quality Assurance Pursuant to Health and Safety Code Sec. 32155.

B. Conference with Labor Negotiators (pursuant to Government Code Section 554957.6) Agency negotiators: John Hardy, Vice President of Human Resources: California Nurse Association, NUHW, Local 1

C. Conference with Legal Counsel: Pending Litigation pursuant to Government Code Section 54956.9(a): Pitchford vs DMC & West Contra Costa Healthcare District Case# 10-000360, Cabugos vs DMC & West Contra Costa Healthcare District Case # 11-01197, Goundar vs DMC & West Contra Costa Healthcare District Case#11-02685, Warfield vs DMC & West Contra Costa Healthcare District Case# 11-000509, Settlement out of court: Mikes vs DMC & West Contra Costa Healthcare District, Gardner vs DMC & West Contra Costa Healthcare District.

D. Conference with Legal Counsel: Anticipated Litigation pursuant to Government Code Section 54956.9(b)(1) (Potential Cases: 3)

E. Quality Assurance Matters (pursuant to Health & Safety Code Section 32155)

ANNOUNCEMENT OF REPORTABLE ACTION(S) TAKEN IN CLOSED SESSION, IF ANY.

DOCTORS
MEDICAL CENTER

MINUTES
February 22, 2012

TAB 3

DOCTORS MEDICAL CENTER

WCCHD DOCTORS MEDICAL CENTER
GOVERNING BODY BOARD OF DIRECTORS

February 29, 2012, 4:30 P.M.
DMC – Auditorium
2000 Vale Road
San Pablo, CA 94806

MINUTES

1. **CALL TO ORDER**

The meeting was called to order at 4:30 P.M.

2. **ROLL CALL**

Quorum was established and roll was called:

Present: *Supervisor John Gioia, Chair*
Eric Zell, Vice Chair
Wendel Brunner, M.D.
Deborah Campbell
Nancy Casazza
Sharon Drager, M.D.
Pat Godley
Richard Stern, M.D.
Beverly Wallace

Excused: *Irma Anderson*
William Walker, M.D.

3. **APPROVAL OF JANUARY 25, 2012 MINUTES**

The motion made by Dr. Sharon Drager and seconded by Director Campbell to approve the January 25, 2012 minutes passed unanimously.

4. **PUBLIC COMMENTS**

There were no public comments.

5. MEDICAL EXECUTIVE REPORT

Dr. Laurel Hodgson sought approval for the January Credentials Report and sought approval for the revised Look-Alike/Sound-Alike Medications Errors (LASA) Policy.

The motion made by Dr. Sharon Drager and seconded by Director Nancy Casazza to approve the Credentials Report and the revised Look-Alike/Sound-Alike Medications Errors (LASA) Policy passed unanimously.

6. FINANCIALS –JANUARY 2012

Mr. Jim Boatman, CFO, presented and sought approval of the January 2012 Financials. He reported patient volume decreased in January inpatient days was under by 7.7%. Year-to-date outpatient visits increased 1.75% in volume. Discharge LOS was under budget at 2.5.

Mr. Boatman reported a net loss was $1.6M in January, over what we anticipated. Payroll and supply expenses were under budget again. Worked FTE's were 5.8% below budget. Accounts Receivable Days grew to 80 days.

A motion made by Director Eric Zell and seconded by Dr. Sharon Drager to approve the January 2012 Financials passed unanimously.

7. CAPITAL EXPENDITURE REVIEW PROCESS POLICY: SIGNATURE AUTHORIZATION MATRIX

Mr. Boatman sought approval of the Capital Expenditure Review Policy, which included the Signature Authorization Matrix.

Supervisor John Gioia suggested that the approval dollar threshold by the Governing Board change from $100,000 to $25,000 for unbudgeted capital items.

A motion was made by Director Deborah Campbell and seconded by Director Nancy Casazza to approve the Capital Expenditure Review Process Policy, contingent to the approval dollar threshold change from $100,000 to $25,000 in the signature authorization matrix passed unanimously.

8. PATIENT CARE SERVICES POLICY: NURSING CARE FOR PATIENTS WITH ACUTE STROKE

Ms. Bobbie Ellerston, Vice President of Patient Care Services sought approval of the Patient Care Services Policy, to set nursing care guideline for patients with an acute stroke.

A motion made by Dr. Sharon Drager and seconded by Director Nancy Casazza to approve the Nursing Care for Patients with Acute Stroke Policy passed unanimously.

9. NURSING SERVICES

Ms. Ellerston gave a presentation on Nursing Services and provided the following overview:

- Leadership: Assessment planning for nursing leadership and organizational structure, provide education and mentoring program for new directors and leaders
- Quality: continue to build on quality improvements, strengthen wound and service recovery programs
- Fiscal Responsibility and Accountably
- Improving relations internally and externally

10. CEO UPDATE

Ms. Dawn Gideon, Interim President and CEO began her report by introducing Ms. Remy Goldsmith, the new Director of Community Relations. Ms. Goldsmith will start on March 12, 2012.

Ms. Gideon revisited three priorities:

1) Development of the Strategic Plan: We have retained the Camden Group to lead us through the strategic planning process. Steve Valentine, president of the organization has personally committed to work with us in this engagement. Camden is a national firm, California based, working with many providers in the Northern California market.

   All Directors have been contacted to interview with Camden for the week of March 12th. The goal is to have the Board involved throughout the development of the plan, and to take action in terms of approval of the plan in September 2012.

2) Patient Satisfaction: We participated in a group that came together back in January for the Patient Satisfaction Retreat. The group of 30 participants outlined many recommendations and initiatives to pursue, some of the back to basics and physicians activities that came out of the session. Most importantly, the group identified the biggest issues and greatest barriers to achieving patient satisfaction. The group was asked to come up with high visibility, quick hit opportunities to impact and improve patient satisfaction. The next meeting of this group will b scheduled for April, at which time we will review a proposed plan to address foundational issues, and specific patient dissatisfiers, and also our approach to some quick hit opportunities.

3) Recruiting Permanent Leadership: We have explored two different avenues, one is recruiting a permanent CEO, who would then come in and build a management team. The second option is to bring in a group who do long-term hospital management that

will be able to come in with significant depth and expertise in management team-building.

Mark Colins with Korn Ferry who had previously been retained by the Board is now reengaged in the process, and working to identify CEO candidate resumes. Ms. Gideon and Ms. Kathy White, Interim COO will initially interview a slate of candidates to present to the Board for consideration.

The Board will have the option to explore both opportunities and work to make a decision on the best approach, and then the best individual to bring to the organization. The process is underway. Ms. Gideon and Ms. White met with three of the five candidates and hope to have a recommendation on a slate of candidates to advance in the near future.

The urgency in making a decision on permanent leadership ties directly to the development of the strategic plan. We need to make sure that the people will be here helping the Board implement that plan are at here for some portion of its development.

11. ELECTION OF CHAIR AND VICE CHAIR

Supervisor Gioia opened the floor to nominations for a new Chair and Vice Chair of the Governing Body Board of Directors.

A motion was made by Dr. Sharon Drager and seconded by Director Deborah Campbell to appoint Direct Eric Zell as the Chair and Supervisor Gioia as Vice Chair of the Governing Body passed unanimously.

THE MEETING ADJOURNED TO CLOSED SESSION, 6:00 P.M.

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE REPORT

TAB 5

DOCTORS
MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
REPORT TO THE BOARD OF DIRECTORS
MARCH 2012

ITEM	ACTION
A. CHIEF OF STAFF REPORT	Informational
B. POLICIES, PROCEDURES & FORMS	Approval
C. CREDENTIALS REPORT – February 2012	Approval

DOCTORS MEDICAL CENTER

MEC APPROVAL DATE: 03/12/12

BOARD OF DIRECTORS APPROVAL DATE: 03/28/12

POLICY, PROCEDURE AND FORMS REPORT

March 2012

IN ACCORDANCE WITH MEDICAL STAFF BYLAWS, REGULATORY AND ACCREDITATION STANDARDS, THE POLICIES, PROCEDURES AND FORMS LISTED BELOW HAVE BEEN DEVELOPED AND/OR REVISED BY APPROPRIATE HOSPITAL AND/OR MEDICAL STAFF COMMITTEES AND HAVE BEEN APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE.

**NOTE: COPIES OF ALL POLICIES LISTED IN SECTION A AND SECTION B BELOW ARE ATTACHED TO THIS REPORT; THOSE POLICIES/DOCUMENTS LISTED IN SECTION C: REVISED WITH MINOR/NON-SUBSTANTIVE CHANGES, WILL BE AVAILABLE FOR REVIEW IN THE MEDICAL STAFF OFFICE AND ADMINISTRATION.*

POLICY/PROCEDURE/FORMS	TYPE	REASON FOR REVIEW	PAGE
A. Revised With Minor/Non-Substantive Changes			
1. Disclosure and Resolution	Medical Education/CME P&P	Revised to include definitions and to detail the process for any disclosed relevant financial relationships	1-3
2. Honorarium and Reimbursement	Medical Education/CME P&P	Revised to include definitions, added a faculty confirmation letter regarding payments and deleted honorariums to medical staff	4-6

DOCTORS MEDICAL CENTER

Manual: MEDICAL STAFF POLICIES AND PROCEDURES	Sub Folder: CME
Title: Disclosure and Resolution Policy	Reviewed: Revised: 2/21/12
Effective Date: 9/1/2010	Page 1 of 3

PURPOSE: To outline a process for assuring the Commercial Support Guidelines from ACCME relative to Planner and Faculty disclosure and resolution are met routinely.

POLICY: All conflicts of interest must be resolved prior to planner or faculty controlling any content approved for *AMA PRA Category 1 Credit™*.

DEFINITIONS:

A. ACCME – Accreditation Council for Continuing Medical Education is the nationally recognized accrediting agency for continuing medical education.

B. *AMA PRA Category 1 Credit™* – AMA's Physician's Recognition Award Credit System; also, referred as Category 1 CME.

C. CMA – California Medical Association is an advocacy organization active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients.

D. CME – Continuing Medical Education: Educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession.

E. CME Provider – Hospitals, professional societies and other entities that provide accredited CME to physicians.

F. Planner – Anyone in a position to control content during the planning stages of a CME activity.

G. Author – Anyone who controls content for a CME activity that is of a written nature.

H. Commercial Interest – Any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies.

I. Relevant Financial Relationships – Those relationships in which the individual benefits in any amount by receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g. Stocks, stock options or other ownership interest, excluding diversified mutual funds), or other financial benefit. Financial benefits are usually associated with roles such as employment, management position, independent contractor (including contracted research), consulting, clinical trials, speaking and teaching,

membership on advisory committees or review panels, board membership, and other activities from which remuneration is received or expected. ACCME considers relationships of the person involved in the CME activity to include financial relationships of a spouse or partner.

J. Conflict of Interest – A relationship with a commercial interest (a) that benefits the individual in any financial amount and (b) that has occurred in the past twelve (12) months; and the opportunity to affect the content of CME about the products or services of that commercial interest.

K. Resolution of Conflict of Interest – To alter the financial relationship with the commercial interest; and/or alter the individual's control over the CME content about the products or services of the commercial interest.

PROCEDURE:

A. The CME Coordinator sends a Faculty Disclosure Form and a copy of the ACCME Standards on Commercial Support to all faculty.

B. CME Committee member planners are given a new Planner Disclosure Form each year and asked to complete and sign it.

C. Planner Disclosure forms asks for disclosure of all RFRs that could possibly become a COI in any topic that may be approved for CME credit.

D. Faculty are asked for disclosure of any RFRs relating to the specific topic being presented.

E. At each CME Committee meeting member planners are asked if their disclosures have changed since the last meeting and are reminded that if they have any RFRs relative to the activities planned, they need to recuse themselves from planning content.

F. Any planner, faculty, or author not willing to make disclosure will not be allowed to control content of any CME activity.

G. Any planner with a RFR that becomes a COI must recuse him/herself from controlling content in any manner.

H. Faculty/Author who list RFRs, whether or not the RFRs are COIs, will be required to submit his/her PowerPoint slides and/or other written materials to the CME Coordinator at least one week prior to the scheduled activity.

I. CME Coordinator will submit the PowerPoint slides and/or written materials to a clinical member of the CME Committee.

J. A copy of the review, approval, request for change, etc. of the slides and/or written materials will be kept in the activity file until after the next IMQ survey of the CME program.

K. If review of slides/materials reveals any type of bias, the faculty/author will be asked to make necessary changes to removed bias.

L. If faculty/author does not make requested changes, prior to the activity, the activity will not be given CME credit.

M. A disclosure statement of all who controlled content must be made to the learners prior to the start of the activity either in writing or verbally.

N. Disclosure must include the following:
1. Name of planner, faculty, author who has or does not have a RFR
2. Whether the RFR is a COI
3. The type of RFR
4. The commercial company with which the RFR exists
5. How the COI was resolved
6. Whether or not a commercial grant was received for the activity

O. Written attestation of verbal disclosure of the above must be signed, placed in the activity file within 30 days, and kept in the activity file until after the next IMQ survey of the CME program.

P. Proof of written disclosure must be kept in the activity file until after the next IMQ survey of the CME program.

REFERENCES:

A. ACCME Standards for Commercial Support
B. IMQ/CMA CME Accreditation Standards Manual

CROSS REFERENCES:

A. None

ASSOCIATED DOCUMENTS:

A. Planner Disclosure Form
B. Faculty Disclosure Form
C. Disclosure Statement

APPROVALS:

A. CME Committee
B. Medical Executive Committee
C. Board of Directors

Responsible for review/updating (Title/Dept)	**CME Coordinator**	**Medical Staff Services**

DOCTORS MEDICAL CENTER

Manual: MEDICAL STAFF POLICIES AND PROCEDURES	Sub Folder: CME
Title: Honorarium & Reimbursement	Reviewed: Revised: 2/21/12
Effective Date: 9/1/2010	Page 1 of 3

PURPOSE: To establish guidelines to be used when offering payment amounts to faculty of CME activities.

POLICY: Honorarium & Reimbursement

DEFINITIONS:

A. ACCME – Accreditation Council for Continuing Medical Education is the nationally recognized accrediting agency for continuing medical education.

B. *AMA PRA Category 1 Credit*™ – AMA's Physician's Recognition Award Credit System; also, referred as Category 1 CME.

C. CMA – California Medical Association is an advocacy organization active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients.

D. CME – Continuing Medical Education: Educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession.

E. CME Provider – Hospitals, professional societies and other entities that provide accredited CME to physicians.

F. ACCME Standards for Commercial Support – Standard 2 – Appropriate Use of Commercial Support – 3.7 States "The provider must have written policies and procedures governing honoraria and reimbursement of out-of-pocket expenses in compliance with the provider's written policies and procedures."

G. Planner – Anyone in a position to control content during the planning stages of a CME activity.

H. Author – Anyone who controls content for a CME activity that is of a written nature.

I. Faculty – Anyone who controls content of a CME activity during the verbal presentation.

PROCEDURE:

1. Planners are not paid an honorarium for their role as a planner.

2. Faculty are only paid for that portion of an activity which they are responsible for the content.

3. After an activity is planned, the CME Coordinator contacts commercial companies and requests an educational grant to help underwrite honoraria and other activity expenses.

4. Faculty confirmation letters outline the amount of money they will be paid for their time and expertise. They are told they are not to accept payment from any other source for their services relating to the specific activity.

5. Without prior CME Committee approval honoraria is negotiated between speaker and the CME Coordinator. The Coordinator is authorized to offer up to $500 standard honoraria.

6. Requests for more than $500.00 must be approved by the CME Committee. When there is insufficient time for Committee approval, the Chair may approve up to $750.00.

7. Members of our medical staff are not paid an honorarium.

8. Outside our Medical Staff faculty will receive payment of reasonable honoraria and may receive reimbursement of out-of-pocket expenses. Honoraria amounts may range between $250.00 and $3,000.00 depending upon the following criteria:
    1. Length of activity
    2. Number of presentations delivered
    3. Distance traveled
    4. Time away from primary occupation
    5. Level of expertise with subject matter
    6. Local, regional or national stature

9. The honorarium for CME activities publicized with multiple faculty (including, but not limited to, panel members, physician facilitators, etc.) will be determined and approved by the CME Committee. The CME Committee will base its determination on the amount of preparation time required of each faculty member. The combined honoraria of multiple faculty members shall not exceed the amount of reasonable honorarium offered a single speaker.

10. Out-of-pocket expenses incurred by a planner, faculty, author, volunteer, or staff are reimbursed only for their official participation as agreed upon in advance and outlined in an agreement signed by the CME Coordinator and the person with whom the expense will occur.

11. Out-of-pocket expenses incurred by a planner/faculty/author on behalf of an activity approved by the CME Committee or the CME Chair are reimbursed. Types of expenses eligible for reimbursement are:
    1. Roundtrip Airfare (economy)
    2. Public or Private Ground Transportation (taxi, shuttle, bus)
    3. Rental Car (mid size)
    4. Gasoline for rental car
    5. Mileage at the current IRS rate
    6. Hotel (not to exceed $150.00 per night)
    7. Food (not to exceed $50.00 per day)

12. When payment of honorarium is required, the CME Coordinator requests a check in the amount needed from Medical Staff funds. The honorarium is mailed to the speaker along with a summary of the evaluation forms and thank you letter.

REFERENCES:

A. ACCME Standards for Commercial Support
B. IMQ/CMA CME Accreditation Standards Manual

CROSS REFERENCES:

A. Faculty Letter

ASSOCIATED DOCUMENTS

A. Faculty Letter
B. Honorarium & Reimbursement Form

APPROVALS

A. CME Committee
B. Medical Executive Committee
C. Board of Directors

Responsible for review/updating (Title/Dept)	**CME Coordinator**	**Medical Staff Services**

DOCTORS MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE
CREDENTIALS REPORT TO THE BOARD

FEBRUARY 2012

The following practitioners' applications for appointment and/or reappointment have been reviewed by the appropriate committees of the Medical Staff and have been deemed as complete and are recommended for approval by the Credentials Committee (02/23/12) and the Medical Executive Committee (03/12/12).

CREDENTIALS REPORT TO THE BOARD FEBRUARY 2012	
INITIAL APPOINTMENTS	
NAME	***DEPARTMENT/SPECIALTY***
Ariyan, Wendy, PAC	Surgery/Physician Assistant
Candell, Peter, MD	Medicine/Family Practice
Shiffman, Adam, PAC	Medicine/Family Practice/Emergency Medicine
Wu, Roland, MD	Medicine/Family Practice/Cardiology
REAPPOINTMENTS	
NAME	***DEPARTMENT/SPECIALTY***
Barazangi, Nobl, MD	Medicine/Family Practice/Neurology
Fox, Robert, MD	Medicine/Family Practice/Neurology
Iota-Herbei, Claudia, MD	Medicine/Family Practice/Nephrology
Moore, Jude, MD	Medicine/Family Practice/Emergency Medicine
Rose, Jack, MD	Medicine/Family Practice/Neurology
Tong, David, MD	Medicine/Family Practice/Neurology
RESIGNATIONS	
Barry, Piers, MD	Surgery/Orthopedic Surgery
Madiraju, Nalini, MD	Surgery/Pathology
Mealey, Forrest, DO	Medicine/Family Practice/Pulmonary Medicine
Schaner, Gregory, MD	Medicine/Family Practice/Radiology

DOCTORS
MEDICAL CENTER

MOSS ADAMS FINAL DRAFT AUDIT FOR FISCAL YEAR 2001 ANNUAL REPORT

TAB 6

DRAFT
3/21/12

Report of Independent Auditors and
Financial Statements with Supplemental Information

West Contra Costa Healthcare District

December 31, 2011 and 2010

CONTENTS

MANAGEMENT DISCUSSION AND ANALYSIS

Our discussion and analysis of West Contra Costa County Healthcare District's (the "District") financial performance provides an overview of the District's financial activities for the fiscal years ended December 31, 2011, 2010, and 2009. Please read it in conjunction with the District's financial statements, which begin on page 7.

Financial Highlights

- The District's net assets decreased in 2011 from 2010 by $18.7 million (65.9%) after an increase in 2010 from 2009 by $2.5 million (9.8%) and an increase in 2009 from 2008 of $11.0 million (74.6%).
- The District reported an operating loss of $31.2 million in 2011 after operating losses of $15.5 million in 2010 and $13.2 million in 2009.
- The District's net nonoperating revenues were $12.4 million in 2011 as compared to $18.0 million in 2010 and $24.3 million in 2009.

Using This Annual Report

The District's financial statements consist of three statements – a balance sheet; a statement of revenues, expenses, and changes in net assets; and a statement of cash flows. These financial statements and related notes provide information about the activities of the District, including resources held by the District but restricted for specific purposes by contributors, grantors, or enabling legislation.

The Balance Sheet and Statement of Revenues, Expenses, and Changes in Net Assets

Our analysis of the District's finances begins on page 1. One of the most important questions asked about the finances is, "Is the District as a whole better or worse off as a result of the year's activities?" The balance sheet and the statement of revenues, expenses, and changes in net assets report information about the District's resources and its activities in a way that helps answer this question. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All of the current year's revenues and expenses are taken into account regardless of when cash is received or paid.

These two statements report the District's net assets and changes in them. You can think of the District's net assets – the difference between assets and liabilities – as one way to measure the District's financial health, or financial position. Over time, increases or decreases in the District's assets are one indicator of whether its financial health is improving or deteriorating. You will need to consider other nonfinancial factors, however, such as changes in the District's patient base and measures of the quality of service it provides to the community, as well as local economic factors to assess the overall health of the District. Overall, the District is worse off at December 31, 2011 than it was December 31, 2010.

The Statement of Cash Flows

The final required statement is the statement of cash flows. The statement reports cash receipts, cash payments, and net changes in cash resulting from operations, investing, and financing activities. It provides answers to such questions as "Where did cash come from?" "What was cash used for?" and "What was the change in cash balance during the reporting period?"

The District's Net Assets

The District's net assets are the difference between its assets and liabilities reported in the balance sheets on page 7. The net assets decreased in 2011 by $18.7 million over 2010 after an increase in 2010 by $2.5 million over 2009 and an increase in 2009 by $11.0 million over 2008.

Table 1: Assets, Liabilities, and Net Assets

	2011	2010	2009
Assets			
Current assets	$ 67,264,000	$ 37,105,000	$ 39,577,000
Capital assets, net	44,782,000	45,407,000	44,033,000
Other noncurrent assets	1,992,000	1,186,000	1,228,000
Total assets	$ 114,038,000	$ 83,698,000	$ 84,838,000
Liabilities			
Current liabilities	$ 35,514,000	$ 32,316,000	$ 31,906,000
Other	68,852,000	22,982,000	27,077,000
Total liabilities	104,366,000	55,298,000	58,983,000
Net Assets (deficit)			
Invested in capital assets, net of related debt	8,380,000	21,890,000	18,667,000
Restricted expendable net assets	2,829,000	4,006,000	4,435,000
Unrestricted	(1,537,000)	2,504,000	2,753,000
Total net assets (deficit)	9,672,000	28,400,000	25,855,000
Total net assets and liabilities	$ 114,038,000	$ 83,698,000	$ 84,838,000

Net patient service revenue decreased in 2011 from 2010 by $13.8 million (-10.6%), while operating expenses increased by $2.0 million (1.3%). The two significant changes in the financial position of the District was an increase in operating cash due to the issuance of a $40 million COP bond in December 2011 and a $10 million borrowing from Contra Costa County. Both the borrowings had the impact of increasing cash and increasing long term debt. The District also was able to lower the other long term debt by making the scheduled payments on the bond, certificates of participation, and pay off the original Contra Costa County tax advance. During 2011, the District was advanced $17.3 million on their revolving line of credit, backed by accounts receivables of which $13.9 million was paid back by the end of the year. This loan was necessary as a cash bridge prior to the borrowing of the $40 million bond.

In 2011, the District also paid down its long term debt by $5.6 million, including the final $1.8 million payment on the District's bankruptcy debt. The balance of the long term debt payments were to Contra Costa County and for the District's bonds. The estimates from third party settlements decreased in 2011. This was the result of a component of the Medicare payment calculation being updated. This caused management to revise Medicare cost report estimates back to 2007 cost reports. This was reflected in the 2011 balances only.

The District's operating loss increased by $15.7 million from 2010 to 2011. Management's 2011 operating budget was established to reduce the operating loss by 2012 to a level that is fully supported by only the property tax revenue. That goal was not achieved due to changes in payor mix and a significant loss in non-operating revenues that will be explained below. There was also significant turnover in executive level management during 2010 and 2011.

In 2011, the District reported an operating loss of $31.2 million. The increase in the District's operating loss was directly related to the District's change in payor mix and continued loss of outside funding from other sources. The District has experienced losses in managed care revenue and increases in Medi-Cal and patients without insurance. The District believes that this shift is directly related to the economic conditions. These losses are partially offset by the California Hospital Tax. The District received $1.6 million in 2011. This amount is reported in net patient service revenue.

The new interim management team started developing a turnaround plan for the District in May of 2011. In August 2011, a reduction in force was implemented with 33 FTE's eliminated saving the hospital $2.5 million annually. During the 2012 budget process, additional cuts were made to expenses bringing the total annual savings to $5.5 million. In November, a new parcel tax was passed by the voters in the district that will create $5.1 million of additional annual tax income. The district also secured $40 million from a bond measure in December which gives the hospital funds to operate for approximately 5 years while a complete strategic plan is developed. By incorporating the changes made to operations, the loss run rate will have been cut to an $8.1 million loss in 2012 and with a full year effect of $5.5 million when compensating for the full year effect of the new parcel tax.

Net patient service revenue increased in 2010 from 2009 by $7.6 million (6.2%), while operating expenses increased by $9.8 million (7.2%). The significant change in the financial position of the District was a decrease in operating cash caused by not receiving the anticipated CMAC payment discussed below. Not receiving this $8.0 million payment caused the District to delay payment to vendors and to cancel or put on hold anticipated capital projects. The District was able to lower the long term debt by making the scheduled payments on the bond, certificates of participation, and Contra Costa County tax advance.

In 2010, the District also paid down its long term debt by $7.0 million, including a $3.2 million payment on the District's bankruptcy debt. The balance of the long term debt payments were to Contra Costa County and for the District's bonds. The estimates from third party settlements decreased in 2010. This was the result of a component of the Medicare payment calculation being updated. This caused management to revise Medicare cost report estimates back to 2007 cost reports. This was reflected in the 2010 balances only.

The District's operating loss increased by $2.2 million from 2009 to 2010. The District's property tax revenue was approved by the residents to supplement operations. Management's 2010 operating budget was established to reduce the operating loss by 2011 to a level that is fully supported by only the property tax revenue. That goal was not achieved due to changes in payor mix and a significant loss in nonoperating revenues that will be explained below. There was also significant turnover in executive level management during 2010 and in January 2011. The new management team is currently developing a turnaround plan for the District.

In 2010, the District reported an operating loss of $15.5 million. The increase in the District's operating loss was directly related to the District's change in payor mix. The District has experienced losses in managed care revenue and increases in Medi-Cal and patients without insurance. The District believes that this shift is directly related to the economic conditions. The District also had higher inpatient lengths of stay than anticipated in the first half of 2010. Management put processes in place to better manage patients' length of stay to more medically appropriate stays. These were practically offset by the implementation of the California Hospital Tax. The District received $1.4 million in 2010. This amount is reported in net patient service revenue.

In the District's 2010 operating budget, there was an anticipated receipt of $12.0 million in Federal Matching Funding. The District anticipated three $4.0 million payments; the first in March, second in August and the third in December. In September, the District was notified that the second and third payments would not be received. The loss of the anticipated $8.0 million has caused significant cash flow issues and accelerated the District's strained financial condition caused by the payor mix shift as discussed above.

Net patient service revenue increased in 2009 by $6.5 million (5.5%), patient accounts receivable, net of estimated uncollectible amounts, increased by $7.2 million (60.4%) in 2009. The increase in accounts receivable from 2008 to 2009 is due to several factors. At December 2008, the gross accounts receivable had a large amount of aged self pay accounts and accounts older than 151 days. The self pay accounts were 100% reserved as uncollectable. During 2009, management put a significant amount of effort in resolving the self pay and 151 days plus accounts. The self pay accounts receivable was reduced during 2009 from a high of $33.2 million to a December 31, 2009 balance of $9.4 million (70.6%). Accounts older than 151 days were reduced from a high of $56.4 million to $21.2 million at December 31, 2009 (61.5%). The cash collections goal on patient accounts for 2009 was $114.0 million. The actual cash collections were $117.0 million or $3.0 million over the goal. The net accounts receivable increased by $10.5 million from 2008 to 2009. This increase is the result of decreases in gross accounts receivable from 2008 to 2009 by $54.5 million due to improvements in the age of accounts and the decrease in self pay accounts.

In 2009, the District also paid down its long term debt by $10.4 million, including a $3.4 million payment on the District's bankruptcy debt. The balance of the long term debt payments were to Contra Costa County and for the District's bonds. The estimates from third party settlements increased in 2009. This was the result of a component of the Medicare payment calculation being updated. This caused management to revise Medicare cost report estimates back to 2007 cost reports. This was reflected in the 2009 balances only.

The primary reasons for the decrease in operating income from 2010 to 2011 are:

- Decrease in CMAC funding.
- Decrease in length of stay for payers that reimburse based on days in the hospital.
- Decrease in managed care revenue due to a payor mix shift from managed care payor to Medi-Cal and self pay.
- Increase in benefit costs in employee medical insurance plan.

The primary reasons for the decrease in operating income from 2009 to 2010 are:

- Decrease in CMAC funding.
- Decrease in managed care revenue due to a payor mix shift from managed care payor to Medi-Cal and self pay.
- Increase in salaries due to increased inpatient lengths of stay related to a higher portion of non surgical medicine patients than in prior years.
- Increases in supply costs that were related to higher surgical volumes for joint replacement and other major implant surgeries.

Table 2: Operating Results and Changes in Net Assets

	2011	2010	2009
Operating revenues			
Net patient service revenue	$ 116,419,000	$ 130,185,000	$ 122,576,000
Other operating revenue	1,166,000	1,130,000	1,149,000
Total operating revenues	117,585,000	131,315,000	123,725,000
Operating expenses			
Salaries and benefits	96,749,000	95,529,000	92,915,000
Supplies	18,777,000	20,928,000	18,275,000
Depreciation and amortization	4,165,000	3,593,000	3,511,000
Other operating expenses	29,056,000	26,721,000	22,251,000
Total operating expenses	148,747,000	146,771,000	136,952,000
Operating loss	(31,162,000)	(15,456,000)	(13,227,000)
Nonoperating revenues (expenses):			
District tax revenue	8,498,000	8,492,000	8,591,000
Investment income	46,000	92,000	198,000
Noncapital grants and contributions	5,443,000	10,813,000	17,000,000
Interest expense	(1,553,000)	(1,396,000)	(1,514,000)
Total net nonoperating revenues	12,434,000	18,001,000	24,275,000
(Deficit) Excess of revenues over expenses	(18,728,000)	2,545,000	11,048,000
Increase in net assets	(18,728,000)	2,545,000	11,048,000
Net assets at beginning of the year	28,400,000	25,855,000	14,807,000
Net assets at end of the year	$ 9,672,000	$ 28,400,000	$ 25,855,000

The District sometimes provides care for patients who have little or no health insurance or other means of repayment. As discussed, this service to the community is consistent with the goals established for the District when it was founded. Because there is no expectation of repayment, charity care is not reported as patient service revenues of the District. The cost of providing care to the uninsured patients was approximately $6.9 million in 2011 and $3.6 million in 2010. The majority of charity care amounts written off in 2009 aggregated roughly $46,649,000 of which $23,663,000 is related to charity care accounts from prior years. In 2009, management performed a detailed review of prior year accounts to determine if these accounts met the criteria in the District's charity care policy even though these accounts were previously included in their allowance for doubtful accounts. Because these accounts were included in the allowance for doubtful accounts in previous years, there was no income effect of writing the amounts off as charity care in 2009. The amount of charges foregone for services and supplies furnished under the District's charity care policy aggregated approximately $6,940,000 and $6,658,000 in 2011 and 2010, respectively.

Nonoperating Revenues and Expenses

Nonoperating revenues consist primarily of property taxes levied by the District, noncapital grants and contributions, interest revenue, and investment earnings. The change in non-operating revenues was discussed above.

The District's Cash Flows

Changes in the District's cash flows are consistent with changes in operating losses and nonoperating revenues and expenses, discussed earlier.

Capital Assets

At the end of 2011, the District had $44.8 million invested in capital assets, net of accumulated depreciation, as detailed in Note 8 to the financial statements. In 2011, the District purchased new equipment costing $3.9 million.

At the end of 2010, the District had $45.4 million invested in capital assets, net of accumulated depreciation, as detailed in Note 8 to the financial statements. In 2010, the District purchased new equipment costing $4.9 million.

At the end of 2009, the District had $44.0 million invested in capital assets, net of accumulated depreciation, as detailed in Note 8 to the financial statements. In 2009, the District purchased new equipment costing $4.1 million.

Contacting the District's Financial Management

This financial report is designed to provide our patients, suppliers, taxpayers, and creditors with a general overview of the District's finances and to show the District's accountability for the money it receives. If you have questions about this report or need additional financial information, contact the District's Chief Financial Officer's office at Doctors Medical Center, 2000 Vale Road, San Pablo, CA 94806.

REPORT OF INDEPENDENT AUDITORS

The Board of Directors
West Contra Costa Healthcare District

We have audited the accompanying balance sheets of West Contra Costa Healthcare District (the "District") as of December 31, 2011 and 2010, and the related statements of revenues, expenses, and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the District's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform our audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of December 31, 2011 and 2010, and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The Management's Discussion and Analysis on pages 1 through 5 is not a required part of the basic financial statements but is supplementary information required by accounting principles generally accepted in the United States of America. This schedule is the responsibility of the District's management. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

The accompanying Required Supplementary Information - Pension on page 26 is not a required part of the basic financial statements but is supplementary information required by accounting principles generally accepted in the United States of America. This schedule is the responsibility of the District's management. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the required supplementary information. However, we did not audit such information and we do not express an opinion on it.

San Francisco, California

FINANCIAL STATEMENTS

WEST CONTRA COSTA HEALTHCARE DISTRICT
BALANCE SHEETS
December 31, 2011 and 2010

	2011	2010
ASSETS		
Current assets		
Cash and cash equivalents	$ 13,972,000	$ 5,229,000
Patient accounts receivable, net of estimated uncollectibles of $12,105,000 and $7,092,000 at 2011 and 2010, respectively	19,177,000	19,942,000
Other receivables	1,160,000	4,055,000
Current portion of board designated and trusteed assets	29,847,000	4,006,000
Supplies	2,109,000	2,252,000
Prepaid expenses and deposits	999,000	1,621,000
Total current assets	67,264,000	37,105,000
Board designated and trusteed assets, net of current portion	642,000	642,000
Capital assets, net of accumulated depreciation	44,782,000	45,407,000
Other assets	1,350,000	544,000
Total assets	$ 114,038,000	$ 83,698,000
LIABILITIES AND NET ASSETS		
Current liabilities		
Current maturities of debt borrowings	$ 4,979,000	$ 3,646,000
Accounts payable and accrued expenses	12,675,000	14,012,000
Accrued payroll and related liabilities	13,640,000	11,356,000
Other current liabilities	2,880,000	801,000
Estimated third-party payor settlements	1,340,000	2,501,000
Total current liabilities	35,514,000	32,316,000
Debt borrowings, net of current maturities	62,747,000	22,982,000
Other long-term liabilities	6,105,000	-
Total liabilities	104,366,000	55,298,000
Net assets		
Invested in capital assets, net of related debt	21,312,000	21,890,000
Restricted expendable	2,829,000	4,006,000
Unrestricted	(14,469,000)	2,504,000
Total net assets	9,672,000	28,400,000
Total liabilities and net assets	$ 114,038,000	$ 83,698,000

See accompanying notes.

WEST CONTRA COSTA HEALTHCARE DISTRICT
STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET ASSETS
Years Ended December 31, 2011 and 2010

	2011	2010
Operating revenues		
Net patient service revenue (net of provision for bad debts of $60,603,000 in 2011 and $59,707,000 in 2010)	$ 116,419,000	$ 130,185,000
Other operating revenue	1,166,000	1,130,000
Total operating revenues	117,585,000	131,315,000
Operating expenses		
Salaries and wages	61,659,000	64,690,000
Employee benefits	35,090,000	30,839,000
Supplies	18,777,000	20,928,000
Professional fees	10,907,000	10,022,000
Purchased services	10,309,000	9,507,000
Other operating expenses	3,845,000	4,344,000
Depreciation and amortization	4,165,000	3,593,000
Rentals and leases	3,995,000	2,848,000
Total operating expenses	148,747,000	146,771,000
Operating loss	(31,162,000)	(15,456,000)
Nonoperating revenues (expenses):		
District tax revenue	8,498,000	8,492,000
Investment income	46,000	92,000
Noncapital grants and contributions	5,443,000	10,813,000
Interest expense	(1,553,000)	(1,396,000)
Total nonoperating revenues	12,434,000	18,001,000
(Deficit) excess of revenues over expenses	(18,728,000)	2,545,000
Net assets beginning of the year	28,400,000	25,855,000
Net assets end of the year	$ 9,672,000	$ 28,400,000

See accompanying notes.

WEST CONTRA COSTA HEALTHCARE DISTRICT
STATEMENTS OF CASH FLOWS
Years Ended December 31, 2011 and 2010

	2011	2010
Cash flows from operating activities:		
Cash received from patients and third-parties on behalf of patients	$ 116,023,000	$ 128,430,000
Cash received from operations, other than patient services	4,057,000	2,442,000
Cash payments to suppliers and contractors	(48,243,000)	(48,443,000)
Cash payments to employees and benefits programs	(94,465,000)	(93,576,000)
Net cash used in operating activities	(22,628,000)	(11,147,000)
Cash flows from noncapital financing activities:		
Noncapital grants and contributions	5,443,000	10,813,000
Proceeds from county loan	10,000,000	-
Payments on county loan	(801,000)	(2,849,000)
Proceeds from debt borrowings	39,833,000	-
Principal payments on debt borrowings	(799,000)	(779,000)
Interest payments on debt borrowings	(1,327,000)	(1,143,000)
Proceeds from line of credit, net	3,346,000	-
Cash paid for debt issuance costs	(840,000)	-
Parcel tax revenues levied for debt service	5,618,000	5,643,000
Ad valorem tax revenues to support operations	1,865,000	2,849,000
Net cash provided by noncapital and related financing activities	62,338,000	14,534,000
Cash flows from capital and related financing activities:		
Purchases of capital assets	(1,875,000)	(4,942,000)
Proceeds from sale of capital assets	20,000	-
Proceeds from debt borrowings	-	1,500,000
Principal payments on debt borrowings	(3,091,000)	(3,033,000)
Interest payments on debt borrowings	(226,000)	(156,000)
Net cash used in capital and related financing activities	(5,172,000)	(6,631,000)
Cash flows from investing activities:		
Proceeds from sale of investments	1,228,000	715,000
Purchases of investments	(27,069,000)	-
Interest and dividends received from investments	46,000	92,000
Net cash (used in) provided by investing activities	(25,795,000)	807,000
Net increase (decrease) in cash and cash equivalents	8,743,000	(2,437,000)
Cash and cash equivalents at beginning of year	5,229,000	7,666,000
Cash and cash equivalents at end of year	$ 13,972,000	$ 5,229,000

See accompanying notes.

Reconciliation of operating loss to net cash used in operating activities:		
Operating loss	$ (31,162,000)	$ (15,456,000)
Adjustments to reconcile operating loss to net cash used in operating activities:		
Depreciation and amortization	4,165,000	3,593,000
Gain on disposal of capital assets	(4,000)	-
Provision for bad debts	60,603,000	59,707,000
Changes in operating assets and liabilities:		
Patient accounts receivables	(59,838,000)	(60,492,000)
Other receivables	2,895,000	1,312,000
Supplies	143,000	(196,000)
Prepaid expenses and deposits	622,000	(1,011,000)
Accounts payable and accrued expenses	(1,175,000)	3,598,000
Accrued payroll and related liabilities	2,284,000	1,953,000
Other liabilities related to operating activities	-	(3,185,000)
Estimated third-party payor settlements	(1,161,000)	(970,000)
Net cash used in operating activities	$ (22,628,000)	$ (11,147,000)
Non cash disclosures		
Purchase of capital assets with capital lease	$ 1,809,000	$ -
Non cash proceeds from sale of capital assets	$ 162,000	$ -
Non cash payments on county loan	$ 1,015,000	$ -

See accompanying notes.

NOTE 1 – ORGANIZATION AND ACCOUNTING POLICIES

Reporting entity – West Contra Costa Healthcare District (the "District") is a public agency organized under Local Hospital District Law as set forth in the Health and Safety Code of the State of California. The District is a political subdivision of the State of California and is not subject to federal or state income taxes. The District was formed in 1948 for the purpose of building and operating a hospital to benefit the residents of West Contra Costa County. The District is governed by a Board of Directors elected from within the Healthcare District to specified terms of office. The District operates a full-service acute care facility and provides services to both inpatients and outpatients. The District provides health care services primarily to individuals who reside in the local geographic area.

WCCHD Financing Corporation II – The Corporation is a nonprofit public benefit corporation to provide financial assistance to the District by financing, refinancing, acquiring, constructing, improving, leasing and selling buildings, building improvements, equipment, and any other real or personal property (collectively, the "Facilities"), for the use, benefit and enjoyment of the public served by the District and any other purpose incidental thereto.

Basis of preparation – The District is a governmental health care provider and, accordingly, follows governmental accounting standards. The accrual basis of accounting is used in accordance with provisions for proprietary fund types.

Pursuant to Governmental Accounting Standards Board ("GASB") Statement No. 62, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements, the District's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989.

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

Cash and cash equivalents – The District considers cash and cash equivalents to include certain investments in highly liquid debt instruments, when present, with an original maturity of three months or less or subject to withdrawal upon request.

Patient accounts receivable – Patient accounts receivable consist of amounts reimbursable by various governmental agencies and insurance companies through the assignment process and private patients. The District manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectability and providing for allowances on their accounting records for estimates, contractual adjustments, and uncollectible accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

Investments in marketable securities – Investments in marketable securities consist primarily of short-term, interest-bearing certificates of deposit, money market funds, and mutual funds and include assets held by trustees under indenture agreements and designated assets set aside by the Board of Directors for future funding of certain District obligations.

Supplies – Inventories are stated at cost, which is determined using the first-in, first-out method.

Capital assets – Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Capital purchases over $1,000 are capitalized. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 30 years for buildings and improvements, and 3 to 10 years for equipment. Leasehold improvements are amortized using the straight-line method over the shorter of the lease term or the estimated useful life of the related assets. The District periodically reviews its capital assets for value impairment. As of December 31, 2011 and 2010, the District has determined that no capital assets are impaired.

Other assets – Other assets include debt issuance costs. Debt issuance costs incurred in connection with the issuance of tax-exempt bonds have been deferred and are being amortized over the term of the bonds using a straight-line method.

Costs of borrowing – Except for capital assets acquired through gifts, contributions, or capital grants, interest cost on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. None of the District's interest cost was capitalized for the years ended December 31, 2011 and 2010.

Compensated absences – District employees earn vacation benefits at varying rates depending on years of service. Employees also earn sick leave benefits based on varying rates depending on years of service. Both benefits can accumulate up to specified maximum levels. Employees are not paid for accumulated sick leave benefits if they leave either upon termination or before retirement. However, accumulated vacation benefits are paid to an employee upon either termination or retirement. Accrued vacation and sick leave liabilities as of December 31, 2011 and 2010 are $3,266,000 and $3,823,000, respectively.

Risk management – The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years.

Risk retention plans – The District maintains professional liability insurance on a claims-made basis, with liability limits of $10,000,000 per claim, and which is subject to a $25,000 deductible. Additionally, the District is self-insured for workers' compensation claims, with a self-insured retention of $350,000 per occurrence, and has excess insurance coverage for the portion of each occurrence in excess of $350,000. In the case of employee health coverage, the District is self-insured for those claims. Management estimates of uninsured losses for professional liability, workers' compensation and employee health coverage have been accrued as liabilities in the accompanying financial statements.

Net assets – Net assets of the District are classified in three components:

- Net assets invested in capital assets, net of related debt consist of capital assets net of accumulated depreciation and reduced by any outstanding borrowings used to finance the purchase or construction of those assets.

- Restricted expendable net assets are noncapital net assets that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the District, including amounts deposited with trustees as required by revenue bond indentures, discussed in Note 3.

- Unrestricted net assets are remaining net assets that do not meet the definition of invested in capital assets net of related debt or restricted expendable net assets.

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

Charity care – The District accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the District. Essentially, these policies define charity services as those services for which no payment is anticipated. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Charity care amounts are included in net patient revenues in the financial statements.

Uncollectible accounts – The District provides care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. A provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible.

Grants and contributions – From time to time, the District receives grants from various governmental agencies and private organizations. The District also receives contributions from related foundation and auxiliary organizations, as well as from individuals and other private organizations. Revenues from grants and contributions are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either operating purposes or capital acquisitions. These amounts, when recognized upon meeting all requirements, are reported as components of the statements of revenues, expenses and changes in net assets.

Operating revenues and expenses – The District's statement of revenues, expense and changes in net assets distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, which is the District's principal activity. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Nonoperating revenues and expenses are those transactions not considered directly linked to providing health care services.

Income taxes – The District operates under the purview of the Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to state or federal taxes on income.

Property taxes – The authority received approximately 6.5% in 2011 and 5.6% in 2010 of its financial support from property taxes. These funds were used as follows:

	2011	2010
Levied for debt service	$ 5,618,000	$ 5,643,000
Used to support operations	$ 2,880,000	$ 2,849,000

Property taxes are levied by the County on the District's behalf on January 1 and are intended to finance the District's activities of the same calendar year. Amounts levied are based on assessed property values as of the preceding July 1. Property taxes are considered delinquent on the day following each payment due date. Property taxes are recorded as nonoperating revenue by the District when they are earned.

Reclassifications – Certain amounts in the 2010 financial statements have been reclassified to conform to the 2011 presentation.

New accounting pronouncements – The Governmental Accounting Standards Board ("GASB") issued GASB Statement No. 61, The Financial Reporting Entity: Omnibus (November 2010). GASB 61 clarifies certain aspects of GASB 14, The Financial Reporting Entity, which establishes the criteria governing which of a governmental entity's related parties should be formally incorporated into its financial statements. The adoption of GASB 61 is effective for the District beginning January 1, 2013. The adoption of GASB 61 is not expected to have a material impact on the District's financial statements.

NOTE 2 – CASH AND CASH EQUIVALENTS, BOARD DESIGNATED AND TRUSTEED ASSETS

As of December 31, 2011 and 2010, the District had deposits invested in various financial institutions in the form of cash and cash equivalents including amounts classified as board designated assets amounting to $44,461,000 and $9,877,000, respectively. All of these funds were held in deposits, which are collateralized in accordance with the California Government Code ("CGC"), except for $250,000 per account that is federally insured.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the District's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the District's deposits. California law also allows financial institutes to secure District deposits by pledging first trust deed mortgage notes having a value of 150% of the District's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the District.

The composition of board designated and trusteed assets at December 31, 2011 and 2010, is set forth in the following table. Investments are stated at fair value.

	2011	2010
Board designated		
Cash and cash equivalents	$ 642,000	$ 642,000
Certificates of deposit	352,000	351,000
Held by trustee		
Money market	29,495,000	3,655,000
	$ 30,489,000	$ 4,648,000

Interest and dividend income for investments and gains from assets limited as to use is $46,000, and $92,000 for the years ended December 31, 2011 and 2010, respectively.

NOTE 3 – NET PATIENT SERVICE REVENUE AND REIMBURSEMENT PROGRAMS

The District renders services to patients under contractual arrangements with the Medicare and Medi-Cal programs, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"). Patient service revenues from Medicare approximate 49% and 47% of gross patient service revenues, whereas patient service revenues from Medi-Cal approximate 24% and 25% for the years ended December 31, 2011 and 2010, respectively.

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, fee schedules, prepaid payments per member, and per diem payments or a combination of these methods. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated settlements under reimbursement agreements with third-party payors.

Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system based on clinical, diagnostic, and other factors. Inpatient nonacute services related to Medicare beneficiaries are paid based on a cost-reimbursement methodology through March 31, 2004. Inpatient nonacute services subsequent to April 1, 2004, are paid at prospectively determined rates per discharge. Payments for outpatient services are based on a stipulated amount per diagnosis. The District is reimbursed for cost reimbursable items at a tentative rate, with final settlements determined after submission of annual cost reports by the District and audits thereof by the Medicare fiscal intermediary. The effect of updating prior year estimates for Medicare and other liabilities was to decrease net operating income by $143,000 in 2011 and an increase of net operating income by $2,414,000 in 2010. The District's cost reports have been audited by the Medicare fiscal intermediary through 2008.

Medicare accounts for approximately 50% and 50% of the District's net patient service revenues whereas Medi-Cal revenue accounts for approximately 22% and 24% for the years ended December 31, 2011 and 2010, respectively. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change in the near term.

In November 2009, the California Hospital Fee Program (the "Program") was signed into California state law and became effective for 2010 after approval from the Centers for Medicare and Medicaid Services ("CMS"). The program provides supplemental Medi-Cal payments to certain California hospitals. The Program is funded by a quality assurance fee (the "Fee") paid by participating hospitals and by matching federal funds. Hospitals receive supplemental payments from either the California Department of Health Care Services ("DHCS"), managed care plans or a combination of both. The Program provided payments relating to the period beginning April 1, 2009 through December 31, 2010. The District recognized total supplemental payments of $1,608,000 in 2011 and $1,358,000 in 2010 from Medi-Cal as a part of the Program and has recorded this as a part of net patient service revenue in the statement of revenues, expenses, and changes in net assets.

NOTE 4 – CONCENTRATION OF CREDIT RISK

The District grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the District and management does not believe that there are any credit risks associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the District. The District's policy is to maintain a 100% reserve for all private pay patient accounts receivables outstanding aged over 240 days. Concentration of patient accounts receivable at December 31, 2011 and 2010, were as follows:

	2011	2010
Medicare	44%	44%
Other third-party payors	46%	43%
Medi-Cal and Medi-Cal pending	10%	13%
Total	100%	100%

NOTE 5 – OTHER RECEIVABLES

Other receivables as of December 31, 2011 and 2010 were comprised of the following:

	2011	2010
Advances to physicians, notes and related receivables	$ 632,000	$ 572,000
Deposits	252,000	316,000
Refunds and rebates receivable	137,000	1,000,000
Third-party settlement receivable	139,000	1,935,000
Other	-	232,000
Total other receivables	$ 1,160,000	$ 4,055,000

Advances to physicians are comprised of physician income guarantees and/or business loans to those physicians requiring assistance to begin a local practice. The District has entered into agreements with certain physicians whereby the District guarantees their income for a specified period of time. These agreements are structured so that if a physician maintains a practice in the area for a specified period of time, the income guarantee advances are forgiven.

NOTE 6 – CAPITAL ASSETS

Capital assets as of December 31, 2011, were comprised of the following:

	Balance at December 31, 2010	Additions	Retirements & Adjustments	Balance at December 31, 2011
Capital assets not being depreciated				
Land and land improvements	$ 12,120,000	$ -	$ -	$ 12,120,000
Construction-in-progress	960,000	3,931,000	(246,000)	4,645,000
	13,080,000	3,931,000	(246,000)	16,765,000
Capital assets being depreciated				
Buildings and improvements	16,955,000	-	(97,000)	16,858,000
Equipment	31,988,000	-	(999,000)	30,989,000
	48,943,000	-	(1,096,000)	47,847,000
Totals at historical cost	62,023,000	3,931,000	(1,342,000)	64,612,000
Less accumulated depreciation	(16,616,000)	(4,132,000)	918,000	(19,830,000)
Total capital assets, net	$ 45,407,000	$ (201,000)	$ (424,000)	$ 44,782,000

Capital assets as of December 31, 2010, were comprised of the following:

	Balance at December 31, 2009	Additions	Retirements & Adjustments	Balance at December 31, 2010
Capital assets not being depreciated				
Land and land improvements	$ 12,090,000	$ 30,000	$ -	$ 12,120,000
Construction-in-progress	1,280,000	-	(320,000)	960,000
	13,370,000	30,000	(320,000)	13,080,000
Capital assets being depreciated				
Buildings and improvements	16,931,000	24,000	-	16,955,000
Equipment	31,856,000	4,888,000	(4,756,000)	31,988,000
	48,787,000	4,912,000	(4,756,000)	48,943,000
Totals at historical cost	62,157,000	4,942,000	(5,076,000)	62,023,000
Less accumulated depreciation	(18,124,000)	(3,568,000)	5,076,000	(16,616,000)
Total capital assets, net	$ 44,033,000	$ 1,374,000	$ -	$ 45,407,000

Future construction commitments of approximately $2,099,000 and $4,702,000 exist for the upgrade of the Paragon system and installation of medical equipment at December 31, 2011 and 2010.

NOTE 7 – DEBT BORROWINGS

A schedule of changes in the District's debt borrowings for the year ended December 31, 2011, is as follows:

	December 31, 2010	Additions	Reductions	December 31, 2011
Notes payable:				
American Savings	$ 31,000	$ -	$ (5,000)	$ 26,000
City of San Pablo	1,346,000	-	(479,000)	867,000
Bonds payable:				
Certificates of participation - Series 2004	22,865,000	-	(799,000)	22,066,000
Certificates of participation - Series 2011	-	39,833,000	-	39,833,000
Revenue bonds	1,181,000	-	(1,181,000)	-
Capital leases - equipment	1,205,000	1,809,000	(1,426,000)	1,588,000
	$ 26,628,000	$ 41,642,000	$ (3,890,000)	$ 64,380,000

A schedule of changes in the District's debt borrowings, for the year ended December 31, 2010, is as follows:

	December 31, 2009	Additions	Reductions	December 31, 2010
Notes payable:				
American Savings	$ 36,000	$ -	$ (5,000)	$ 31,000
City of San Pablo	-	1,500,000	(154,000)	1,346,000
Bonds payable:				
Certificates of participation - Series 2004	23,644,000	-	(779,000)	22,865,000
Revenue bonds	2,321,000	-	(1,140,000)	1,181,000
Capital leases - equipment	2,939,000	-	(1,734,000)	1,205,000
	$ 28,940,000	$ 1,500,000	$ (3,812,000)	$ 26,628,000

The terms and due dates of the District's debt borrowings, including capital lease obligations, at December 31, 2011, are as follows:

- American Savings notes payable dated September 1986, interest at 9.5%, maturing November 2015, principal payable in annual amounts ranging from $5,000 in 2012 to $7,000 in 2015, secured by property.

- City of San Pablo notes payable dated August 2010, interest at 6.0%, maturing July 2013, principal payable amount ranging from $509,000 in 2012 to $357,000 in 2013, unsecured.

- Series 2004 Certificates of Participation dated July 2004, plus unamortized bond premium of $422,000, principal payable in annual installments ranging from $800,000 in 2012 to $1,795,000 in 2029, interest at stated coupon rates ranging from 2.0% to 5.5%, payable annually and collateralized by a pledge of the District's parcel tax revenues. Management believes the District is in compliance with the financial covenants and financial reporting requirements as specified in the Indenture Trust Agreement.

- Series 2011 Certificates of Participation dated December 2011, plus unamortized bond discount of $167,000, principal payable in annual installments ranging from $70,000 in 2013 to $4,100,000 in 2042, interest ranging from 3% to 6.25%, payable semi annually and collateralized by a pledge of the District's parcel tax revenues. Management believes the District is in compliance with the financial covenants and financial reporting requirements as specified in the Indenture Trust Agreement.

- Equipment under capital leases dated March 2011, maturing at March 2016, with interest at 9.45%.

The District executed a credit agreement with Gemino Healthcare Finance, LLC dated November 2011, for a maximum amount of $8 million, expiring November 3, 2014. The agreement is defined as a revolving loan that is collateralized by the District's accounts receivable collections. During 2011, the District was advanced $17.3 million and repaid $13.9 million for an ending outstanding balance of $3.4 million on this line of credit. The line of credit bears interest on the outstanding principal amount at a rate per annum equal to the LIBOR rate plus 4.95%.

Aggregate principal maturities on debt borrowings, based on scheduled maturities are as follows:

Year Ending December 31:	Debt Borrowings		Capital Lease Obligations	
	Principal	Interest	Principal	Interest
2012	$ 4,679,000	$ 2,341,000	$ 300,000	$ 137,000
2013	1,282,000	3,463,000	350,000	106,000
2014	960,000	3,422,000	385,000	71,000
2015	995,000	3,387,000	423,000	33,000
2016-2020	5,582,000	16,281,000	132,000	2,000
2021-2025	7,142,000	14,714,000	-	-
2026-2030	9,248,000	12,577,000	-	-
2031-2035	12,152,000	9,590,000	-	-
2036-2040	16,147,000	5,592,000	-	-
2041-2045	7,949,000	753,000	-	-
	$ 66,136,000	$ 72,120,000	$ 1,590,000	$ 349,000

NOTE 8 – OTHER LONG TERM LIABILITIES

The District entered into an agreement with the County of Contra Costa (the "County") in April 2011, receiving a cash advance of $10 million. The County Auditor shall allocate and transfer to the County pursuant to this agreement the entirety of the general ad valorem property tax revenues that otherwise would be collected and allocated to the District commencing July 1, 2011 and continuing from year to year thereafter until a total up to $11.5 million of transfers are made. The current and long term outstanding advance balance is included in other liabilities in the balance sheet.

NOTE 9 – RETIREMENT PLANS

The District offers two defined contribution savings plans intended to qualify under section 457(b) of the Internal Revenue Code ("IRC"). The plans are destined to provide participants with a means to defer a portion of their compensation for retirement and to provide benefits in the event of death, disability, or financial hardship. The plans cover both former and current employees of the District who meet certain eligibility requirements. The District is the administrator of the plans and has delegated certain responsibilities for the operation and administration of the plans to outside third-party trustees. Under the plans employer contributions are discretionary. The District has not contributed to the plans since 2007.

The District also offers two Employer Contributory Tax Deferred Annuity Plans intended to qualify under section 403(b) and 457 of the IRC. The plans are designed to provide participants with a means to defer a portion of their compensation for retirement and to provide benefits in the event of death, disability, or financial hardship. The plan covers employees of the District, who meet certain eligibility requirements. Under the plan, the District may make matching contributions up to 5.0% of the participant's annual compensation to the plan. The District contributed $3,723,000 and $3,568,000 to the plans in 2011 and 2010, respectively.

The District also provides a non-contributory single employer defined benefit pension plan. The plan covers all eligible employees of the previous Brookside Hospital. Brookside Hospital was the previous name of Doctors Medical Center prior to the Tenet purchase. The plan provides retirement and death benefits to plan members and beneficiaries based on each employee's years of service and annual compensation. No new employees have been enrolled in the plan since 1996. There are no current District employees participating in the plan.

Annual pension cost and net pension obligation – The plan's annual pension cost and net pension obligation for the current and prior year were as follows:

	2011	2010
Annual required contribution	$ 431,000	$ 444,000
Interest on net pension obligation	61,000	26,000
Adjustment to annual required contribution	(86,000)	(37,000)
Annual pension cost	406,000	433,000
Net increase in pension obligation	$ 406,000	$ 433,000
Net pension obligation (prepaid pension asset), beginning of year	$ 764,000	$ 331,000
Net increase in pension obligation	407,000	433,000
Actuarial loss	-	-
Net pension obligation, end of year	$ 1,171,000	$ 764,000

The annual required contribution for the current year was determined as part of the January 1, 2011 and January 1, 2010, actuarial valuations using the entry age actuarial cost method. The actuarial assumptions include (a) 7.5% and 8.0% in 2011 and 2010, respectively, of investment rate of return (net of administrative expenses) and (b) post-retirement benefit increases of 2.0% per year. Both assumptions included an inflation component of 2.0%. The actuarial value of assets for both valuations was determined using market value adjusted to recognize market value gains and losses over five years. The unfunded actuarial accrued liability is amortized using the level dollar method on a closed basis. The remaining equivalent single amortization period at December 31, 2011, was 15 years.

The following table summarizes the net pension obligation ("NPO") for the District's pension plan:

Fiscal Year Ending December 31,	Beginning of Year NPO (a)	Annual Pension Cost (b)	Actual Contribution (c)	Increase (Decrease) in NPO (b-c)	End of Year NPO (Prepaid Pension Cost) ((a)+(b-c)
2009	$ (134,000)	$ 465,000	$ -	$ 465,000	$ 331,000
2010	$ 331,000	$ 433,000	$ -	$ 433,000	$ 764,000
2011	$ 764,000	$ 407,000	$ -	$ 407,000	$ 1,171,000

Funding policy – The District is required to contribute the actuarially determined amounts necessary to fund the benefits for its participants. Active plan participants are not required to contribute. The actuarial methods and assumptions used are those adopted by the District.

NOTE 10 – COMMITMENTS AND CONTINGENCIES

Litigation – The District may from time-to-time be involved in litigation and regulatory investigations, which arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters existing as of December 31, 2011, will be resolved without material adverse effect on the District's future financial position, results from operations or cash flows.

Lease commitments – The District is obligated for land and office rentals under the terms of various noncancelable operating lease agreements. These expire in various years through 2014. The District also entered into various noncancelable operating sublease agreements for office space. These expire in various years through 2014. Following is a schedule by year of future minimum lease payments and future minimum rental revenues under operating leases as of December 31, 2011:

	Operating Lease Commitments	Lease Income	Net Lease Expense
2012	$ 1,662,000	$ 392,000	$ 1,270,000
2013	909,000	398,000	511,000
2014	854,000	404,000	450,000
2015	-	-	-
	$ 3,425,000	$ 1,194,000	$ 2,231,000

Total rental expense in 2011 and 2010 for all operating leases was approximately $3,995,000 and $2,848,000, respectively. Total rental income in 2011 and 2010 for all operating subleases was approximately $588,000 and $620,000, respectively.

Regulatory environment – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. The District is subject to routine surveys and reviews by federal, state and local regulatory authorities. The District has also received inquiries from health care regulatory authorities regarding its compliance with laws and regulations. Although the District management is not aware of any violations of laws and regulations, it has received corrective action requests as a result of completed and on going surveys from applicable regulatory authorities. Management continually works in a timely manner to implement operational changes and procedures to address all corrective action requests from regulatory authorities. Breaches of these laws and regulations and non-compliance with survey corrective action requests could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

REQUIRED SUPPLEMENTARY INFORMATION - PENSION

Analysis of funding progress - pension plan – The following table summarizes the funding status of the District's pension plan:

Actuarial Valuation Date December 31,	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) - Entry Age (b)	Unfunded AAL (UAAL) (b-a)	Funded Ratio (a/b)	Covered Payroll (c)	UAAL as a Percentage of Covered Payroll ((b-a)/c)
2009	$ 6,626,000	$ 10,726,000	$ 4,100,000	62%	N/A	N/A
2010	$ 6,470,000	$ 10,458,000	$ 3,988,000	62%	N/A	N/A
2011	$ 5,460,000	$ 10,436,000	$ 4,976,000	52%	N/A	N/A

DRAFT
03/21/12

Communication with
Those Charged with Governance

West Contra Costa Healthcare District

December 31, 2011

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

To the Board of Directors
West Contra Costa Healthcare District

We have audited the financial statements of West Contra Costa Healthcare District (the "District") as of and for the year ended December 31, 2011, and have issued our report thereon dated June 21, 2012. Professional standards require that we advise you of the following matters relating to our audit.

Our Responsibility under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated September 28, 2011, our responsibility, as described by professional standards, is to form and express an opinion about whether the financial statements that have been prepared by management with your oversight are presented fairly, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your respective responsibilities.

Our responsibility, as prescribed by professional standards, is to plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control over financial reporting. Accordingly, as part of our audit, we considered the District's internal control solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control.

We are also responsible for communicating significant matters related to the audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Other Information in Documents Containing Audited Financial Statements

Our responsibility for other information in the financial statements does not extend beyond the financial information identified in our report. We do not have an obligation to perform any procedures to corroborate other information contained in these documents. However, we have read the information and nothing came to our attention that caused us to believe that such information or its manner of presentation is materially inconsistent with the information or manner of its presentation appearing in the financial statements.

Planned Scope and Timing of the Audit

We conducted our audit consistent with the planned scope and timing we previously communicated to you in our engagement letter dated September 28, 2011.

Significant Audit Findings

Qualitative Aspects of the Organization's Significant Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the District are described in Note 1 to the financial statements. During the year, the District adopted a Statement of the Governmental Accounting Standards Board ("GASB") No. 61, *The Financial Reporting Entity: Omnibus (November 2010)*. There have been no other new accounting policies adopted and there were no changes in the application of existing policies during 2011. We noted no transactions entered into by the District during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management's estimate of net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts and determined that they are reasonable in relation to the financial statements taken as a whole.

- Management's estimate of provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible. The District provides care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. We evaluated the key factors and assumptions used to develop the provision for uncollectible accounts and determined that it is reasonable in relation to the financial statements taken as a whole.

- Management recorded an estimated liability for claims that may be covered under a medical malpractice claims-made policy. The estimated liability was based on management's estimate of historical claims experience. We have gained an understanding of management's estimate methodology and have examined the documentation supporting this methodology. We found management's process to be reasonable in relation to the financial statements taken as a whole.

- Management recorded an estimated liability for employee health benefit claims, for which the District is self-insured. The estimated liability for health benefits is based on management's estimate of historical claims experience and known activity subsequent to year-end. We have gained an understanding of management's estimate methodologies and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable in relation to the financial statements taken as a whole.

- Management recorded an estimated liability for workers' compensation claims, for which the District is self-insured. The estimated liability for workers' compensation liability is based on management's estimate of historical claims experience and known activity subsequent to year-end. We have gained an understanding of management's estimate methodology and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the pension benefit obligation is actuarially determined using assumptions on the long-term rate of return on plan assets, the discount rate used to determine the present value of benefit obligations and the rate of compensation increase. These assumptions are provided by management. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable in relation to the financial statements taken as a whole.

- Management's estimate of useful lives of capital assets is based on the intended use and are within accounting principles generally accepted in the United States of America. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

Actual results could differ from these estimates. In accordance with accounting principles generally accepted in the United States of America, any change in these estimates is reflected in the financial statements in the year of change.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the District's financial statements are the disclosures surrounding significant concentration of net patient accounts receivable and net patient service revenues.

Significant Difficulties Encountered During the Audit

We encountered no significant difficulties in dealing with management relating to the performance of the audit.

Uncorrected and Corrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. None of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

The schedule below summarizes uncorrected financial statement misstatement of the financial statements Management has determined that the effect is immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Passed adjustment # 1 To increase revenue and receivable with FY 2011 dates of services posted in FY 2012				
Dr.	Revenue accrual receivable	$ 135,000		
Cr.	Revenue accrual		$	135,000
Total		$ 135,000	$	135,000

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a matter, whether or not resolved to our satisfaction, concerning a financial accounting, reporting, or auditing matter, which could be significant to the District's financial statements or the auditor's report. No such disagreements arose during the course of the audit.

Representations Requested from Management

We have requested certain written representations from management that are included in the attached management representation letter dated June 21, 2012.

Management's Consultations with Other Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the District's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and the District that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of the District within the meaning of professional standards.

Other Significant Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the District's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Board of Directors and management of the District and is not intended to be and should not be used by anyone other than these specified parties.

San Francisco, California
June 21, 2012

DRAFT
03/21/12

Communication of
Internal Control Related Matters

West Contra Costa Healthcare District

December 31, 2011

COMMUNICATION OF INTERNAL CONTROL RELATED MATTERS

To the Management and Board of Directors of
West Contra Costa Healthcare District

In planning and performing our audit of the financial statements of West Contra Costa Healthcare District (the "District") as of and for the year ended December 31, 2011, in accordance with auditing standards generally accepted in the United States of America, we considered the District's internal control over financial reporting ("internal control") as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

Our consideration of internal control was for the limited purpose described above and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the entity's financial statements that is more than inconsequential will not be prevented or detected by the entity's internal control.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by the entity's internal control.

We believe the following operational recommendation is beneficial to the District:

Observation: We noted there are multiple individuals that process and collect payments from patients. The process is manual and the individual is not required to sign off on payments received or issue receipts.

Recommendation: We recommend that a process and policy is formally set up where sequenced receipts have to be mandatorily printed and provided to the patients upon payment. Additionally, cash receipts per patient account should be reconciled to cash receipts per the lockbox and Cash Receipt Journals ("CRJs") on a daily basis.

This communication is intended solely for the information and use of management, the Board of Directors, and others within the District, and is not intended to be and should not be used by anyone other than these specified parties.

San Francisco, California
June 21, 2012

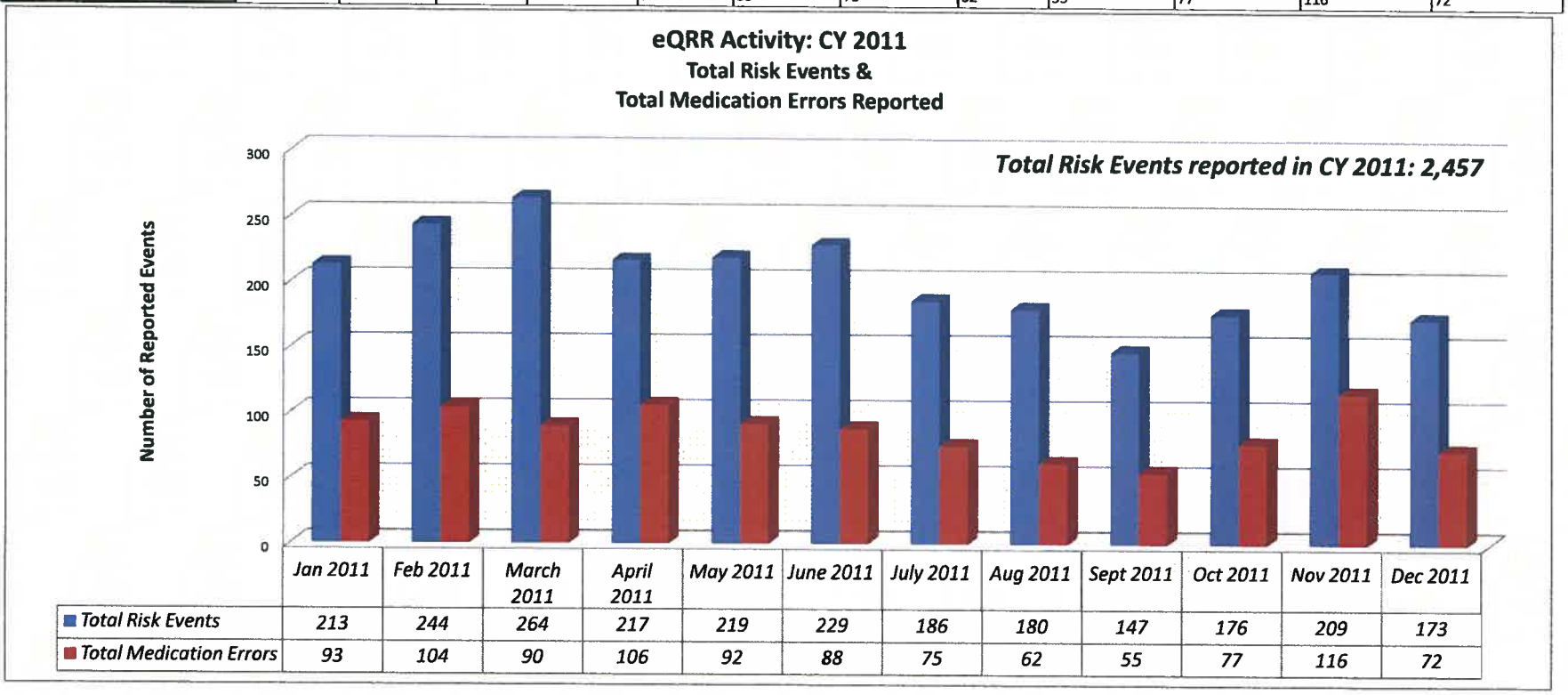
DOCTORS MEDICAL CENTER

QUALITY

TAB 7

Quality/Patient Safety Metrics

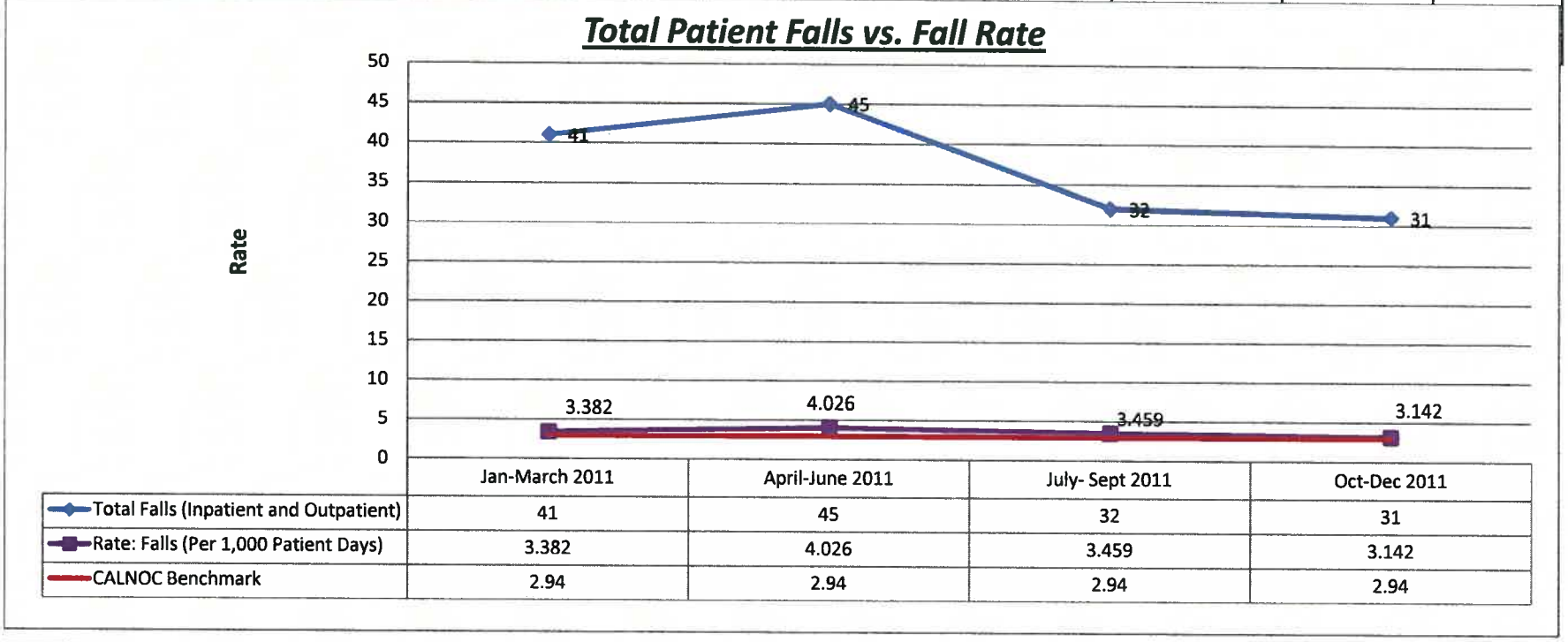
e-QRR Activity CY 2011												
Indicator	*Jan 2011*	*Feb 2011*	*March 2011*	*April 2011*	*May 2011*	*June 2011*	*July 2011*	*Aug 2011*	*Sept 2011*	*Oct 2011*	*Nov 2011*	*Dec 2011*
Total Risk Events	213	244	264	217	219	229	186	180	147	176	209	173
Total Medication Errors	93	104	90	106	92	88	75	62	55	77	116	72



DOCTORS MEDICAL CENTER

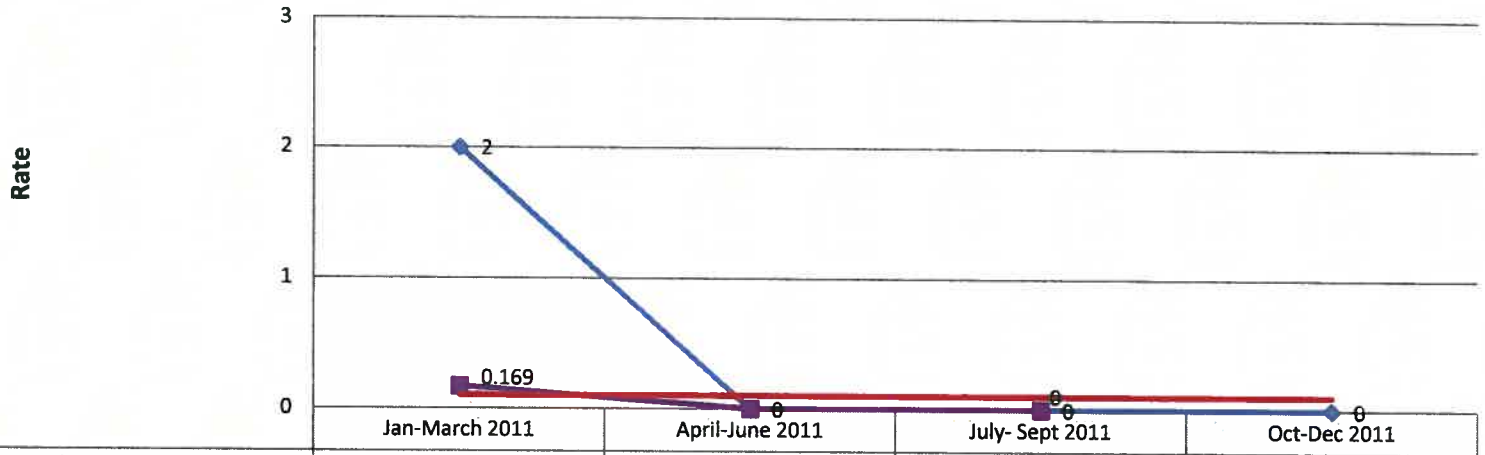
Quality/Patient Safety Metrics

Patient Safety: Falls							
Indicator	*Jan-March 2011*	*April-June 2011*	*July- Sept 2011*	*Oct-Dec 2011*	*CY 2011*	*CALNOC Benchmark*	*Total*
Total Falls (Inpatient and Outpatient)	41	45	32	31	149	N/A	149
Total Falls With Injury (Inpatient and Outpatient)	2	0	0	0	2	N/A	2
% Falls with Injury	0.05%	0.00%	0.00%	0.00%	0.05%	N/A	1.340%
Rate: Falls (Per 1,000 Patient Days)	3.382	4.026	3.459	3.142	3.538	2.94	3.538
Rate: Falls with Injury (Per 1,000 Patient Days)	0.169	0	0	0	0.047	0.1	0.047



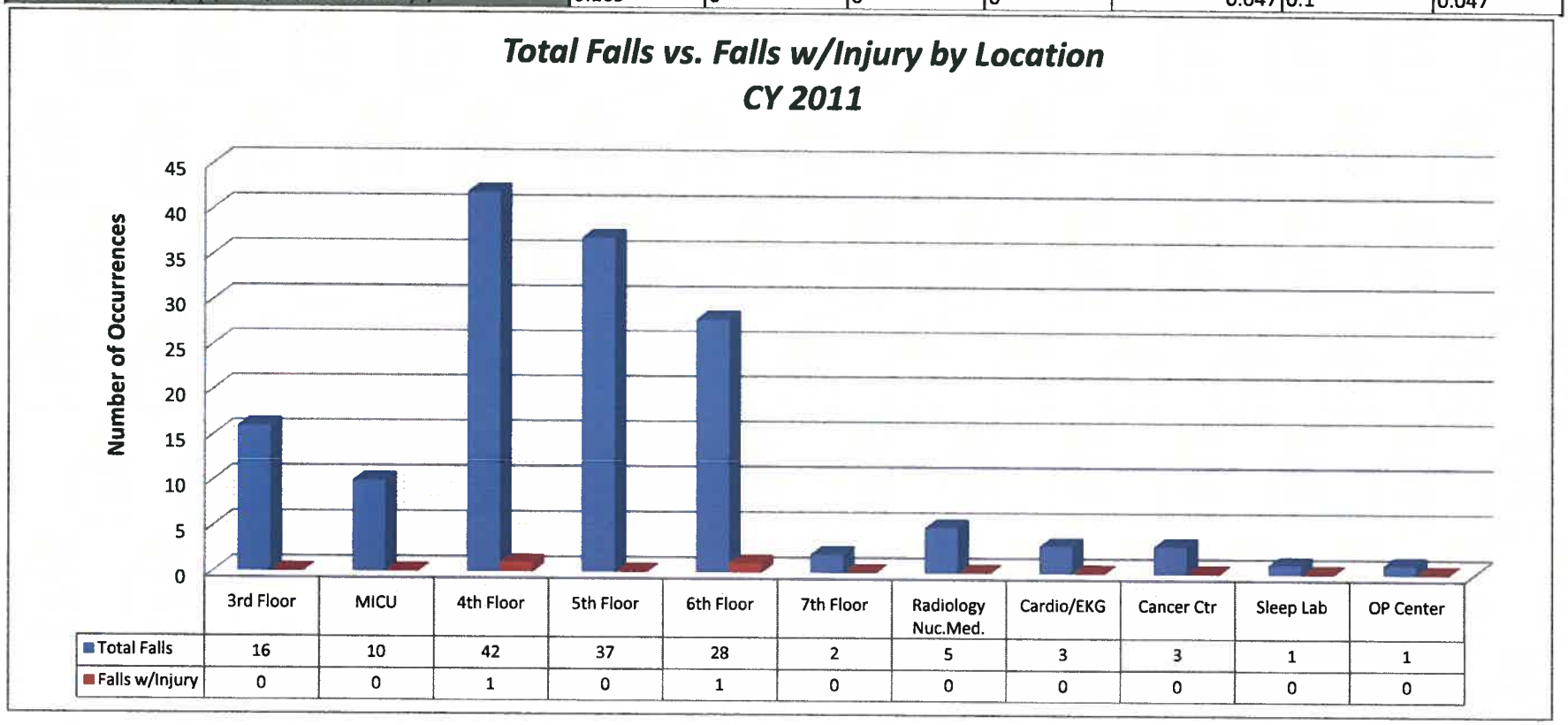
Patient Safety: Falls							
Indicator	*Jan-March 2011*	*April-June 2011*	*July- Sept 2011*	*Oct-Dec 2011*	*CY 2011*	*CALNOC Benchmark*	*Total*
Total Falls (Inpatient and Outpatient)	41	45	32	31	149	N/A	149
Total Falls With Injury (Inpatient and Outpatient)	2	0	0	0	2	N/A	2
% Falls with Injury	0.05%	0.00%	0.00%	0.00%	0.05%	N/A	1.340%
Rate: Falls (Per 1,000 Patient Days)	3.382	4.026	3.459	3.142	3.538	2.94	3.538
Rate: Falls with Injury (Per 1,000 Patient Days)	0.169	0	0	0	0.047	0.1	0.047

Patient Falls with Injury vs. Falls with Injury Rate



	Jan-March 2011	April-June 2011	July- Sept 2011	Oct-Dec 2011
Total Falls With Injury (Inpatient and Outpatient)	2	0	0	0
Rate: Falls with Injury (Per 1,000 Patient Days)	0.169	0	0	
CALNOC Benchmark	0.1	0.1	0.1	0.1

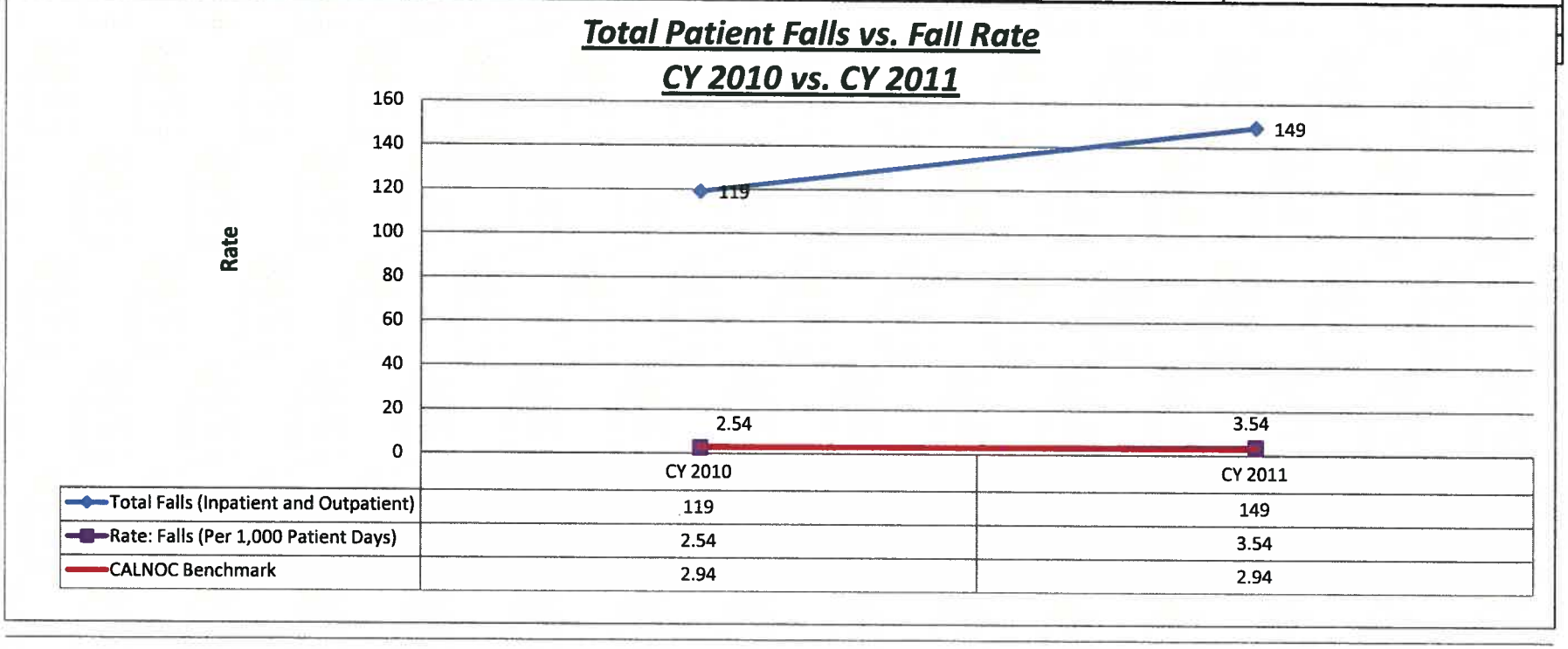
Patient Safety: Falls							
Indicator	*Jan-March 2011*	*April-June 2011*	*July- Sept 2011*	*Oct-Dec 2011*	*CY 2011*	*CALNOC Benchmark*	*Total*
Total Falls (Inpatient and Outpatient)	41	45	32	31	149	N/A	149
Total Falls With Injury (Inpatient and Outpatient)	2	0	0	0	2	N/A	2
% Falls with Injury	0.05%	0.00%	0.00%	0.00%	0.05%	N/A	1.340%
Rate: Falls (Per 1,000 Patient Days)	3.382	4.026	3.459	3.142	3.538	2.94	3.538
Rate: Falls with Injury (Per 1,000 Patient Days)	0.169	0	0	0	0.047	0.1	0.047



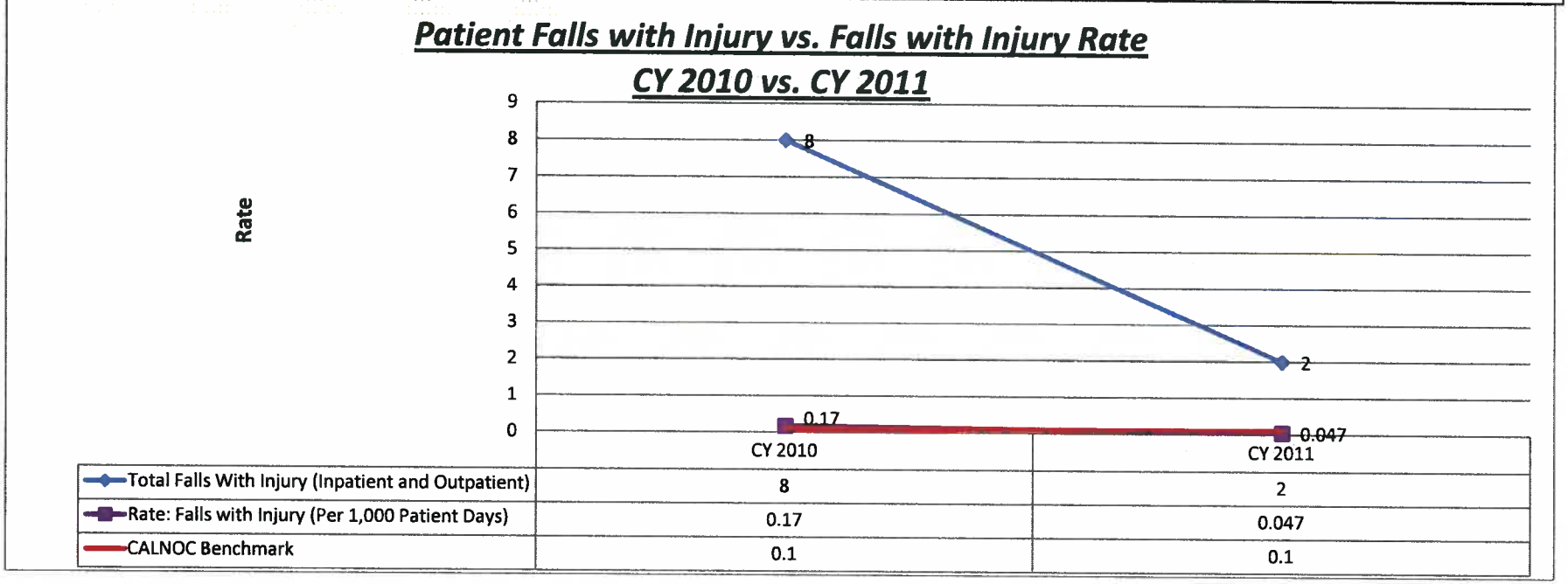
	3rd Floor	MICU	4th Floor	5th Floor	6th Floor	7th Floor	Radiology Nuc.Med.	Cardio/EKG	Cancer Ctr	Sleep Lab	OP Center
Total Falls	16	10	42	37	28	2	5	3	3	1	1
Falls w/Injury	0	0	1	0	1	0	0	0	0	0	0

Quality/Patient Safety Metrics

Patient Safety: Falls				
Indicator	*CY 2010*	*CY 2011*	*CALNOC Benchmark*	*Total*
Total Falls (Inpatient and Outpatient)	119	149	N/A	268
Total Falls With Injury (Inpatient and Outpatient)	8	2	N/A	10
% Falls with Injury	6.70%	0.05%	N/A	2.976%
Rate: Falls (Per 1,000 Patient Days)	2.54	3.54	2.94	3.04
Rate: Falls with Injury (Per 1,000 Patient Days)	0.17	0.047	0.1	0.108



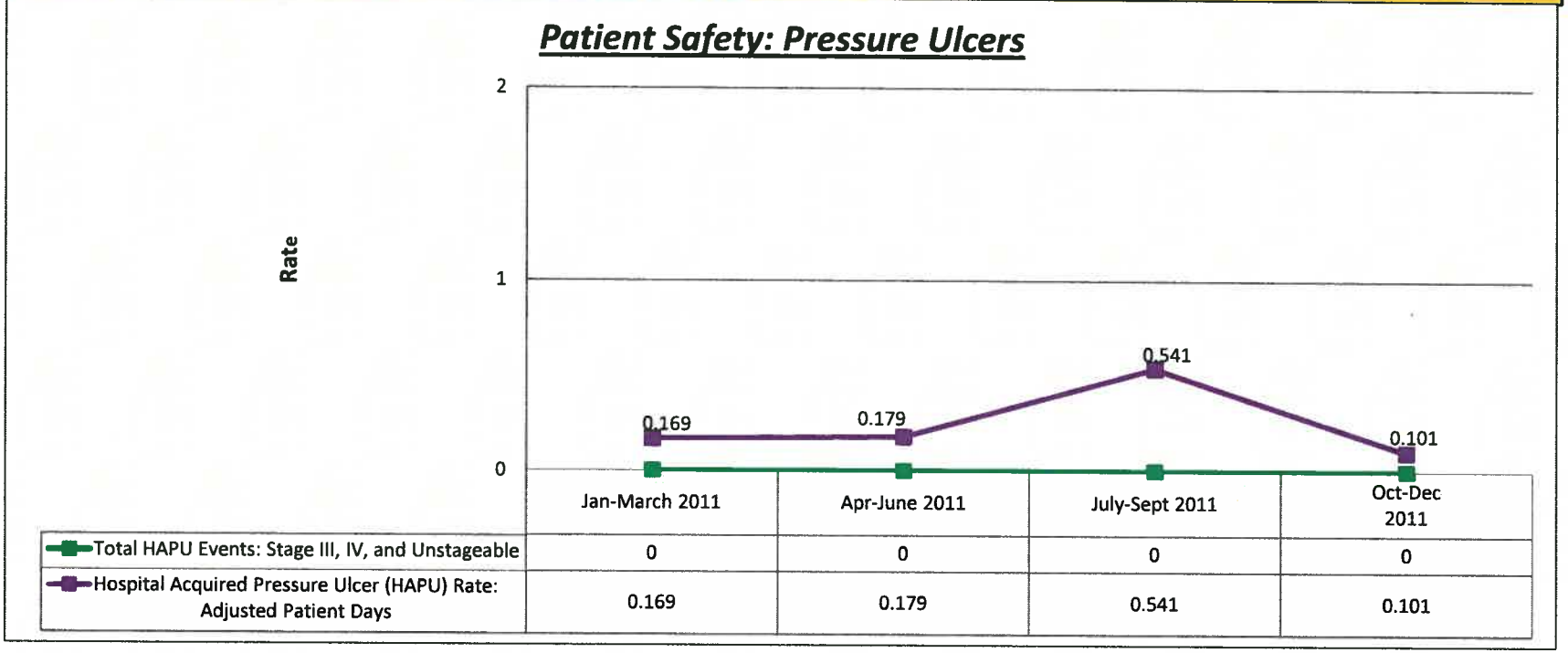
Patient Safety: Falls				
Indicator	*CY 2010*	*CY 2011*	*CALNOC Benchmark*	*Total*
Total Falls (Inpatient and Outpatient)	119	149	N/A	268
Total Falls With Injury (Inpatient and Outpatient)	8	2	N/A	10
% Falls with Injury	6.70%	0.05%	N/A	2.976%
Rate: Falls (Per 1,000 Patient Days)	2.54	3.54	2.94	3.04
Rate: Falls with Injury (Per 1,000 Patient Days)	0.17	0.047	0.1	0.108



Quality/Patient Safety Metrics

Patient Safety: Pressure Ulcers							
Indicator	*Jan-March 2011*	*Apr-June 2011*	*July-Sept 2011*	*Oct-Dec 2011*	*CY 2011*	*Beacon 10/28/10 Benchmark*	*Total*
Total HAPU Events: Stage III, IV, and Unstageable	0	0	0	0	0	N/A	0
Patient Skin/Wound Integrity Events (All reported events)	57	33	53	14	157	N/A	157
Hospital Acquired Pressure Ulcer (HAPU) Rate: Adjusted Patient Days	0.169	0.179	0.541	0.101	0.237	Beacon Collaborative Benchmark **0.2**	0.237

Statistical Process Control Charts



DOCTORS MEDICAL CENTER

Patient Satisfaction (HCAHPS)								
INDICATOR	Threshold	Target	Goal	1st Qtr 2011	2nd Qtr 2011	3rd Qtr 2011	4th Qtr 2011	3rd to 4th Qtr 2011
Patient Satisfaction -Top Box Scores(HCAHPS)	US Average	CA Average	DMC	Top Box	Top Box	Top Box	Top Box	%Change
Number of Surveys Returned	CMS Required Minimum= 300+ Annually			314	279	242	231	N/A
Mean Score (Related to Press Ganey Supplemental Questions)	Unavailable	Unavailable	80%	77%	76%	79%	75%	↓ 4%
Patients who gave DMC a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	67%	63%	63%	48%	44%	50%	44%	↓ 6%
Patients who reported YES, they would definitely recommend the hospital.	69%	67%	67%	45%	49%	52%	46%	↓ 6%
Patients who reported that their nurses "Always" communicated well.	76%	71%	70%	64%	60%	62%	60%	↓ 2%
Patients who reported that their doctors "Always" communicated well.	80%	76%	76%	70%	71%	73%	70%	↓ 3%
Patients who reported that they "Always" received help as soon as they wanted.	64%	57%	57%	44%	44%	49%	40%	↓ 9%
Patients who reported that their pain was "Always" well controlled.	69%	66%	65%	59%	56%	53%	55%	↑ 2%
Patients who reported that staff "Always" explained about medicines before giving it to them.	61%	56%	56%	51%	46%	49%	46%	↓ 3%
Patients who reported that the area around their room was "Always" quiet at night.	58%	48%	47%	38%	38%	41%	41%	–
Patients who reported that their room and bathroom were "Always" clean.	71%	68%	67%	61%	59%	60%	55%	↓ 5%
Patients who reported that YES, they were given information about what to do during their recovery at home.	81%	79%	79%	74%	71%	75%	71%	↓ 4%

Definitions

Top Box- HCAHPS response rates of patients who provided the highest score in each domain or stand alone question. Example: Definitely Yes, Always and 9-10
Mean Score- An average of all Press Ganey Supplemental question responses based on a 0-100 scoring system. Example: Very Poor=0, Poor=25, Fair=50, Good=75, Very Good=100

Doctors Medical Center

QUALITY MEASURES / PERFORMANCE IMPROVEMENT TREND REPORT

TEAM/DEPARTMENT/SERVICE: **Worker's Safety- Employee Health**

Data Range: CY 2011

Legend: N = Numerator D = Denominator

PERFORMANCE IMPROVEMENT REPORT		JAN AVG	FEB AVG	MAR AVG	1STQTR 2011 AVG	APR AVG	MAY AVG	JUN AVG	2ND QTR 2011 AVG	JULY AVG	AUG AVG	SEPT AVG	3RD QTR 2011 AVG	OCT AVG	NOV AVG	DEC AVG	4TH QTR 2011 AVG	2011 AVG
NUMERATOR/DENOMINATOR																		
Employee Exposures		0	0	0	0	0	0	0	0	0	70	0	23	0	70	0	23	11.67
Employee PPD Conversion Rate		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00
PPD Compliance Rate	N	957	956	953	955	961	951	945	952	967	929	883	926	862	882	852	865	
	D	971	976	978	975	985	986	987	986	996	973	960	976	960	954	940	951	
		99%	98%	97%	98%	98%	96%	96%	97%	97%	95%	92%	95%	90%	92%	91%	91%	95%
FIT Compliance Rate	N	960	966	953	960	954	947	940	947	973	929	902	935	902	884	858	881	
	D	971	976	978	975	985	986	987	986	996	973	960	976	960	954	940	951	
		99%	99%	97%	98%	97%	96%	95%	96%	98%	95%	94%	98%	94%	93%	91%	93%	96%
Bloodborne Exposures: Needle Sticks		1	1	2	1	1	1	2	1	1	1	0	1	6	2	1	3	1.58

Variance

Oct 2011: 6 Needlesticks; 2 punctures
Nov 2011: 2 Needlesticks
Dec 2011: 2 Needlesticks;1 puncture

Q4 2011: *10 Needlesticks; 3 punctures*

Variance: *+8 Needlesticks; +2 punctures; 0 lacerations; 0 splash*

Action Plan

Situation: 6 Needlesticks in 2011 from Kendall Monoject Insulin Safety Syringe. Recapping is antiquated and requires two hands, often resulting in needlestick while capping, instant distraction resulting in needlestick as capping not completed.

Background: Ordering Kendall Safety Insulin Syringe since July, 2006. Outdated.

Action Taken & Results: Have completed re-education for nurses on recapping by placing posters on floors and verbal education. Needlesticks continue. Education completed with each employee involved in needlestick.

Recommendations & follow-up: Consulted with vendor for choices in updated, safer syringes. Vendor supplied cost analysis. Recommend to upgrade to Megallan Insulin Safety Syringe. Will schedule recommendation on Supply Committee agenda for Feb. 2012. Presented recommendation to Infection Control meeting in January 2012 and had unanimous approval for change.

Doctors Medical Center

PERFORMANCE MEASUREMENT REPORT - Annual Risk Management Summary

TEAM/DEPARTMENT/SERVICE: **Annual Risk Management Report** Year: _____

Legend: N = Numerator D = Denominator CDPH = California Department of Public Health

PERFORMANCE MEASURE NUMERATOR/DENOMINATOR	Change		JAN AVG	FEB AVG	MAR AVG	1ST QTR AVG	APR AVG	MAY AVG	JUN AVG	2ND QTR AVG	JUL AVG	AUG AVG	SEP AVG	3RD QTR AVG	OCT AVG	NOV AVG	DEC AVG	4TH QTR AVG	YTD AVG
Visitor Falls/Total Patient Falls	▬	V	1			1		3		3			2	2			1	1	7
		P				41				45				32				31	149
Potential Risk Claims Reported /Resulted in Claims at the end of 2011	▬	N				0				0				0				0	0
		D				0	1			1	3	1	1	5	2		4	6	12
2011 Healthcare Liability Claims Opened/Claims Opened since 2004	↓	N	1			1	1			2		3		3		2		2	7
		D				NA				NA				NA				NA	16
2011 Wrongful Employment Cases/4 open from prior years	↑	N				0		11	1	12	1			1	1			1	14
		D				NA				NA				NA				NA	17
Total Number of Claims Closed /All Closed Cases (Current & Prior Years) 70 Cases - 2004	↑	N	1	1	4	6	1	2		3	3			3	3		3	6	18
		D				NA				NA				NA				NA	54
Pressure Ulcers (Total vs # Reported to CDPH - Stage III/IV & Unstageable) - 2 Pending Investigation		N				0				0				1				2	3
		D				NA				NA				NA				NA	157

2011 Resouce Funds Remaining for Use : $5,343.00. 9.9 million in aggregate funds remaining for 2011.

PERFORMANCE MEASUREMENT REPORT

TEAM/DEPARTMENT/SERVICE: _____ Quarter: 0 Year: _____

Legend: N = Numerator D = Denominator

PERFORMANCE MEASURE NUMERATOR/DENOMINATOR	LEVEL OF COMPARISON TRIGGER		1ST QTR AVG	2ND QTR AVG	3RD QTR AVG	4TH QTR AVG	YTD AVG	COMPARISON LAST YEAR	COMPARISON BENCH MARK
Visitor Falls/Total Patient Falls	0	N	1	3	2	1	7	#REF!	#REF!
		D	41	45	32	31	149		
		%	#REF!	0	0	0	0		
0	0	N	0	1	5	6	12	0	#REF!
		D	0	2	3	2	7		
		%	#REF!	NA	NA	NA	16		
2011 Wrongful Employment Cases/4 open from prior years	0	N	1	12	1	1	14	0	#REF!
		D	NA	NA	NA	NA	17		
		%	#REF!	3	3	6	18		
0	0	N	0	NA	NA	NA	54	0	#REF!
		D	NA	0	1	2	3		
		%	#REF!	NA	NA	NA	157		
0	0	N	6	0	0	0	0	0	#REF!
		D	NA	0	0	0	0		
		%	#REF!	0	0	0	0		
0	0	N	0	0	0	0	0	0	#REF!
		D	NA	0	0	0	0		
		%	0	0	0	0	0		
0	0	N	#REF!	0	0	0	0	0	#REF!
		D	#REF!	0	0	0	0		
		%	#REF!	0	0	0	0		

#REF! #REF!

BETA Risk Management Authority
Report For West Contra Costa Healthcare District
Claims Financial Summary As Of 1/31/2012
Coverage Contract: Directors & Officers Liability

CONTRACT YEAR		BETA DEDUCTIBLE PAID PAID	BETA DEDUCTIBLE PAID BY MEMBER	TOTAL PAID	OUTSTANDING RESERVES	DEDUCTIBLE OUTSTANDING	TOTAL INCURRED GROSS	TOTAL INCURRED NET	CLAIM COUNTS OPEN	CLAIM COUNTS CLOSED	CLAIM COUNTS TOTAL
2004	INDEMNITY	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	EXPENSE	0.00	5.00	5.00	0.00	0.00	5.00	0.00			
	TOTAL	**0.00**	**5.00**	**5.00**	**0.00**	**0.00**	**5.00**	**0.00**	**0**	**1**	**1**
2005	INDEMNITY	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	EXPENSE	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	TOTAL	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0**	**0**	**0**
2006	INDEMNITY	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	EXPENSE	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	TOTAL	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0**	**0**	**0**
2007	INDEMNITY	125,000.00	0.00	125,000.00	25,000.00	0.00	150,000.00	150,000.00			
	EXPENSE	57,446.75	78,166.00	135,612.75	1,058.78	0.00	136,671.53	58,505.53			
	TOTAL	**182,446.75**	**78,166.00**	**260,612.75**	**26,058.78**	**0.00**	**286,671.53**	**208,505.53**	**1**	**3**	**4**
2008	INDEMNITY	44,000.00	0.00	44,000.00	0.00	0.00	44,000.00	44,000.00			
	EXPENSE	6,710.74	27,642.50	34,353.24	0.00	0.00	34,353.24	6,710.74			
	TOTAL	**50,710.74**	**27,642.50**	**78,353.24**	**0.00**	**0.00**	**78,353.24**	**50,710.74**	**0**	**2**	**2**
2009	INDEMNITY	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	EXPENSE	0.00	21,296.51	21,296.51	0.00	0.00	21,296.51	0.00			
	TOTAL	**0.00**	**21,296.51**	**21,296.51**	**0.00**	**0.00**	**21,296.51**	**0.00**	**0**	**4**	**4**
2010	INDEMNITY	0.00	0.00	0.00	90,000.00	10,000.00	90,000.00	80,000.00			
	EXPENSE	2,288.90	52,935.30	55,224.20	46,861.42	19,150.32	102,085.62	30,000.00			
	TOTAL	**2,288.90**	**52,935.30**	**55,224.20**	**136,861.42**	**29,150.32**	**192,085.62**	**110,000.00**	**13**	**1**	**14**
2011	INDEMNITY	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	EXPENSE	0.00	10,677.74	10,677.74	29,322.26	29,322.26	40,000.00	0.00			
	TOTAL	**0.00**	**10,677.74**	**10,677.74**	**29,322.26**	**29,322.26**	**40,000.00**	**0.00**	**3**	**0**	**3**
ALL YEARS:	INDEMNITY	169,000.00	0.00	169,000.00	115,000.00	10,000.00	284,000.00	274,000.00			
	EXPENSE	66,446.39	190,723.05	257,169.44	77,242.46	48,472.58	334,411.90	95,216.27			
	TOTAL	**235,446.39**	**190,723.05**	**426,169.44**	**192,242.46**	**58,472.58**	**618,411.90**	**369,216.27**	**17**	**11**	**28**

Definitions: *Deductible Outstanding is the maximum anticipated deductible remaining based on current reserves and payments*
Gross Incurred = Outstanding Reserves + Total Paid
Net Incurred = Gross Incurred - Deductible Paid - Deductible Outstanding By Member

Privileged and Confidential Communication

BETA Risk Management Authority
Report For West Contra Costa Healthcare District
Claims Financial Summary As Of 1/31/2012
Coverage Contract: Healthcare Entity Comprehensive Liability

CONTRACT YEAR		BETA DEDUCTIBLE PAID PAID	BETA DEDUCTIBLE PAID BY MEMBER	TOTAL PAID	OUTSTANDING RESERVES	DEDUCTIBLE OUTSTANDING	TOTAL INCURRED GROSS	TOTAL INCURRED NET	CLAIM COUNTS OPEN	CLAIM COUNTS CLOSED	CLAIM COUNTS TOTAL
2004	INDEMNITY	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	EXPENSE	149,965.10	0.00	149,965.10	0.00	0.00	149,965.10	149,965.10			
	TOTAL	**149,965.10**	**0.00**	**149,965.10**	**0.00**	**0.00**	**149,965.10**	**149,965.10**	**0**	**5**	**5**
2005	INDEMNITY	75,000.00	10,000.00	85,000.00	0.00	0.00	85,000.00	75,000.00			
	EXPENSE	67,743.01	67,343.50	135,086.51	0.00	0.00	135,086.51	67,743.01			
	TOTAL	**142,743.01**	**77,343.50**	**220,086.51**	**0.00**	**0.00**	**220,086.51**	**142,743.01**	**0**	**11**	**11**
2006	INDEMNITY	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	EXPENSE	0.00	22,516.51	22,516.51	0.00	0.00	22,516.51	0.00			
	TOTAL	**0.00**	**22,516.51**	**22,516.51**	**0.00**	**0.00**	**22,516.51**	**0.00**	**0**	**8**	**8**
2007	INDEMNITY	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	EXPENSE	257,618.47	83,919.46	341,537.93	0.00	0.00	341,537.93	257,618.47			
	TOTAL	**257,618.47**	**83,919.46**	**341,537.93**	**0.00**	**0.00**	**341,537.93**	**257,618.47**	**0**	**8**	**8**
2008	INDEMNITY	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	EXPENSE	0.00	32,339.43	32,339.43	0.00	0.00	32,339.43	0.00			
	TOTAL	**0.00**	**32,339.43**	**32,339.43**	**0.00**	**0.00**	**32,339.43**	**0.00**	**0**	**8**	**8**
2009	INDEMNITY	18,028.05	15,756.67	33,784.72	75,000.00	0.00	108,784.72	93,028.05			
	EXPENSE	49,272.09	74,579.40	123,851.49	9,570.95	7,646.69	133,422.44	51,196.35			
	TOTAL	**67,300.14**	**90,336.07**	**157,636.21**	**84,570.95**	**7,646.69**	**242,207.16**	**144,224.40**	**2**	**9**	**11**
2010	INDEMNITY	0.00	8,242.34	8,242.34	10,000.00	10,000.00	18,242.34	0.00			
	EXPENSE	9,674.77	15,580.03	25,254.80	35,854.35	20,529.12	61,109.15	25,000.00			
	TOTAL	**9,674.77**	**23,822.37**	**33,497.14**	**45,854.35**	**30,529.12**	**79,351.49**	**25,000.00**	**6**	**6**	**12**
2011	INDEMNITY	4,999.00	25,000.00	29,999.00	0.00	0.00	29,999.00	4,999.00			
	EXPENSE	214.27	2,583.17	2,797.44	21,202.56	20,916.83	24,000.00	500.00			
	TOTAL	**5,213.27**	**27,583.17**	**32,796.44**	**21,202.56**	**20,916.83**	**53,999.00**	**5,499.00**	**8**	**0**	**8**
ALL YEARS:	INDEMNITY	98,027.05	58,999.01	157,026.06	85,000.00	10,000.00	242,026.06	173,027.05			
	EXPENSE	534,487.71	298,861.50	833,349.21	66,627.86	49,092.64	899,977.07	552,022.93			
	TOTAL	**632,514.76**	**357,860.51**	**990,375.27**	**151,627.86**	**59,092.64**	**1,142,003.13**	**725,049.98**	**16**	**55**	**71**

Definitions: *Deductible Outstanding is the maximum anticipated deductible remaining based on current reserves and payments*
Gross Incurred = Outstanding Reserves + Total Paid
Net Incurred = Gross Incurred - Deductible Paid - Deductible Outstanding By Member

Privileged and Confidential Communication

DOCTORS
MEDICAL CENTER

FINANCIALS

TAB 8

DOCTORS MEDICAL CENTER

Board Presentation

February 2012 Financial Report

Statement of Activity – Summary

For the Period Ending

February 29, 2012

(Thousands)

Month to Date				Year to Date		
Actual	Budget	Var		Actual	Budget	Var
9,373	10,432	(1,059)	Net Operating Revenues $	18,910	21,408	(2,498)
11,636	12,416	780	Total Operating Expenses $	23,595	25,353	1,758
(2,263)	(1,984)	(279)	Income/(Loss) from Operations $	(4,685)	(3,945)	(740)
541	641	(100)	Income from Other Sources $	1,069	1,082	(13)
(1,722)	(1,343)	(379)	Net Income / (Loss) $	(3,616)	(2,863)	(753)
2,182	2,454	(272)	Patient Days	4,551	5,022	(471)
463	534	(71)	Discharges	956	1,031	(75)
6,267	6,111	156	Outpatient Visits	13,029	12,758	271
645	648	3	Worked FTE's	629	649	20
1.44	1.63	0.19	Medicare CMI	1.57	1.59	0.02

Budget Variances – Net Revenue

- Government - ($257K).
- Medi-Cal / Medi-Cal HMO - ($715K).
- Medicare / Medicare HMO- ($257K).

Budget Variances – Expenses

- Salaries & Benefits $227 – Increased cost for staffing for Paragon upgrade, reduction in standby cost.
- Supplies $382K – Reduction in implants.
- Purchased Services $129K – Reduced cost for services in many departments.
- Rentals Expenses $62K – Lower rental of medical equipment.

Cash Position
February 29, 2012

(Thousands)

	February 29, 2012	December 31, 2011
Unrestricted Cash	$3,316	$13,972
Restricted Cash	$29,174	$29,847
Total Cash	$32,490	$43,819
Days Unrestricted Cash	8	33
Days Restricted	74	72
Total Days of Cash	83	106

California Benchmark Average	34
Top 25%	82
Top 10%	183

Cash Flow
February 29, 2012

(Thousands)

	Year to Date
Beginning Balance	$13,900
Operations Loss	(3,600)
Operation Non-Cash Items	(700)
Gemino Loan	(1,500)
Reduced Payables	(3,200)
Accounts Receivable Change	(3,700)
Payroll Timing	2,100
Cash Balance	$3,300

Accounts Receivable

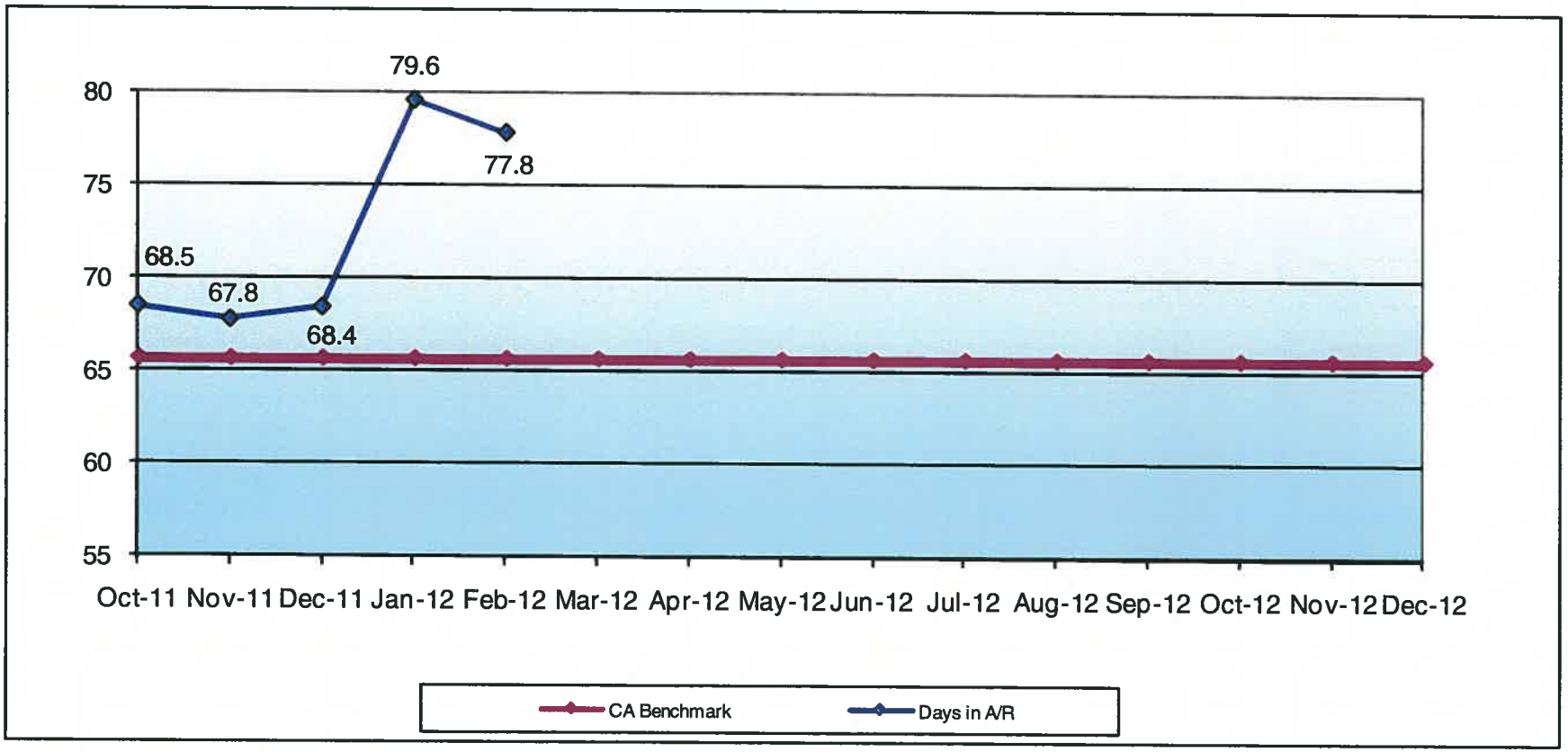
February 29, 2012

(Thousands)

	February 29, 2012	December 31, 2011
Net Patient Accounts Receivable	$22,850	$19,177
Net Days in Accounts Receivable	77.8	60.7

California Benchmark Average	65.7 days
Top 25%	45.2 days
Top 10%	35.5 days

Accounts Receivable
Net Days in A/R



Financial Report Key Points

- Net Loss was $1.7M in February.
- Expenses generally under budget
- Paragon increase costs and increased Accounts Receivables.
- Increased Accounts receivable decreased cash available.

DOCTORS MEDICAL CENTER

February 2012 Executive Report

Doctors Medical Center had a Net Loss of $1,722,000 in the month of February. As a result, net income was under budget by $379,000. The following are the other factors leading to the Net Income variance:

Net Patient Revenue Factors	**Over / (Under)**
Government	($257,000)
Medi-Cal / Medi-Cal HMO	(715,000)
Medicare / Medicare HMO	($244,000)
Expenses	
Salaries & Benefits	$227,000
Supplies	$382,000
Purchased Services	$129,000
Rentals	$62,000
Other	$54,000

Net patient revenue was under budget by $1,013,000. Gross charges were under budget in February 12.2%. Patient days were 11.1% under budget and discharges were 13.3% under budget. The revenue variance of $715,000 for Medi-Cal is due to the reduction in Medi-Cal days. The Medi-Cal mix was down 7% in February. The Government payors were under budget in volume for the month with Medicare's variance due to the low case mix.

Salaries and Benefits combined were under budget $227,000 or 2.9% while patient days were 11.1% under budget. Worked FTE's were over budget 0.4%. We staffed up the hospital for the go live of the Paragon system and this increased staffing levels which also increased overtime. Overtime by itself accounted for a negative $67,000 variance. Our Standby costs are under budget with $290,000 of the reduction in the Cath Lab. We also incurred severance pay for an employee.

Supplies were under budget $382,000. All of the supply reduction was for implant costs.

Purchased services was under budget $129,000 in February. Costs for purchased services were down in many departments for dialysis, lab referrals and general purchased services.

Rentals were under budget $62,000. We incurred insignificant rental costs for medical equipment in the month of February

Other Expenses were under $54,000. We continue to restrict travel in the organization and we have yet to incur the budgeted recruitment costs.

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
February 29, 2012
(Amounts in Thousands)

	CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
	ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
						OPERATING REVENUE					
1	9,304	10,317	(1,013)	-9.8%	10,255	Net Patient Service Revenue	18,766	21,176	(2,410)	-11.4%	21,755
2	69	115	(46)	-39.8%	91	Other Revenue	144	232	(88)	-37.9%	170
3	9,373	10,432	(1,059)	-10.1%	10,346	**Total Operating Revenue**	18,910	21,408	(2,498)	-11.7%	21,925
						OPERATING EXPENSES					
4	5,097	4,994	(103)	-2.1%	5,437	Salaries & Wages	10,265	10,286	21	0.2%	10,914
5	2,565	2,895	330	11.4%	2,470	Employee Benefits	5,323	5,845	522	8.9%	5,408
6	937	881	(56)	-6.4%	912	Professional Fees	1,717	1,766	49	2.8%	1,806
7	1,327	1,709	382	22.3%	1,677	Supplies	2,824	3,524	700	19.9%	3,663
8	847	976	129	13.2%	941	Purchased Services	1,632	1,943	311	16.0%	1,713
9	208	270	62	23.0%	225	Rentals & Leases	506	537	31	5.7%	397
10	386	369	(17)	-4.7%	346	Depreciation & Amortization	734	738	4	0.5%	692
11	-	-	-			Restructuring Costs	-	-	-		
11	269	323	54	16.6%	354	Other Operating Expenses	594	716	122	17.0%	667
12	11,636	12,416	780	6.3%	12,362	**Total Operating Expenses**	23,595	25,353	1,758	6.9%	25,260
13	(2,263)	(1,984)	(279)	14.1%	(2,016)	**Operating Profit / Loss**	(4,685)	(3,945)	(740)	18.8%	(3,335)
						NON-OPERATING REVENUES (EXPENSES)					
14	-	100	(100)	0.0%	-	Other Non-Operating Revenue	-	-	-	0.0%	-
15	708	706	2	-0.3%	708	District Tax Revenue	1,416	1,412	4	-0.3%	1,459
16	1	4	(3)	-76.4%	5	Investment Income	5	8	(3)	-41.0%	9
17	(168)	(169)	1	0.0%	(110)	Less: Interest Expense	(352)	(339)	(13)	3.9%	(224)
18	541	641	(100)	-15.7%	603	**Total Net Non-Operating**	1,069	1,082	(13)	-1.2%	1,244
19	(1,722)	(1,343)	(379)	28.3%	(1,413)	**Income Profit (Loss)**	(3,616)	(2,863)	(753)	26%	(2,091)
						Profitability Ratios:					
20	-24.1%	-19.0%	26.3%		-19.5%	Operating Margin %	-24.8%	-18.4%	29.6%		-15.2%
21	-18.4%	-12.9%	-5.5%		-13.7%	Profit Margin %	-19.1%	-13.4%	-5.7%		-9.5%

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
February 29, 2012
(Amounts in Thousands)

22	2,262	2,250	(12)	-0.5%	2,198	SWB / APD	2,213	2,202	(11)	-0.5%	2,172
23	65.8%	63.5%			64.0%	SWB / Total Operating Expenses	66.1%	63.6%			64.6%
24	3,435	3,541	106	3.0%	3,437	Total Operating Expenses / APD	3,349	3,461	112	3.2%	3,362
25	34,390	42,572	(8,182)	-19.2%	43,742	I/P Gross Charges	71,486	85,512	(14,026)	-16.4%	87,656
26	19,002	18,251	751	4.1%	18,123	O/P Gross Charges	39,174	39,225	(51)	-0.1%	38,729
27	**53,392**	**60,823**	**(7,431)**	**-12.2%**	**61,865**	**Total Gross Charges**	**110,660**	**124,737**	**(14,077)**	**-11.3%**	**126,385**
						Payor Mix (IP and OP)					
28	39%	40%	-1%		40%	Medicare %	38%	40%	-2%		42%
29	6%	16%	-10%		15%	Medi-Cal %	8%	16%	-8%		15%
30	15%	12%	3%		11%	Managed Care HMO / PPO %	14%	12%	2%		11%
31	13%	9%	4%		9%	Medicare HMO %	12%	10%	3%		10%
32	12%	9%	3%		11%	Medi-Cal HMO %	14%	9%	5%		9%
33	0%	0%	0%		0%	Commercial %	0%	0%	0%		0%
34	1%	1%	0%		1%	Worker's Comp %	1%	1%	0%		1%
35	3%	3%	0%		4%	Other Government %	3%	3%	-1%		4%
36	11%	10%	1%		9%	Self Pay /Charity %	11%	10%	2%		9%
						STATISTICS					
37	470	542	(72)	-13.3%	546	Admissions	959	1,052	(93)	-8.8%	1,106
38	463	534	(71)	-13.3%	537	Discharges	956	1,031	(75)	-7.3%	1,080
39	2,182	2,454	(272)	-11.1%	2,543	Patient Days	4,551	5,022	(471)	-9.4%	5,211
40	75.2	84.6	(9.4)	-11.1%	90.8	Average Daily Census (ADC)	75.9	83.7	(7.9)	-9.4%	88.3
41	4.71	4.60	(0.12)	-2.6%	4.74	Average Length of Stay (LOS)	4.76	4.87	0.11	2.3%	4.83
42	29	29			28	Days in Month	60	60			59
43	719	763	(44)	-5.8%	759	Adjusted Discharges (AD)	1,480	1,504	(24)	-1.6%	1,557
44	3,388	3,506	(118)	-3.4%	3,597	Adjusted Patient Days (APD)	7,045	7,326	(281)	-3.8%	7,513
45	117	121	(4)	-3.4%	128	Adjusted ADC (AADC)	117	122	(5)	-3.8%	127
46	70	91	(21)	-23.1%	91	Inpatient Surgeries	142	185	(43)	-23.2%	185
47	95	79	16	20.3%	79	Outpatient Surgeries	200	164	36	22.0%	164
48	**165**	**170**	(5)	-2.9%	**170**	**Total Surgeries**	**342**	**349**	(7)	-2.0%	**349**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
February 29, 2012
(Amounts in Thousands)

49	2,954	2,648	306	11.6%	2,818	ED Outpatient Visits	6,021	5,482	539	9.8%	5,819
50	3,218	3,384	(166)	-4.9%	3,384	Ancillary Outpatient Visits	6,808	7,112	(304)	-4.3%	7,112
51	95	79	16	20.3%	79	Outpatient Surgeries	200	164	36	22.0%	164
52	**6,267**	**6,111**	156	2.6%	**6,281**	**Total Outpatient Visits**	**13,029**	**12,758**	271	2.1%	**13,095**
53	435	459	(24)	-5.2%	480	Emergency Room Admits	882	950	(68)	-7.2%	968
54	14.7%	17.3%			17.0%	% of Total E/R Visits	14.6%	17.3%			16.6%
55	92.6%	84.7%			87.9%	% of Acute Admissions	92.0%	90.3%			87.5%
56	645	648	3	0.4%	749	Worked FTE	629	649	20	3.1%	707
57	718	731	13	1.8%	826	Paid FTE	738	742	4	0.6%	820
58	5.52	5.36	(0.17)	-3.1%	5.83	Worked FTE / AADC	5.36	5.24	(0.11)	-2.1%	5.55
59	6.14	6.05	(0.10)	-1.6%	6.43	Paid FTE / AADC	6.28	5.99	(0.29)	-4.9%	6.44
60	2,746	2,943	(196)	-6.7%	2,851	Net Patient Revenue / APD	2,664	2,891	(227)	-7.9%	2,896
61	15,761	17,348	(1,587)	-9.1%	17,201	I/P Charges / Patient Days	15,708	17,027	(1,320)	-7.8%	16,821
62	3,032	2,987	45	1.5%	2,885	O/P Charges / Visit	3,007	3,075	(68)	-2.2%	2,958
63	1,505	1,424	(80)	-5.6%	1,512	Salary Expense / APD	1,457	1,404	(53)	-3.8%	1,453
64	4.5	5.4	0.90	16.5%	5.1	Medicare LOS	4.6	5.8	1.14	19.7%	5.1
65	1.44	1.63	0.19	11.4%	1.63	Medicare CMI	1.57	1.59	0.02	1.4%	1.6
66	3.15	3.34	0.19	5.8%	3.12	Medicare CMI Adjusted LOS	2.96	3.64	0.68	18.6%	3.19
67	4.7	4.7	0.05	1.1%	4.39	Total LOS	4.7	4.8	0.09	1.9%	4.72
68	1.450	1.515	0.06	4.3%	1.51	Total CMI	1.485	1.496	0.01	0.7%	1.50
69	3.23	3.13	(0.10)	-3.3%	2.90	Total CMI Adjusted LOS	3.19	3.23	0.04	1.2%	3.15

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
February 29, 2012
(Amounts in Thousands)

		Current Month	Dec. 31, 2011
	ASSETS		
70	Cash	3,316	13,972
71	Net Patient Accounts Receivable	22,850	19,177
72	Other Receivables	2,118	1,160
73	Inventory	2,125	2,109
73	Current Assets With Limited Use	29,174	29,847
74	Prepaid Expenses and Deposits	745	999
75	**TOTAL CURRENT ASSETS**	**60,328**	**67,264**
76	**Assets With Limited Use**	**642**	**642**
	Property Plant & Equipment		
77	Land	12,120	12,120
78	Bldg/Leasehold Improvements	29,432	33,733
79	Capital Leases	10,926	10,926
80	Equipment	41,673	34,074
81	CIP	319	3,129
82	Total Property, Plant & Equipment	94,470	93,982
83	Accumulated Depreciation	-49,923	-49,200
84	**Net Property, Plant & Equipment**	**44,547**	**44,782**
85	**Intangible Assets**	**1,507**	**1,517**
86	**Total Assets**	**107,024**	**114,205**
87	Current Ratio (CA/CL)	***1.85***	***1.89***
88	Net Working Capital (CA-CL)	***27,749***	***31,750***
89	Long Term Debt Ratio (LTD/TA)	***0.59***	***0.55***
90	Long Term Debt to Capital (LTD/(LTD+TE)	***0.91***	***0.87***
91	Financial Leverage (TA/TE)	***17.7***	***11.8***
92	Quick Ratio	**0.80**	**0.93**
93	Unrestricted Cash Days	**8**	**33**
94	Restricted Cash Days	**74**	**72**
95	Net A/R Days	**77.8**	**60.7**

		Current Month	Dec. 31, 2011
	LIABILITIES		
96	Current Maturities of Debt Borrowings	1,644	1,634
97	Accounts Payable and Accrued Expenses	11,264	16,021
98	Accrued Payroll and Related Liabilities	15,359	13,639
99	Deferred District Tax Revenue	2,880	2,880
100	Estimated Third Party Payor Settlements	1,432	1,340
101	**Total Current Liabilities**	**32,579**	**35,514**
	Other Liabilities		
102	Other Deferred Liabilities	5,624	6,105
103	Chapter 9 Bankruptcy	0	0
	Long Term Debt		
104	Notes Payable - Secured	62,063	62,067
105	Capital Leases	2,346	2,481
106	Less Current Portion LTD	-1,644	-1,634
107	**Total Long Term Debt**	**62,765**	**62,914**
108	**Total Liabilities**	**100,968**	**104,533**
	EQUITY		
109	Retained Earnings	9,672	28,400
110	Year to Date Profit / (Loss)	-3,616	-18,728
111	**Total Equity**	**6,056**	**9,672**
112	**Total Liabilities & Equity**	**107,024**	**114,205**

DOCTORS
MEDICAL CENTER

3RD FLOOR TELEMETRY EXPANSION

TAB 9

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
GOVERNING BODY
BOARD OF DIRECTORS
CONTRACT RECOMMENDATION FORM

TO: **GOVERNING BODY**
BOARD OF F DIRECTORS

FROM: **BOBBIE ELLERSTON, INTERIM VICE PRESIDENT, PATIENT CARE SERVICES**

DATE: **March 28, 2012**

SUBJECT: **3RD FLOOR TELEMETRY EXPANSION**

SPECIFIC REQUEST(S) OR RECOMMENDATION(S) AND BACKGROUND WITH JUSTIFICATION

REQUEST / RECOMMENDATION(S): Recommend to the District Board to approve and authorize the Vice President of Patient Care Services to execute on behalf of DMC, approval of the proposal to add a new 1.4HGz wireless telemetry system to the 3rd floor.

FISCAL IMPACT:		
	Project Management by Philips Healthcare	**$27,676**
	Telemetry equipment, including software	**$199,000**
	Installation of CAT 5 cabling	**$20,000 (estimate)**
	Total	**$246,676**

STRATEGIC IMPACT: This will allow the facility to add 12 (twelve) additional beds to the existing system. By completing this upgrade, we will be able to de-congest the 4th floor, and allow for more opportunities to provide private rooms for our monitored patients.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: The existing telemetry system has reach end-of-life, and is no longer supported by the manufacturer. By expanding the telemetry system, we will also upgrade the 4th floor with the most current software revision.

Presentation Attachments: Yes____No____

Requesting Signature: _____ Date: ___ / ___ / ___

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____

Vote of Board Members:

____ Unanimous (Absent____)
Ayes: ____ Noes: ____
Absent: ____ Abstain: ____

I HEREBY ATTEST THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person:

Attested by: _____
Eric Zell, Chair, Governing Body
Board of Directors

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

PHILIPS

Dear Philips Monitoring Customer,

Philips Medical Systems values its worldwide leadership role in acute-care patient monitoring systems and critical-care clinical information systems. We continue to focus on our mission to provide you with a strong line of patient monitors with a platform that grows with your clinical needs.

In 1989, the first Component Monitoring System (CMS) patient monitor was introduced to the healthcare world. At that time, a vision to build a monitoring system with the power to grow . . . and grow . . . and grow was developed. For over fifteen years, CMS has proven to be the world's best-selling family of patient monitors.

In 2002, the latest evolution of the world's best-selling series of patient monitors was introduced -- the Philips IntelliVue Patient Monitoring System with portal technology. In 2004, the Philips intelliVue Telemetry System was introduced.

Philips' IntelliVue Patient Monitoring Systems are the most reliable and flexible in the industry. This new line of patient monitors, wireless monitors and patient worn devices takes the "Monitor for Life" story to the next chapter by providing coexistence, investment protection and a phased approach to technology evolution.

With the introduction and proven success of IntelliVue WMTS Telemetry (M4841A), the Philips Telemetry System (and it's associated components) will enter End of Life / Obsolescence. Please see the chart below for specific product information and important dates:

Product Number	Description	Last Order Date	End of Life / Obsolescence
M2600A	Philips Classic Transmitters	12/2006	12/2006
M2601B	Philips Enhanced (upgradeable) Transmitter	12/2008	12/2011
M2636C	Telemon C	7/31/2008	12/2011
78581B	Serial Communications Controller	7/31/2008	12/2011
M1403A	Philips Telemetry Receiver Mainframe	6/2007	12/2011

Please contact your local sales representative for specific information pertaining to this notification.

Thank you,

Philips Ultrasound and Monitoring
Business Development and Marketing

PHILIPS

Value-Added Services
Statement of Work

Valid for 60 days

Customer:	Doctors Medical Center 2000 Vale Road San Pablo, CA 94806	**Quote Date:** **Quote Number:** **Project ID:**	February 29, 2012 DP110311CAF02DK-B
Project Contact:	Wally Blackwood Biomedical Engineer Phone: 510-260-8609 wblackwood@dmc-sp.org	**Clinical Contact:**	
Prepared by:	Duane Kellogg Pre-Sales Technical Engineer Phone: 916-781-7746 duane.kellogg@philips.com		

Project Description: **3rd Floor Telemetry Expansion - 12ea. PWD's with connection to 1ea. A12 PIC's through 5 ea. AP's tied to upgraded DBS**

Recap of the Current Situation:

This scope of work is for adding a new 1.4GHz wireless telemetry system to the 3rd floor which currently has no patient monitoring. The system will include 12ea. PWD's with connection to an. A12 PIC through 5 ea. AP's tied to upgraded DBS. The new PIC will be located at the 3rd floor nurse station with the PIC CPU being remote to the 4th floor equipment room along with the telemetry stack. The remote PIC and AP cables will run to the 4th floor equipment closet as well with Philips being responsible for providing, pulling, terminating and testing. The existing 4th floor telemetry system includes 4 PIC's tied to a DBS all of which will need to be upgraded to the latest software revision to enable the connection of the new 3rd floor telemetry system.

Solution Description:

The following value added materials and services will be included as part of this quote:

Facilities Services:

- Shelving with mounting hardware to install in the customer provided open frame rack for the remote PIC CPU and system console.
- Labor and materials needed to pull, terminate and test all of the ICN and ITS cables including dust containment for infection control.
- MXU0066 A01M Single Telemetry Transmitter Storage Rack.

Project Management Services:

- Value added services installation and management time needed for network and configuration change planning as well as materials and resource planning and coordination.

Remote Hardware Services:

- A remote KVM extender kit including cables and mounting hardware needed to remote the PIC CPU.
- A Smart1000VA 2RMU UPS needed for the upgraded DBS

Telemetry Implementation Services:

- Telemetry network design, WMTS / ComSearch registration, access point installation and MXU0066 A01M transmitter storage racks.

Product Upgrade Services:

- Upgrade labor needed to bring all of the 4th floor telemetry PIC's and DBS up to the latest software platform.

Value Added Services Details

System	Description	Qty
CENTRAL STATIONS / CLIENTS		
	Installation/ De-Installation/ Re-Location of equip includes services to de-install, install, move, pack, ship, etc (when not bundled w/ equip purchase)	8
	Keyboard: Black, Sealed, USB	1
	Mouse: Black, Sealed, USB	1
	Cabling pulling (includes cable termination, cable testing, penetrations/sealing & cable hangers as required) per location using Non-Union resources	4
	AHA Infection Control Dust Containment; "Tenting" (Per cable location)	2
	12" Dual Channel Counter Top Column (Customer must secure mount to hospital structure.)	1
	Flush Flat Panel Wall Mount	1
	System Console Interface Cable 15'	1
	23" double-sided shelf	2
	Remote single display touch USB recorder KVM Extender kit	2
	Smart1000VA 2RMU UPS	1
TELEMETRY M4841		
	Value Added Services Basic Project Management	2
	Provides for the design and drawings for Access Point design and layout per Access Point	2
	Ceiling wire attachment to antenna base to facilitate seismic requirements (Per Antenna) (Customer must secure mount to hospital structure.)	5
	Single Telemetry Transmitter Storage Rack (Customer must secure mount to hospital structure.)	12
	WMTS Registration Services for 608MHz and 1.4GHz Medical Devices (FCC Mandated)	1
	Cabling pulling (includes cable termination, cable testing, penetrations/sealing & cable hangers as required) per location using Non-Union resources	5
	AHA Infection Control Dust Containment; "Tenting" (Per cable location)	5
UPGRADES		
	Per Unit Price for IIC, Client, DBS Upgrade - Software Only (Includes Labor & Travel to upgrade software and configure)	1
	Per Unit Price for IIC & Client Upgrade - Hardware Box Swap Only (Includes Labor & Travel to upgrade hardware and configure)	4
	Value Added Services Basic Project Management	4

Value Added Services Summary

890500 A04	Facilities Services	$7,124
890500 A07	Project Management Services	$3,220
890500 A09	Remote Hardware Services	$8,095
890500 A12	Telemetry Implementation Services	$1,172
890500 A13	Product Upgrade Services	$5,290
MXU0040	WMTS Registration Services	$1,575
MXU0066 A01M	Single Telemetry Transmitter Storage Rack	$1,200
	Total:	**$27,676**

Hospital's Responsibilities Include:

- Providing access to patient rooms, central station, hallways, and equipment rooms during normal business hours for implementation of all cable runs, mounting hardware installation, and general system installation requirements.
- Providing a single point of contact to work with in planning and implementing the services described.
- Working with Philips Healthcare to accomplish their task, in an agreed upon timeframe, in order to facilitate the project in as few trips as possible.
- The Hospital will perform and document IEC CAT5, 5e and 6 cable certification tests on the critical care monitoring system network. Certification test documentation must be presented to the installation team prior to performing the medical system installation. Store the CAT5, 5e and 6 certification test documentation for 25 years.
- Asbestos removal and containment within all Philips Healthcare work areas above and below ceiling. If it is determined during the implementation that asbestos is present, Philips Healthcare will halt all work and notify the customer to schedule removal or containment.

Additional Customer Responsibilities (if checked):

☐ Customer to install all CAT5, 5e and 6 UTP, STP or FTP cable prior to Philips installation.

☐ Customer to terminate and certify all CAT5, 5e and 6 UTP, STP or FTP cable prior to Philips installation.

☑ Customer to install all Telemetry Antenna cabling as designed by Philips.

☑ Customer to install all Emergency Power as required by Philips.

☑ Customer to install all wall mount channels/ceiling mounts to Hospital structure.

☑ Customer is responsible for any structural changes (cabinets, desks, etc.).

☑ Customer is responsible for providing cable access with boxes to monitored areas.

☐ Customer is responsible to contact the anesthesia cart vendor to check if any cart upgrades may be required when installing mounting hardware to support patient monitoring devices to the cart.

Additional Philips Value-Added Service Responsibilities (if checked):

☑ Quote includes Infection Control/Dust Abatement procedures.

☐ SDC/ITL has Blueprints.

☑ SDC/ITL Did a Pre-Order Pre-site visit.

All prices are based on the following General Qualifications unless specified otherwise:

1 All work is scheduled within normal working hours: Monday – Friday, 8 a.m. to 5 p.m., excluding Philips holidays.

2 It is the hospital's responsibility to provide Philips Healthcare with the access necessary to complete the work on a start to finish manner. Excessive delays and multiple visits will result in additional charges.

3 All prices are based upon t-bar ceilings or hard ceilings with "adequate access" that is free from obstruction.

4 All prices are based upon "adequate access" to work areas that is free from obstruction.

5 Unless stated in the "Services Included" section, this proposal does not include adding additional support structure to the wall or ceiling for attaching mounting hardware. (Philips Healthcare can provide this service for an additional price.)

6 Unless stated otherwise in the "Services Included" section, this proposal does not include the following services:

a. Power receptacle or conduit installation. (Philips Healthcare can provide this service for an additional price.)
b. Conduit or conduit installation. (Philips Healthcare can provide this service for an additional price.)
c. De-installation of existing cabling in ceilings or walls. (Philips Healthcare can provide cable removal and disposal service meeting NFPA and EPA standards for an additional price.)
d. Cabinetry or cabinetry modifications. (Philips Healthcare can provide this service for an additional price.)
e. Interface engine if the hospital's information system does not accept HL7 according to the Philips HL7 PDI specification. (Philips Healthcare can provide this service for an additional price.)
f. Dust containment or HEPA room air filtering control measures. (Philips Healthcare can provide dust containment and room filtering services meeting HEPA and Hospital Infection Control standards for an additional price.)
g. Warranty for hardware provided as part of the value-added service. Most VAS hardware comes with OEM warranty only, and service is the responsibility of the OEM and customer.
h. Existing monitoring instrumentation de-installation. (Philips Healthcare can provide this service for an additional price.)
i. Trash collection, packing material removal, equipment removal, or disposal. (Philips Healthcare can provide removal and disposal services meeting HIPAA and EPA standards for an additional price.)
j. Room or hallway cleaning service. (Philips Healthcare can provide this service for an additional price.)
k. Construction permits and licensing, prevailing wage requirements, and Union Labor. (Philips Healthcare can provide this service for an additional price if agreed upon prior to the proposal acceptance.)

This proposal is good for sixty days from the date listed on the proposal document.

Entire Agreement:

This Statement of Work constitutes the entire agreement between Philips Healthcare and the hospital, and supersedes any previous communications, representations, or agreements between the parties, whether oral or written, regarding the scope and deliverables of this engagement. The terms and conditions to which this document is an exhibit will govern this Statement of Work.

Terms and Conditions:

The enclosed information is for budgetary purposes only. This document does not constitute an offer to sell on the part of Philips Healthcare. Philips Healthcare makes no representation or guarantees of any kind with respect to price, availability, delivery, or other information contained herein, and all such information is subject to change without notice. Philips Healthcare will be happy to provide a formal quotation on request.

Signature:

☐ **Customized Statement of Work - Signature Required**

Signature below indicates acceptance of this consulting services Statement of Work and, combined with a valid signed contract, constitutes authorization for Philips Healthcare to begin work as well as to issue invoices in accordance with the "Payment Schedule" section of the formal quote.

☑ **Standard Statement of Work - Signature Not Required**

Issuance of a Purchase Order (PO) and Philips acceptance of that PO, indicates Customer's acknowledgment that no other contract, fee payments to third parties or terms and conditions will apply to the solutions, goods and/or services contained within this SOW and corresponding quote except as identified on the quotation. The PO constitutes authorization for Philips Healthcare to begin work as well as to issue invoices in accordance with the "Payment Schedule" section of the formal quote.

Philips Healthcare	Hospital Name

PHILIPS

Philips Healthcare
3000 Minuteman Road,MS0400
Andover, MA 01810-1099

Email PO to: bc_800fax2nd@philips.com
or
Fax PO to: 1-800-947-3299
or
Mail PO to:
Philips Healthcare
Order Processing, MS0400
Andover, MA 01810-1099

800-934-7372

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PAYMENT TERMS
Net 30 Days
Subject to Credit Approval

FORMAL QUOTE

CUSTOMER:
Attention: William Appling- Director, Bio Med
Doctors Medical Center
2000 Vale Rd
SAN PABLO CA 94806-3808
UNITED STATES
Customer Number : 94039490

SALES REPRESENTATIVE
Doug Olson Ph:
Fax:

QUOTE CONTACT
Kyle Clarke

Federal EIN: 13-3429115

ITEM	PRODUCT	DESCRIPTION	QUANTITY	UNIT OF MEASURE	UNIT AMOUNT (USD)	TOTAL AMOUNT (USD)
		SPECIAL COMMENTS 3RD Floor Telemetry Expansion (12) Beds				
10	989803153021 989803153021	IntelliVue MP2,X2 and MP5 Roll stand	2	PCE	466.00	932.00
		Agreement Discount			-27.00 %	-251.64
		Net price				680.36
		Agreement: MK102A				
20	M1578A 989803104211	Reusable NIBP Comfort Cuff assortment.	2	PCE	168.00	336.00
		Agreement Discount			-28.00 %	-94.08
		Net price				241.92
		Agreement: MK102A				
30	M1599B 989803104341	Adult Pressure Interconnect Cable 3.0m	2	PCE	66.00	132.00
		Agreement Discount			-28.00 %	-36.96
		Net price				95.04
		Agreement: MK102A				
40	862114 862114	M4844A Philips Sync Unit	1	PCE	2,338.00	2,338.00

PHILIPS

Philips Healthcare
3000 Minuteman Road,MS0400
Andover, MA 01810-1099

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ITEM	PRODUCT	DESCRIPTION	QUANTITY	UNIT OF MEASURE	UNIT AMOUNT (USD)	TOTAL AMOUNT (USD)
		Agreement Discount			-27.00 %	-631.26
		Net price				1,706.74
		Agreement: MK102A				
50	862123 862123	PWatchdog UPS	1	PCE	835.00	835.00
		Agreement Discount			-27.00 %	-225.45
		Net price				609.55
		Agreement: MK102A				
60	862152 862152	12 Port Power Over Ethernet	1	PCE	2,671.00	2,671.00
		Agreement Discount			-27.00 %	-721.17
		Net price				1,949.83
		Agreement: MK102A				
70	862439 862439	1.4 GHz IntelliVue Tele TRX	12	PCE		
		K10 5 Ld AAMI Grabber, Colors	12		167.00	2,004.00
		K50 Adult SpO2 Sensor	12		305.00	3,660.00
		OSE Standard and EASI Op Modes	12		.00	.00
		S02 IntelliVue TRx+ SpO2	12		5,513.00	66,156.00
		Agreement Discount			-27.00 %	-19,391.40
		Net price				52,428.60
		Agreement: MK102A				
80	MXU0068 MXU0068	Mounting Kits	5	PCE		
		A03 Tele System Mounting Kit	5		277.00	1,385.00
		Agreement Discount			-27.00 %	-373.95
		Net price				1,011.05
		Agreement: MK102A				
90	MXU0069 MXU0069	Connector Kits	5	PCE		
		A03 Tele System Connector Kit	5		277.00	1,385.00
		A04 Clinical System Cable	5		380.00	1,900.00
		Agreement Discount			-27.00 %	-886.95

PHILIPS

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3000 Minuteman Road,MS0400
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		Net price				2,398.05
		Agreement: MK102A				
100	989803171211 989803171211	ITS4843B Smart-hopping 1.4 GHz AP	5	PCE	1,818.00	9,090.00
		Agreement Discount			-27.00 %	-2,454.30
		Net price				6,635.70
		Agreement: MK102A				
110	865346 865346	ITS3171A Smart-hopping APC	2	PCE	3,848.00	7,696.00
		Agreement Discount			-27.00 %	-2,077.92
		Net price				5,618.08
		Agreement: MK102A				
120	M8105AT 865120	IntelliVue MP5T	2	PCE		
		B02 NBP,Tele-IF	2		5,349.00	10,698.00
		E22 Quick Release Mount	2		.00	.00
		E24 One Lithium-Ion Battery	2		236.00	472.00
		Agreement Discount			-27.00 %	-3,015.90
		Net price				8,154.10
		Agreement: MK102A				
130	865058 865058	Large Flat Panel Display	2	PCE	1,846.00	3,692.00
		Agreement Discount			-27.00 %	-998.84
		Net price				2,695.16
		Agreement: MK102A				
140	865321 865321	Network IIC Laser Jet Printer	1	PCE	3,186.00	3,186.00
		Agreement Discount			-27.00 %	-860.22
		Net price				2,325.78
		Agreement: MK102A				
150	865053 865053	Remote IIC Speaker Kit	2	PCE	299.00	598.00

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Philips Healthcare
3000 Minuteman Road,MS0400
Andover, MA 01810-1099

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ITEM	PRODUCT	DESCRIPTION	QUANTITY	UNIT OF MEASURE	UNIT AMOUNT (USD)	TOTAL AMOUNT (USD)
		Agreement Discount			-27.00 %	-161.46
		Net price				436.54
		Agreement: MK102A				
160	865055 865055	24 Port UTP/FX Switch	1	PCE	4,041.00	4,041.00
		A02 Cisco 100FX Multimode GBIC	2		521.00	1,042.00
		Agreement Discount			-27.00 %	-1,372.41
		Net price				3,710.59
		Agreement: MK102A				
170	989803131311 989803131311	Trackball	2	PCE	225.00	450.00
		Agreement Discount			-27.00 %	-121.50
		Net price				328.50
		Agreement: MK102A				
180	H1028B 890500	Installation Site Services	1	PCE	7,124.00	7,124.00
		A04 Facilities Implem Solutions				
		Net price				7,124.00
190	H1028B 890500	Installation Site Services	1	PCE	3,220.00	3,220.00
		A07 Project Mngemt Impl Solutions				
		Net price				3,220.00
200	H1028B 890500	Installation Site Services	1	PCE	8,095.00	8,095.00
		A09 Remote Hardware Services				
		Net price				8,095.00
210	H1028B 890500	Installation Site Services	1	PCE	1,172.00	1,172.00
		A12 Telemetry Implement Solutns				
		Net price				1,172.00

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3000 Minuteman Road,MS0400
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220	H1028B 890500	Installation Site Services	1	PCE	5,290.00	5,290.00
		A13 Product Upgrade Implem Solutns				
		Net price				5,290.00
230	890539 890539	Clinical Config. & Impl. Services (CMS)	1	PCE		
		A01 1 Standard Shift	1		1,945.00	1,945.00
		Net price				1,945.00
240	890539 890539	Clinical Config. & Impl. Services (CMS)	1	PCE		
		A06 1 Overtime Shift	1		2,520.00	2,520.00
		Net price				2,520.00
250	MXU0066	Telemetry Storage Rack	12	PCE		
		Single Transmitter Storage	12		127.00	1,524.00
		Net price				1,524.00
260	MXU0040	WMTS Registration Services	1	PCE	1,575.00	1,575.00
		Net price				1,575.00
270	MXU0069 MXU0069	Connector Kits	2	PCE		
		A02 Central System Connector Kit	2		689.00	1,378.00
		A04 Clinical System Cable	2		380.00	760.00
		Agreement Discount			-27.00 %	-577.26
		Net price				1,560.74
		Agreement: MK102A				
280	865427 865427	M3155 Upgrade Rel N.0	2	PCE		
		A12 12 Patient Upgrade	2		10,689.00	21,378.00
		C14 Add HL7 Export	2		878.00	1,756.00
		H10 PC Hardware	2		2,504.00	5,008.00
		H20 UPS Hardware	2		600.00	1,200.00

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ITEM	PRODUCT	DESCRIPTION	QUANTITY	UNIT OF MEASURE	UNIT AMOUNT (USD)	TOTAL AMOUNT (USD)
		U03 Software Upgrade	2		.00	.00
		Agreement Discount			-27.00 %	-7,922.34
		Net price				21,419.66
		Agreement: MK102A				
290	865427	M3155 Upgrade Rel N.0	3	PCE		
	865427	A12 12 Patient Upgrade	3		10,689.00	32,067.00
		U03 Software Upgrade	3		.00	.00
		Agreement Discount			-27.00 %	-8,658.09
		Net price				23,408.91
		Agreement: MK102A				
300	865427	M3155 Upgrade Rel N.0	1	PCE		
	865427	A06 6 Patient Upgrade	1		7,000.00	7,000.00
		U03 Software Upgrade	1		.00	.00
		Agreement Discount			-27.00 %	-1,890.00
		Net price				5,110.00
		Agreement: MK102A				
310	865429	M3154 Upgrade Rel N.0	1	PCE		
	865429	AA4 4 M3155 Connect Upgrade	1		6,860.00	6,860.00
		C25 Add 2 M3155 Connectivity	1		12,807.00	12,807.00
		H12 Rack-Mount Server HW	1		11,986.00	11,986.00
		U03 Software Upgrade	1		.00	.00
		Agreement Discount			-27.00 %	-8,546.31
		Net price				23,106.69
		Agreement: MK102A				
		Total Quotation List Price				259,364.00
		Less All Applicable Discounts				-61,267.41
		Total Quotation Net Price				**198,096.59**

Philips Healthcare is pleased to inform you that financing of its products and services is available to qualified applicants. To obtain more information
contact Philips Medical Capital @ 866-513-4PMC.

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Philips Healthcare
3000 Minuteman Road,MS0400
Andover, MA 01810-1099

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*

Contract information for:Medassets

*

Prices quoted are subject to and reflect
applicable discounts per the terms and
conditions of the following contract:
Contract #MK102A Expiration:9/30/14

*

Please be advised that the pricing for the products on this quote are
subject to a price increase on April 1, 2012 .

*

This quotation is issued pursuant to, and any PO for the items herein
will be accepted subject to the Terms of Contract#MK102A.
If no contract is identified in the previous sentence or the products
and/or services are not covered by this contract, this quotation is
issued pursuant to, and any PO for the items herein will be accepted
subject to the Philips Terms and Conditions of Sale posted at
http://www.healthcare.philips.com/main/terms_conditions/ and the terms
herein.

*

*

Under the American Reinvestment and Recovery Act ("ARRA"), it is the
customer's responsibility to inform Philips if the contract contains any
ARRA funding. Please check the following box if any part of this
contract is funded through ARRA:

*

___ This contract is funded in whole or in part through ARRA."

*

*

All work is scheduled within normal working hours;
Monday through Friday, 8 a.m. to 5 p.m. excluding Philips
holidays.
All pricing is based on travel zones 1-3. For travel zones beyond 1-3,
consult your Philips sales rep for alternate pricing.
It is the customers responsibility to provide Philips with
the access necessary to complete the quoted work in a
continuous start to finish manner.
Excessive delays and multiple visits will result in additional charges.
All prices are based upon 'adequate access' to work areas that are free
from obstruction.
If it is determined, during the implementation that asbestos removal is
required; Philips will suspend performance until the Customer remediates
the asbestos.
Philips will work with the customers staff to reduce the downtime during
the system transition.

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Philips Healthcare
3000 Minuteman Road,MS0400
Andover, MA 01810-1099

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ITEM	PRODUCT	DESCRIPTION	QUANTITY	UNIT OF MEASURE	UNIT AMOUNT (USD)	TOTAL AMOUNT (USD)

*
*

Products are for USA end-use only. Taxes, if applicable, are not included unless noted but will be added to the invoice. The Purchase Order must reference the Quote Number and your Purchase Agreement. Please indicate your requested delivery date and your preference, if any, to accept and pay for partial shipments. If this quote includes Value-Added Services, they may be invoiced separately. Additional sold training must be completed within twelve months of delivery/installation. System cabling, if included, is specified at the standard grade unless noted otherwise.

*

This quote specifically excludes Licensing & Permit Fees, Prevailing Wage Compensation and Union Labor.

*

IMPORTANT NOTICE: Health care providers are reminded that if the transactions herein include or involve a loan or a discount (including a rebate or other price reduction), they must fully and accurately report such loan or discount on cost reports or other applicable reports or claims for payment submitted under any federal or state health care program, including but not limited to Medicare and Medicaid, such as may be required by state or federal law, including but not limited to 42 CFR 1001.952(h).

PHILIPS

Philips Healthcare
3000 Minuteman Road,MS0400
Andover, MA 01810-1099

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FORMAL QUOTE

REPRINT

This quotation is issued pursuant to, and any PO for the items herein will be accepted subject to the Terms of any current Contract with the customer. If there is no contract in place, this quotation is issued pursuant to, and any PO for the items herein will be accepted subjected to Philips Terms and Conditions of sale posted at http://www.healthcare.philips.com/main/terms_conditions/ and the terms herein.

DOCTORS
MEDICAL CENTER

PEDIATRIC COLONSCOPE

TAB 10

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
GOVERNING BODY
BOARD OF DIRECTORS
CONTRACT RECOMMENDATION FORM

TO: **GOVERNING BODY**
BOARD OF DIRECTORS

FROM: **Carla Knight RN, BSN**
Director of Perioperative/GI Services

DATE: **March 19, 2012**

SUBJECT: Request for two (2) certified pre-owned flexible colonoscopes

SPECIFIC REQUEST(S) OR RECOMMENDATION(S) AND BACKGROUND WITH JUSTIFICATION

REQUEST / RECOMMENDATION(S): Recommend to the District Board to approve and authorize the Chief Operations Officer to execute on behalf of DMC, approval of two Olympus flexible colonoscopes, totaling $41,956.32, including freight.

FISCAL IMPACT: $41,956.32

STRATEGIC IMPACT: These scopes are replacing two older scopes that are fifteen (15) and seventeen (17) years old, respectively. They will be used for trade in on this transaction. Most flexible scopes would have a life expectancy of around ten years, given our current volumes. Well working scopes are imperative to the GI business.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: Purchase of two certified pre-owned flexible colonoscopes to replace two worn scopes that will be used as trade ins on this transaction. These scopes will be used daily, primarily on smaller females or patients who have had prior colon surgeries. Although described as pre-owned, they still will have the same full warranty as a brand new scope (one year), but at a much reduced price. Without these scopes, patients will need to be transferred to another facility for services.

Presentation Attachments: Yes X No

Requesting Signature Carla Knight RN BSN Date: 3 / 28 / 12

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____

Vote of Board Members:

____ Unanimous (Absent____)
Ayes: ____ Noes: ____
Absent: ____ Abstain: ____

I HEREBY ATTEST THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person:

Attested by: _____
Eric Zell, Chair, Governing Body
Board of Directors

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

OLYMPUS®

Your Vision, Our Future

OLYMPUS AMERICA INC.
CUSTOMER SERVICE
3500 Corporate Parkway
P.O. BOX 610
Center Valley, PA 18034-0610

TEL: (800) 848-9024
FAX: (800) 228-4963

QUOTATION

NO. 236869-Q0-3

Please refer to this number on all correspondence, or other communications

February 22, 2012

Doctors Medical Center
Attention: Valued Customer
2000 Vale Rd
San Pablo, CA 94806

Dear Valued Customer:

Thank you for providing Olympus with the opportunity to quote our Medical products as listed on this quote # 236869-Q0-3.

The quoted prices are either based on the Olympus - Novation CE01051 Tier 1G (GI/Pulmonary-access tier) contract # CE01051 which expires 02/28/2013 (MP Products) or contract # CE01051 which expires 02/28/2013 (SP Products), or are 'open market' purchase prices as specified below. An asterisk (*) in the line number column is used to specify the 2 'open market' items listed on this quote. The additional items may also include discounts that are enhanced beyond our contractual obligation, but are not considered Capital Products as defined by Olympus under the quotation.

Should you have any other questions regarding this quotation or any Olympus services, please contact your Endoscopy Account Manager:

Name:	Tony Rhone
E-Mail:	Tony.Rhone@olympus.com
Phone:	(800) 645-8100 x106184
Fax:	(800) 228-4963
Cell No.:	(707) 975-3777

Thank you for your interest in Olympus and our quality products and services.

Sincerely,

Margaret Kresge
Customer Service Representative

OLYMPUS®

Your Vision, Our Future

OLYMPUS AMERICA INC.
CUSTOMER SERVICE
3500 Corporate Parkway
P.O. BOX 610
Center Valley, PA 18034-0610

TEL: (800) 848-9024
FAX: (800) 228-4963

QUOTATION

NO. 236869-Q0-3

Please refer to this number on all correspondence, or other communications

CUSTOMER INFORMATION

Customer: Doctors Medical Center
Attention: Valued Customer
Address: 2000 Vale Rd
San Pablo, CA 94806
Phone: (000) 000-0000
Fax: (000) 000-0000
E-Mail:

OLYMPUS SALES REP.

Name: Tony Rhone
Endoscopy Account Manager
Home Page: http://www.olympusamerica.com
Cell No.: (707) 975-3777
Phone: (800) 645-8100 x106184
Fax: (800) 228-4963
E-Mail: Tony.Rhone@olympus.com

CUSTOMER PRODUCT TRADE - IN

#	Model	Serial	Qty	Credit Ea.	Ext. Credit
1	SIF-100 Enteroscope, Video, Olympus	2820293	1	$2,000.00	$2,000.00
2	TJF-140F Duodenoscope, Video, Olympus	2900634	1	$2,500.00	$2,500.00
				Total Credit	**$4,500.00**

TRADE-IN TERMS AND CONDITIONS

1. Trade-In equipment must originate from the facility purchasing the new equipment and must have original serial number tags intact.
2. Trade-In credits are offered exclusively on a "one-for-one" basis toward the simultaneous purchase of the equipment listed in the quotation detail section.
3. Trade-in credits are offered exclusively on a one-for-one basis toward the simultaneous purchase of a like-kind product from any product category (i.e. video/fiber GI, SIG, Pulmonary, ENT, Intubation). Olympus reserves the right in its sole discretion to make the final determination of what constitutes like-kind product categories.
4. Trade-In credits will be issued to the facility upon Olympus's receipt and inspection of the Trade-In equipment to verify its condition and value. Trade-In equipment must be received by the Olympus facility in San Jose, CA and must have its RMA closed within 30 days from the date that the customer facility receives the new equipment purchased using the trade credits. If the Trade-In equipment is not received within the 30-day timeframe, Olympus reserves the right to cancel the associated credits to the customer.
5. Traded equipment will be accepted by Olympus for credit only, and under no circumstances will equipment be exchanged for cash.
6. Olympus reserves the right to modify the list of qualified models for trade-in or the stated value for any qualified model from time to time, based on then current market conditions and needs. Trade-in values are valid until the expiration date of this quote.

TERMS AND CONDITIONS

Effective: 02/22/2012	Expires: 3/22/2012
Terms: Net 30 days, subject to Olympus credit approval.	F.O.B.: Shipping Point Freight Charges may apply
Tax: When Applicable.	Delivery: Upon availability of equipment.
Warranty: Generally, Capital equipment manufactured by Olympus is warranted against manufacturers defect for a period of one year. See Limited Warranty for details.	
Price Terms: The quoted prices are either based on the Olympus - Novation CE01051 Tier 1G (GI/Pulmonary-access tier) contract # CE01051 which expires 02/28/2013 (MP Products) or contract # CE01051 which expires 02/28/2013 (SP Products), or are 'open market' purchase prices as specified below. An asterisk (*) in the line number column is used to specify the 2 'open market' items listed on this quote. The additional items may also include discounts that are enhanced beyond our contractual obligation, but are not considered Capital Products as defined by Olympus under the quotation.	

FINANCIAL OPTIONS

1. Net 30 Days/Interest 1 1/12% monthly, subject to Olympus credit approval.
2. American Express, Visa and MasterCard accepted.
3. Olympus offers a wide range of services from financing/leasing options, including a usage-based program that matches payments to procedures performed to a comprehensive service agreement.

ADDITIONAL COMMENTS

Discount Level approved by Area Vice President Mike McNaughton
CPO approved by Carolyn Klimas

OLYMPUS®

Your Vision, Our Future

OLYMPUS AMERICA INC.
CUSTOMER SERVICE
3500 Corporate Parkway
P.O. BOX 610
Center Valley, PA 18034-0610

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QUOTATION

NO. 236869-Q0-3

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QUOTATION DETAIL

	Item / Description	List Price	Your Price	Qty	Extended Price
	PLEASE NOTE: THE FOLLOWING ITEMS REFLECT CERTIFIED PRE-OWNED (CPO) EQUIPMENT PRICING AND ARE SUBJECT TO LIMITED ITEM AVAILABILITY:				
1*	**PCF-H180AL:** Certified Pre-Owned - EVIS EXERA II High-Definition, Narrow Band Imaging compatible, close focus, Innoflex adjustable stiffness, ultra slim video colonoscope with forward water jet and 11.8 mm outer diameter, 3.2 mm channel, 140° field of view, 168 cm working length, and angulation of 180°/180° (up/down) and 160°/160° (right/left)	44,600.00	23,192.00	2 ea	46,384.00
2*	**FREIGHT:** 2nd Day freight, shipping, and/or handling charges. Expedited freight will incur additional charges.	72.32	72.32	1 ea	72.32

I. Price quotes and the total package prices are for listed items only.
II. Changes, additions or deletions from this package quotation may cause pricing adjustments.
III. Service manuals and additional operator manuals are not included and may be ordered by contacting the Customer Care Center at (800) 848-9024.
IV. If freight charge is included, freight charge may not necessarily reflect the exact charges paid by Olympus to the carrier due to volume incentive discount agreements entered into between Olympus and carrier.

List Total Price:	**$89,272.32**
Your Total Price:	**$46,456.32**
Less Trade-In(s):	**$4,500.00**
Net After Credit:	**$41,956.32**

Integrated Medical Systems International
1823 27th Avenue South
Birmingham, Alabama 35209
Phone: 1-800-783-9251
www.imsready.com

Product Estimate	
Date: 07-JAN-2010	Estimate: 1
Order: 605009	Line: 1
Service Request: MSTEWART	
Salesrep: Zealear, Mr. Blake	

Customer Information:

Customer Number	11442
Customer Name	DOCTORS MEDICAL HOSPITAL
Customer Department	Endoscopy

Equipment Information:

Product(s)	OLYMPUS VIDEO PEDIATRIC COLONOSCOPE PCF-H180AL (Qty 2 @ $ 27,500.00 EACH) Limited one-year IMS Equipment Warranty
	OLYMPUS VIDEO GASTROSCOPE GIF-Q140 (Qty 2 @ $ 1,500.00 EACH) Trade In
Price	$ 52,000.00
Comments	2 trade scopes added to estimate.

Terms and Conditions:

Terms	The terms for this purchase are net/15 days. Please allow 30-45 business days for delivery. All sales are subject to availability.
Financing	Financing for all Products and Equipment is available with approved credit

For questions please contact:

Mallory Stewart

Office	205-414-3639
Fax	205-414-3479
Email	mallorystewart@imsready.com

Agreement:

DOCTORS MEDICAL HOSPITAL agrees to purchase from Integrated Medical Systems International, Inc. the equipment referenced above.

By: _____

Title: _____

Date: _____

PO #: _____

Integrated Medical Systems International
1823 27th Avenue South
Birmingham, Alabama 35209
Phone: 1-800-783-9251
www.imsready.com

Product Estimate	
Date: 09-FEB-2012	Estimate: 1
Order: 793817	Line: 1
Service Request: LHILL	
Salesrep: Zealear, Mr. Blake	

Customer Information:

Customer Number	11442
Customer Name	DOCTORS MEDICAL HOSPITAL
Customer Department	Operating Room
Customer Contact	Carla Knight

Equipment Information:

Product(s)	OLYMPUS VIDEO PEDIATRIC COLONOSCOPE PCF-H180AL (Qty 2 @ $ 29,000.00 EACH) Limited one-year IMS Equipment Warranty
Price	$ 58,000.00

Terms and Conditions:

Terms	The terms for this purchase are net/15 days. Please allow 30-45 business days for delivery. All sales are subject to availability.
Financing	Financing for all Products and Equipment is available with approved credit

For questions please contact:

Lisa Hill
Account Manager

Office	205-414-6139
Fax	205-414-3479
Email	lisahill@imsready.com

Agreement:

DOCTORS MEDICAL HOSPITAL agrees to purchase from Integrated Medical Systems International, Inc. the equipment referenced above.

By: _____

Title: _____

Date: _____

PO #: _____

Integrated Medical Systems International
1823 27th Avenue South
Birmingham, Alabama 35209
Phone: 1-800-783-9251
www.imsready.com

Product Estimate	
Date: 09-FEB-2012	Estimate: 1
Order: 793819	Line: 1
Service Request: LHILL	
Salesrep: Zealear, Mr. Blake	

Customer Information:

Customer Number	11442
Customer Name	DOCTORS MEDICAL HOSPITAL
Customer Department	Endoscopy
Customer Contact	Barbara Pastori

Equipment Information:

Product(s)	OLYMPUS VIDEO COLONOSCOPE PCF-Q180AL (Qty 2 @ $ 22,616.00 EACH) Limited one-year IMS Equipment Warranty
Price	$ 45,232.00

Terms and Conditions:

Terms	The terms for this purchase are net/15 days. Please allow 30-45 business days for delivery. All sales are subject to availability.
Financing	Financing for all Products and Equipment is available with approved credit

For questions please contact:

Lisa Hill
Account Manager

Office	205-414-6139
Fax	205-414-3479
Email	lisahill@imsready.com

Agreement:

DOCTORS MEDICAL HOSPITAL agrees to purchase from Integrated Medical Systems International, Inc. the equipment referenced above.

By: _____

Title: _____

Date: _____

PO #: _____

DOCTORS
MEDICAL CENTER

POLICIES

TAB 11

DOCTORS MEDICAL CENTER

PLAN FOR THE PROVISION OF CARE

2011-2012

DOCTORS MEDICAL CENTER
PLAN FOR THE PROVISION OF CARE

Mission Statement:

Doctors Medical Center is dedicated to providing high quality healthcare to meet the diverse needs of our community. Through the allocation of appropriate services, we are committed to improve the community's health status by providing a full spectrum of services.
This will be achieved by:

- Providing a care team of professionals committed to a patient/customer satisfaction and continual performance improvement.
- Assuring technologically sophisticated medical care.
- Promoting community health education and disease prevention.
- Working cooperatively with other healthcare providers.
- Operating in an economically prudent manner while assuring full access to all members of our community.

Vision and Values Statement:

Doctors Medical Center will distinguish itself through our:

- **Community Leadership** in delivering amazing care that surpasses the expectations of the diverse population we serve.
- **Passion for Excellence** manifested through our people who are dedicated to providing a supportive, empowering environment which emphasizes innovation and caring.
- **Continual Search for New Opportunities** to improve our care and enhance our partnership with our community and other healthcare providers.
- **Commitment to Promoting a Healthy Community** by assuring access to healthcare resources and promoting patient, family, and community health education.
- **Respect of Individual** by promoting a high standard of professional ethics and conduct while striving to create a caring and compassionate environment for delivering amazing care.

Goals:

- To maintain the role of patient advocate.
- To promote a collaborative relationship with the physicians and all members of the interdisciplinary team.

- To systematically monitor the efficiency and effectiveness of patient care.
- To respect the right of all individuals and recognize the values, opinions, dignity of everyone who works with or utilizes the services of Doctors Medical Center.
- To promote a working environment that is conducive to creativity, satisfaction, and the advancement of Nursing as a profession.
- To provide a comprehensive education and developmental program that maintains and upgrades the quality of care while prompting personal and professional growth and satisfaction.
- To promote the involvement and education of all patients, families, and significant others from the time of admission, through the healing process, and throughout the continuum of care.
- To provide, promote, and maintain the same standard of excellence in care to all patients in all units, areas, and departments throughout the organization.

Outcomes of Success:

- Customer Satisfaction (patient, employee, and physician)
- Retention of skilled employees and physicians
- Superior clinical skill of employees
- Superior economic performance
- Meeting and exceeding quality benchmarks in key areas (Core Measures, National Patient Safety Goals)

Doctors Medical Center has established standards of care and practice and supports those established by the Joint Commission. Doctors Medical Center believes each member of the staff has the responsibility to pursue excellence in the delivery of care.

Doctors Medical Center provides an organizational structure that promotes:

- Provision of the highest quality of patient care
- Effective utilization of resources
- Support of education programs
- Teaching to utilize knowledge to improve health care and its delivery
- Patient and family involvement in the continuum of care from admission through discharge.

All clinical personnel are expected to strive for excellence in practice. The health care provider must develop respectful, understanding relationships and utilize systematic problem solving and decision-making processes based on accurate assessments, appropriate knowledge, evidence based practice, and standards of care.

Doctors Medical Center believes in responsible action awareness of the public and self-regulation to strive for quality in performance.

Doctors Medical Center believes that professional growth demonstrates a continued pursuit of excellence and support through promotions, continuing education, and recognition of national certification. Doctors Medical Center also believes excellence is demonstrated through the ongoing evaluation of qualifications and competency of personnel related to the performance of their professional duties. Age-specific criteria based job descriptions specific to positions are used to measure these expectations.

Planning Process:

The organization's plan for the provision of care is designated to support the integration of patient services throughout the organization. The goal of the plan is to integrate each department and/or service into the overall functioning of the organization, improve functional relationships by interdisciplinary collaboration on identified patient care issues, and improve communication. The integration of patient care services is accomplished through distribution and management of information such as:

- Policies and Procedures
- Interdisciplinary patient care plans
- Departmental newsletters
- Interdisciplinary meetings
- Review of trending data
- Evidence based practice

Doctors Medical Center, as an organization, plans for the services provided in response to the need of the community it serves. This planning is consistent with the Mission, Vision, and Values of the medical center. The planning process seeks input from many sources, including but not limited to, the community, our customers, and the internal organization. Examples of obtaining such input include:

- Internal and external satisfaction surveys
- Community assessment process
- Administrative and Medical Staff networking with area health care providers
- Involvement with local businesses, schools, churches, and civic organizations

Evaluation Process:

The evaluation process is largely based on feedback, monitoring and evaluation, education, and communication. Identifiable sources of information include, but are not limited to:

- Patient, employee, and physician satisfaction surveys

- Direct patient and family interviews
- Observations and/or recommendations by medical staff
- Observations and/or recommendations by administrative staff
- Observations and/or recommendations by nursing
- Observations and/or recommendations by hospital clinical departments and support staff
- Observations and/or recommendations by members of the community
- Observations and/or recommendations by accrediting bodies
- Review of occurrences with trending data
- Recommendations from medical staff and hospital committees
- Recommendations from the Governing Board
- Policy and Procedure review
- Continuing education
- Performance Improvement teams and work groups
- Ongoing monitoring and evaluation
- Participation and review in national data banks

Patient Assessment:

Patient assessment, both initial and ongoing, involves all disciplines required to meet the needs of the patient. The Interdisciplinary Plan of Care (IPOC), completed by a Registered Nurse on admission, establishes the framework for the assessment process. It provides basic information from which other disciplines develop a more comprehensive assessment in their areas of expertise. The IPOC and other discipline-specific assessment data are found together under the IPOC tab in the medical record as a resource for all members of the health care team.

Each patient is assessed:

- At regular specified times
- To determine response to treatment
- To identify any significant change in condition/diagnosis
- To identify and prioritize need for care and treatment

The plan of care, including identification and prioritization of care needs, is developed from this IPOC data.

Patient Care Services Staff Assessment:

The professional practice at Doctors Medical Center is defined in accordance with the following standards:

- California Nurse Practice Act

- American Nurses Association Professional Ethics
- California Code of Regulations (Title XXII)
- The Joint Commission
- California state licensure requirements
- Code of Federal Regulations
- Departmental policies and procedures

Professional staff who provide inpatient care and are not subject to the medical staff privilege delineation process receive a performance review annually. The annual appraisal is based on specific job descriptions and emphasizes specific work requirements, teamwork, guest relations, and overall employee and organizational development.

Organization and Functional Relationships:

Doctors Medical Center is a not-for-profit acute care hospital, owned and operated by the West Contra Costa Health Care District. The Doctors Medical Center Governing Body, comprised of five (5) District representatives, four (4) County representatives, two (2) representatives of the medical staff, representing West Contra Costa County, has final authority in conducting the affairs of the hospital. The Board has empowered the President and Chief Executive Officer (CEO) to take appropriate steps to ensure clinically effective patient care and to enforce the Bylaws, Rules, and Regulations. The CEO delegates immediate authority to the Administrative Team comprised of (COO/CNO, CFO, VP, Patient Care Services, VP, Human Resources and Director, Community Relations) for daily operational and decision making related to the administrative and financial aspects of the hospital operations and clinical patient care.

The Administrative Team, in collaboration with Board Members, Medical Staff, Department Directors, and Medical Staff Performance Improvement Committee, has established the Mission and strategic direction of the organization.

The Administrative Team, Department Directors and Manager, DMC employees, and Medical Staff actively participate in cross functional performance improvement, service development and/or enhancement, problem solving, and other organizational teams. The results of these teams are communicated through medical staff meetings, employee staff meetings, and related newsletters.

Medical Center Services:

Support Services: Provided to all patient care areas on a regular basis. The core areas providing support services include Internal Support Services and Integrating Services

Internal Support Services – Support the comfort, safety, and efficiency of patient services:

- Environment Services which includes laundry and linen services and housekeeping
- Plant Operations which includes Engineering, Maintenance, Biomedical, and Utilities Management
- Materials Management which includes Purchasing, Central Distribution, and Mail Room
- Admissions
- PBX; Telephone Communications

Integrating Services – Ensures that patient care services are maintained in an uninterrupted and continuous manner.

- Management of Information Systems
- Human Resources
- Organization Education
- Health Information Management
- Infection Control
- Occupational Health
- Business Development
- Financial Services which includes Accounting, Payroll, Patient Business Office and Contracting

Ancillary Services:

- Respiratory Therapy
- Cardiology
- Diagnostic Imaging which includes Ultrasound, Nuclear Medicine, Invasive Radiology, and Cardiac Catheterization Lab
- Case Management
- Social Services
- Food & Nutrition
- Rehabilitation Services which include Physical Therapy, Occupational Therapy, and Speech Therapy
- Cardiac Rehabilitation
- Enterostomal Therapy
- Dialysis
- EEG
- Hyperbaric Medicine
- Cancer Center which includes Chemotherapy, Radiation Therapy, Mammography, Brachytherapy, and Lung Clinic

- Wound
- Pharmacy
- Laboratory, Pathology
- Wellness Services
- Sleep Lab

Nursing Services:

- Emergency Department
- Critical Care which includes Medical Intensive and Medical/Surgical Intensive Care Overflow Units
- Surgical Services which include PACU, Same Day Surgery, Central Sterile, and GI/Endoscopy Lab
- Telemetry (4th Floor), Medical Unit (5th Floor), Surgical Unit (6th Floor), and Forensic Unit (7th Floor)

Nursing Care:

Doctors Medical Center views its responsibility to assure that nursing care includes those functions including basic health care which help people cope with difficulties in daily living which are associated with actual or potential health/illness/problems/treatment which require a substantial amount of scientific knowledge and technical skill. The purpose of Nursing is to promote an optimal level of health and to assist patients, families, and significant others to cope with illness outcomes. Guidelines for practice have been developed with reference to nursing trends, literature, evidence-based best practice, and identified patient needs in concert with regulatory guidelines:

Monitoring:

The provision of Nursing Care is monitored and evaluated on a continuous basic to ascertain the effectiveness of action plans, acuity systems, and patient care requirements throughout the hospital. Assessment and evaluation tools include:

- Performance improvement data
- Staffing guidelines
- Standards of Nursing Practice
- Financial reports
  Outcome statistics
- Customer Satisfaction Surveys

Integration of Information:

It is recognized that a cooperative and collaborative relationship between the Department of Nursing and other services is necessary to ensure that safe and appropriate care is delivered to each patient. It is

the responsibility of the Vice President of Patient Care Services to oversee and evaluate the ongoing care of the patient population and interdepartmental systems that affect this care. The primary methods of communication, problem identification, and resolution include, but are not limited to:

- Performance improvement activities
- Performance improvement Council
- Department head meetings

Interdisciplinary Teams:

- Environment of Care Team
- Department of Nursing Meetings
- Unit Staff Meetings
- Medical Staff Meetings

Staffing Plan:

Staffing plans for patient care services are developed based on the populations served, level and scope of care that needs to be provided, the frequency of the care provided, and a determination of the skill level of staff that can most appropriately provide the type of care needed.

Each department has a formalized staffing plan which is reviewed annually and based on the following:

- Patient care trends and data
- Performance improvement activities
- Changes in customer needs or expectations
- Operating budget
- Customer satisfaction date

Staffing variances are monitored via monthly financial reports and review of patient classifications.

Service Availability:

Medical care is provided to our patients and consultations are provided in accordance with Medical Staff Bylaws, Rules and Regulations, and credentialing requirements.

In circumstances where Doctors Medical Center cannot provide the service necessary to meet a patient's needs, appropriate referrals to outside organizations are made by medical staff members in collaboration with the appropriate hospital staff. The medical staff, in collaboration with hospital staff, the patient, and family, determine the need for referral, transfer, or discharge to another facility or level of care based on the patient's assessed needs and the hospital capacity to provide the necessary care or treatment. Examples of such cases include referral of major trauma, cardiac surgery, obstetrics, complex pediatric

patients to tertiary facilities and psychiatric disorders. Referrals for community-based services are handled by appropriate hospital staff in collaboration with physicians and care givers.

Financial Planning Process:

Financial planning and budgeting will be done on an annual basis and is an essential component of assuring patient care service delivery, as well as the overall long term viability of the organization.

Department directors and manager are responsible and accountable for providing input, implementing, and monitoring their respective departmental budgets.

Capital equipment budgets are developed annually and reviewed throughout the year to prioritize the needs of the medical center. This is done with input from Finance Department Directors/Managers, as will as the Medical Staff.

The Department Directors/Managers, appropriate Medical Staff members, Finance Department, Human Resources, and Administrative Team members collaborate to develop budgeting goals.