# PUBLIC HEARING

# ON THE

# UNITED MEDICAL CENTER (FINANCIAL MANAGEMENT)

**Before the**
**Committee on Health**

**The Honorable David A. Catania**
**Chairman**

**September 29, 2011**
**10:00 a.m.**
**Council Chambers**

**Testimony of**
**Natwar M. Gandhi**
**Chief Financial Officer**
**Government of the District of Columbia**

Good morning Chairman Catania and the members of the Committee. I am Natwar M. Gandhi, Chief Financial Officer for the District of Columbia, and I am here to testify on the current financial status of the Not-for-Profit Hospital Corporation, also referred to as United Medical Center. As you know, the District took over ownership and operations of the Hospital in July 2010. No takeovers are easy, and this one has proven to be especially challenging. Converting a private operation to a government agency is difficult. Government transparency, fiscal, legal and operating requirements hamper flexibility and quick decisions at a business operation.

Prior to the foreclosure, the Hospital was owned and operated for 32 months by Specialty Hospitals of Washington, a private company. After factoring in operating funds that the District provided to the Hospital, it suffered a cash operating loss of approximately $50 million. Since the foreclosure, the Hospital has failed to add any new programs that have provided significant additional funds, although the Hospital has assumed or created programs that have temporarily increased costs. Thus, the Hospital's monthly cash operating loss has increased, even after factoring in additional District Medicaid payments. This cash operating loss has occurred despite the fact that the Hospital, which is the beneficiary of more than $100 million of District funds, does not pay debt service, property,

income or sales taxes, or the bed tax, such that it receives an indirect annual subsidy that reduces its operating costs from that of a privately-owned facility by more than $5 million a year.

Since the foreclosure, I have testified in front of this committee twice – in July 2010 and January 2011. On July 12, 2010, just three days after the District acquired ownership, I provided a worst-case scenario which included potential additional District funding requirements that I estimated to be between $750,000 and $1.28 million per month. I said this loss could be mitigated by a number of factors, including higher Medicaid Disproportionate Share Hospital, or "DSH," payments. The Hospital received an additional $1.26 million per month derived from the three-fold, $10 million annual increase of the DSH payment plus the draw of $5.1 million from the Contingency Reserve Fund. Despite the infusion of these resources, the Hospital's financial position remains fragile. For example, although the median days' cash on hand for hospitals in the United States is 110, the Hospital's days' cash on hand (excluding encumbrances and the District's contribution) seldom exceeds zero and, after adding in the District's contribution, hovers at or below 15 **(see Attachments 1a and 1b)**.

On January 20, 2011, I reported some improvements to the Hospital's bottom line, driven primarily by the three-fold increase in its DSH payments (30 percent of

which are locally funded) from $4.9 million to $14.9 million per year, and I shared the optimism that the partnerships with the Washington Hospital Center's obstetrics department and Children's National Medical Center's emergency department, as well as an increased patient occupancy level and Skilled Nursing Facility (SNF) residency census, would strengthen the Hospital's financial position.

Now, I am happy to report that there are certain positive signs: (1) the DSH payment has made a significant impact, and indications are that it will remain at the same level for FY 2012; (2) the Hospital is well into its program of paying certain settlement plans such that more cash will be available to pay for current operations during the next fiscal year; (3) the SNF has finally passed 100 bed occupancy of the 120 beds available; and (4) the Washington Hospital Center obstetrics program is now underway.

But at the January hearing, I also expressed concerns about the Hospital's cash position, which brings us to today's discussion of the facts that will inform all those who seek to strengthen the medical and financial operations at this District-owned facility. Unfortunately, the good news above regarding the additional funds to become available because of the completion of settlement payments is tempered by the fact that the $8 million operating profit shown by the Hospital in FY 2011 to

date is calculated on an accrual basis, but the seeming conflict between that operating profit and the $7 million of unpaid FY 2011 vendor bills is explained by the fact that the Hospital is paying the pre-FY 2011 settlements and vendor obligations out of FY 2011 funds. This means that FY 2012 funds will be used to pay unpaid FY 2011 vendor obligations, although we hope that there will be some catch-up.

I must begin by saying that some comparisons are difficult. For example, Hospital management prepared a budget for FY 2011 which appears to have been subsequently revised without Board review. The numbers I describe below are based on the original budget approved by the Hospital Board in December 2010.

**Revenues**

For Fiscal Year 2011, the Hospital has a monthly cash collection goal of slightly in excess of $7.6 million, excluding quarterly DSH payments. Based on cash posted to Hospital bank accounts, the Hospital has fallen far short of this goal **(see Attachment 2)**. In only two months this fiscal year has the Hospital approached $7.6 million. From August 2010 through August 2011, the inpatient, outpatient, and emergency portions of the Hospital's operations generated on average $6.3 million in monthly collections. This excludes DSH proceeds.

Only after including all sources of the Hospital-generated funds, including the quarterly DSH payments of approximately $3.7 million, has the Hospital collected an average of $7.5 million per month. Without the SNF, DSH payments and miscellaneous non-medical funds, the inpatient and outpatient portions of the Hospital's operations alone have average monthly cash collections of $5.2 million in the first quarter, $6.2 million in the second quarter (traditionally a high collection period), and $5.4 million in the third quarter.

**Causes**

There are multiple reasons for the Hospital's cash situation. First and foremost, patient and resident volume and occupancy rates declined during February through June of this year, and have only now begun to recover. Based on the Hospital's current license for 234 beds, so far in Fiscal Year 2011, an average of only 40 percent of the licensed beds have been occupied, which is far below the average occupancy rates for similar public hospitals across the country. As the narrative in the Hospital's FY11 budget states, and I quote, "UMC net patient services revenues of $120.1 million *depends upon* achieving 6,879 inpatient admissions, plus associated ancillary services and therapy treatments ordered by physicians. Revenues also are derived from 106,743 outpatient visits and procedures."

There have been only 5,050 inpatient admissions through August 2011, which, if projected to 5,509 for the full fiscal year, is only 80 percent of the annual estimate. This outpatient visit budget cited above includes 42,893 in emergency room visits, leaving 63,850 non-emergency outpatients. However, through August 2011, there have been, according to the August unaudited financial statements, 61,896 total outpatient visits and procedures, comprising 41,936 emergency room visits and, leaving only 19,960 non-emergency outpatients. When projected to 21,775 for the full fiscal year, the non-emergency outpatients will be only 34 percent of the estimates. Finally, when low admissions are combined with the costly above-average acute average length of stay, which, according to the Hospital records is generally between 5.7 and 5.9 days, the cash issues are to be expected. I will discuss the emergency room statistics below.

**Hospital Operations and Capital Improvements**

Several problems have strained the Hospital's operations. In order to reduce or eliminate significant losses in the obstetrics department, the Hospital was to commence a partnership with the Washington Hospital Center. On January 13, 2011, the Hospital executed a contract that, when all the District's obligations were aggregated, exceeded $1 million. The actual commencement of the relationship was delayed due to negotiations over malpractice insurance levels, certifications of

the doctors, the build-out of the space, and other issues, all of which occurred before the contract was sent to the Council and approved on June 7, 2011. But only now, at the very end of this fiscal year, has the Hospital's admissions census increased due to this partnership. Hospital management predicted 959 births in this fiscal year, but through the first 11 months of this fiscal year, the Hospital has delivered 472 babies, which suggests 515 deliveries for the full fiscal year. This is a slight improvement over the prior year, but only 54 percent of the predicted average of 80 births per month. Also, obstetric admissions, predicted to increase to 1,248 this fiscal year, total 525 admissions for the first 11 months of the fiscal year, only 46 percent of the predicted amount. In the meantime, beginning in January of this year, the Hospital paid $80,000 a month for malpractice insurance to cover this arrangement, a portion of which was directly attributed to the new, but not yet functioning, arrangement.

The Skilled Nursing Facility had a lower occupancy rate than anticipated. The FY 2011 budget assumes the SNF would average 105 patients per day, generating $10.9 million in revenue and losing $903,000. In fact, after a slow start and the inability to admit new patients due to citations from the District's Department of Health, the 120-bed SNF has only just achieved 100 patients per day and has averaged 84 residents per day for the fiscal year to date. To further complicate

matters, due to the former patient financial services contractor's and management's inactions, the Hospital only just received a Medicare provider number to enable it to bill for SNF residents insured by Medicare. The SNF's loss this year will be far in excess of the $903,000 loss originally projected in the beginning of the fiscal year.

Hospital management has touted increases in "patient volume" over last year. However, putting aside the fact that the Hospital has counted observation beds as admissions, a large proportion of this increase is attributable to the acquisition of the SNF and to the adult emergency room. At first glance, the adult emergency room appears to be a bright spot, because an average of 3,800 patients have been seen in the adult emergency room each month since October 2010, and that number is on an upward trend. Some of this may be due to the improved reputation of UMC's new pediatric emergency room paid for by the District and operated by Children's National Medical Center. But it is important to note that emergency rooms can be a cash drain, particularly if an insufficient number of emergency room visits are converted to inpatient admissions. Hospital management has expressed great concern that on average only about 9.6 percent of emergency room visits become inpatient admissions (about half the usual level at similar hospitals). Additionally, the number of observation stays, which are

reimbursed at a much less favorable rate than admissions, has risen considerably since the District took over the Hospital, to an average of 122 observations per month this fiscal year.

Furthermore, despite Hospital management's optimistic statements about patient revenues, the actual cash situation is worse than it may first appear because the Hospital is not timely paying its bills. Since the foreclosure, the Hospital's accounts payable have grown to more than $10 million, and that growth began immediately after the foreclosure. As of September 26, 2011, accounts payable for the more than 365-day period (generally pre-foreclosure) total $3.3 million (and that is after the Hospital wrote-off a large amount of pre-foreclosure accounts payable), and for the 0 to 365-day period (post-foreclosure), accounts payable total approximately $6.9 million **(see Attachment 3).**

Yet, simple solutions, such as taking advantage of deeply discounted drugs from the US Department of Defense or the 340(b) drug discount program available to safety net hospitals, have not been implemented.

The cash problem has stalled investment in the physical plant and other capital improvements. The Hospital budgeted $4.6 million for capital improvements in FY 2011, including more than $3 million for investments related to patient care

and life safety. Instead, from October 2010 through August 2011, expenditures for capital purposes, as classified by Hospital management, have been $632,000, although some additional capital items have been ordered but not yet paid.

The Hospital has continued to operate with almost the same management team that managed the Hospital prior to the foreclosure. That is consistent with the District's foreclosure transition strategy that focused on the absolute necessity of continuing Hospital operations without interruption. At that time, I concurred with that strategy and did not replace the prior Hospital CFO or other senior finance staff, but the OCFO is now far along in its nationwide search for a new Hospital CFO.

So how has Hospital management responded to its situation? It has actively, aggressively and openly opposed the OCFO's assumption of its legal status and duties in the financial office (even including telling the Hospital finance staff that it did not report to the OCFO the day after I met with the finance staff). More than a year after the foreclosure, the Hospital's finance staff remains the staff hired by Hospital management, and even post-foreclosure new or replacement financial staff hires have been conducted by the Hospital's, not the OCFO's, personnel office. Even now, after repeated requests, the OCFO has not been provided with the personnel records of the Hospital's finance staff. As I will describe below, the

Hospital fought long and hard for the right to exercise control over the actions of the proposed retention of a patient financial services director.

Only now has this changed, and only after the Hospital Board directed the Hospital to seek an Attorney General's opinion. This opinion verified the OCFO's legal position. The result is that the Hospital now takes the position that the OCFO has been directing the very same finance staff and that, instead of Hospital management, the OCFO has been responsible for the Hospital's billing and collection activities. In addition, even though my office was willing to retain the contracted patient financial services director originally hired by Hospital management by accepting an assignment of the contract from the Hospital. Hospital management refused to do so, and despite the OCFO's subsequent multiple drafts of a contract to satisfy Hospital management's insistence of Hospital management's control of an OCFO employee in direct violation of the Home Rule Act, and despite Hospital management's lengthy delays in responding to the OCFO's contract drafts **(see timeline-Attachment 4)**, Hospital management has attempted to divert the responsibility for the Hospital's stagnant cash collection performance to the failure to have a patient financial services director for five months. Effective September 1, 2011, the CFO has brought in its own patient financial services manager.

Hospital management's assertions that the absence of a contracted patient financial services director to manage the existing billing staff and that collections have decline as a result totally ignore the fact that all hospitals' collections have seasonal highs and lows **(see Attachment 5)**, that the Hospital's collections have been relatively stable throughout the year, that the outstanding accounts receivable days have remained relatively consistent throughout the fiscal year and are within the normal ranges for public hospitals nationwide as well as hospitals in the District metropolitan area, that both the highest and lowest monthly collections were under the former patient financial services director, and that the highest month, March 2011, is traditionally one of the highest collection months.

But of interest in light of management's assertions is the situation at the end of March 2011, the month that the former patient financial services director left and, according to Hospital management, the financial situation began to decline. As you may recall from your last hearing on the Hospital, Mr. Catania, you asked Mr. Hollings about cash on hand and he replied that, at the end of March, the Hospital had $8.3 million of cash, which you deemed "quite remarkable."

That figure is grossly misleading. Mr. Hollings seems to have calculated $8.3 million (as reflected on the March financial statement as "cash and equivalents")

using $5.06 million on the March 31, 2011 cash report as the amount in the Hospital bank accounts but (a) without reducing for $2.78 million of already encumbered amounts (employee contributions to health care plans, employee dues to unions, employee withholding taxes, employee retirement plan payments, checks written but not cleared, state and local taxes from February 2011 and March 2011, employee benefits from March 2011, and payroll checks for those not receiving payments by direct deposit to be distributed the following day in the amount of $270,000, and other payment obligations); and (b) after adding the unused $3 million of the District Contingency Fund.

After reducing these amounts, the Hospital actually had an unencumbered $2.28 million available in its bank accounts on that day, due largely to receipt of its quarterly $3.7 million DSH payment on March 25, 2011, which created a temporary cash bulge. Finally, payroll, due the following day, would be paid from the amount of remaining cash on hand.

Thus, in March 2011, the highest collection month, the average amount of cash in the Hospital's bank accounts was $2.83 million, and the average amount actually available to the Hospital in the same period after deducting previously encumbered funds was $1.29 million. Therefore, without the $2.95 million borrowed from the District, the Hospital would have had a negative cash flow in March 2011.

Another more specific example of the attempt to divert responsibility is Chief Executive Officer Frank DeLisi's report to a Board committee that the OCFO had been operating the SNF, although the OCFO's sole participation in the SNF had been to convert the pre-foreclosure owner's accounts to District accounts.

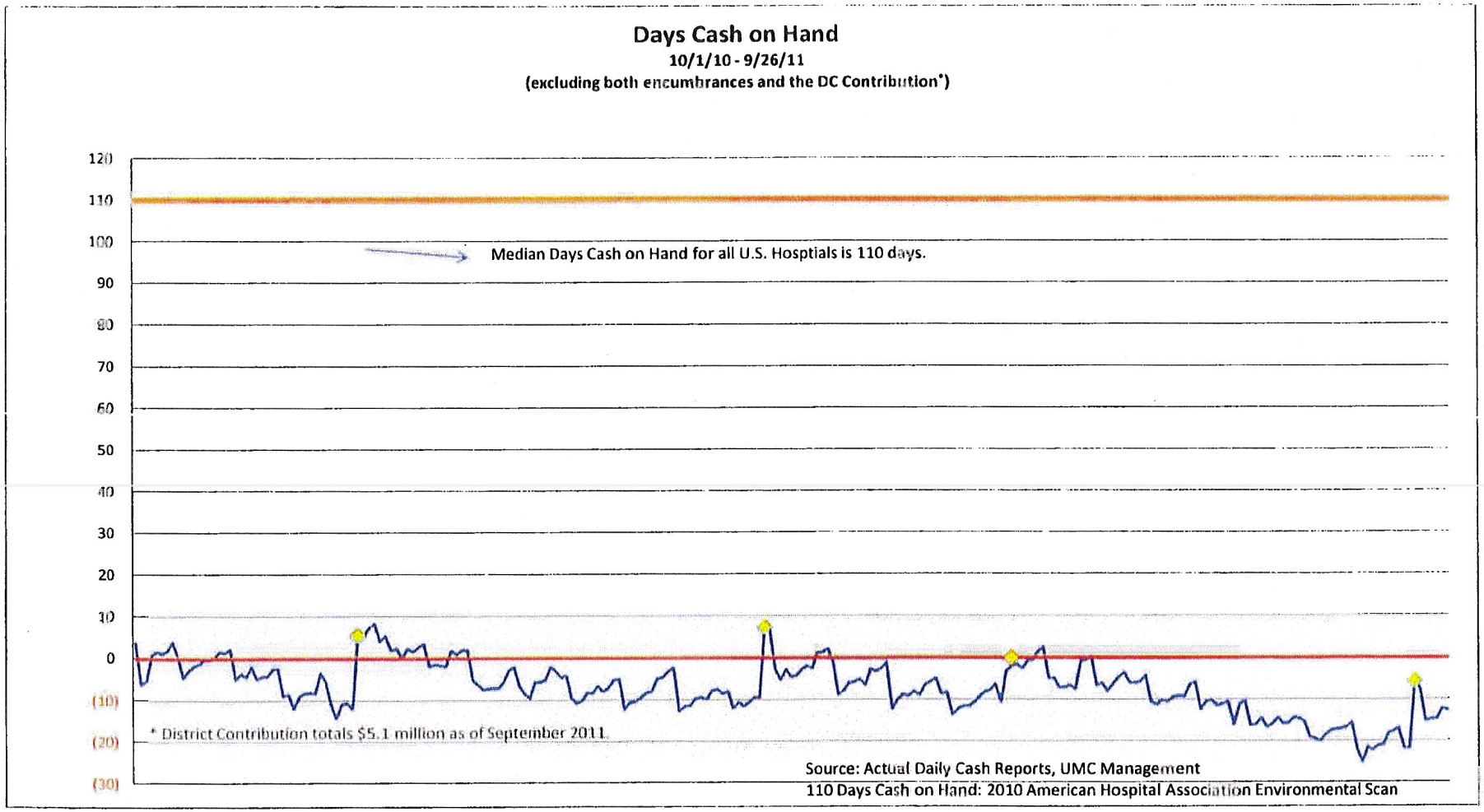
At the July 12, 2010 hearing, I stated that I had profound concerns regarding the legislation establishing the Not-for-Profit Hospital Corporation, as I stated at the time, "the legislation still falls short of the necessary governance arrangements that would ensure sound CFO oversight." That failure, plus the prolonged open and hostile resistance from Hospital management to the participation of my office in the financial oversight of the Hospital, has resulted in a lack of comprehensive financial controls at the Hospital.

However, all District entities, including the Hospital, are subject to the Home Rule Act, and the Home Rule Act directs my office to oversee financial operations of the District. That direction, and the independence of my office, is to ensure that the Mayor, the Council and the Congress are provided accurate and unvarnished financial information.

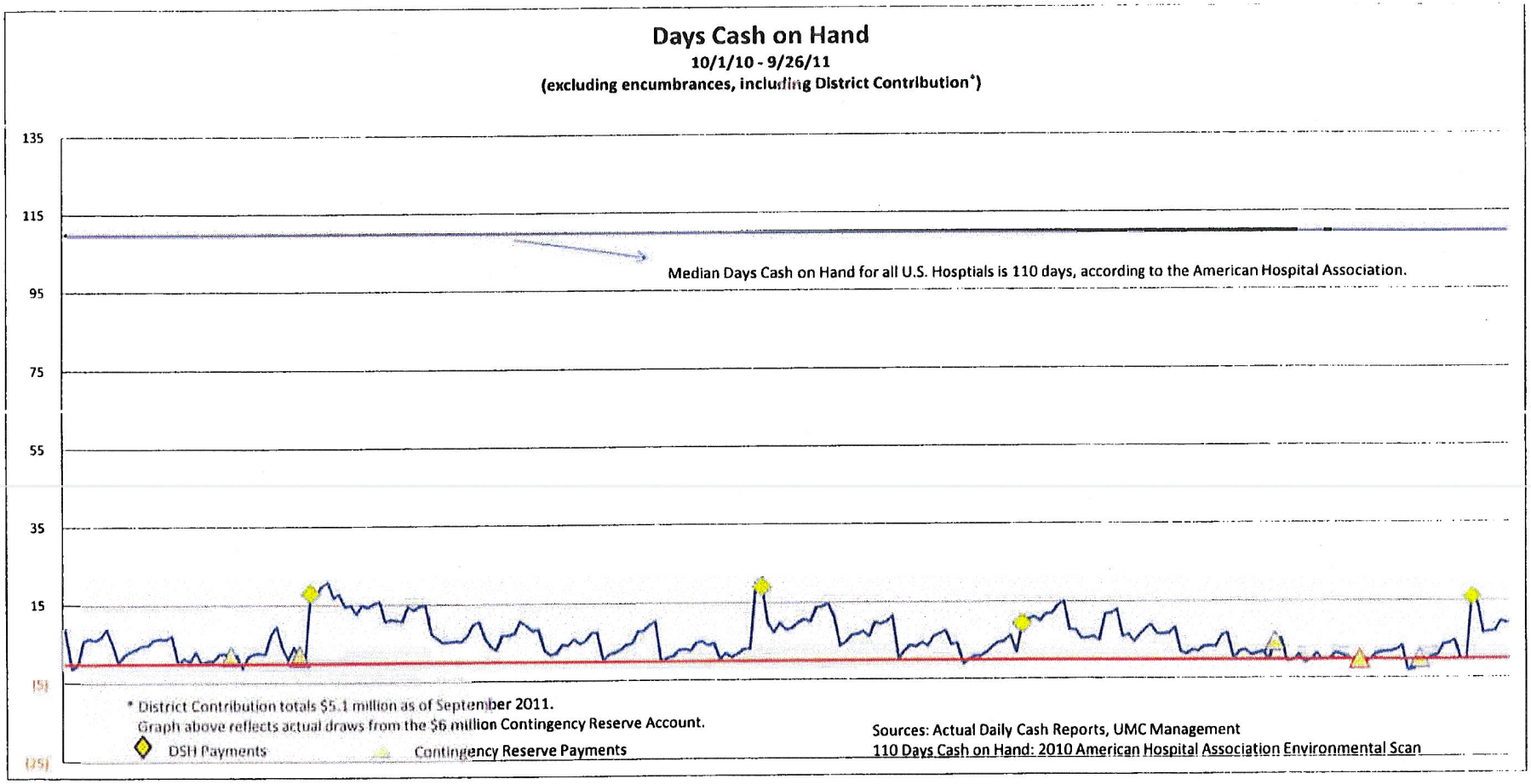
We understand there is no panacea that will cure the financial problems at the Hospital. We are all well aware that public hospitals are under great stress

throughout the United States, so it is not pejorative to state that the Hospital is in the same situation as its peers. While it is up to the Mayor and the Council to determine the future of the Hospital, and it is up to the Mayor and the Council to determine the extent of District support for the Hospital, it is, and will continue to be, my responsibility is to provide the most accurate financial data available to me regarding the Hospital.

**Attachment 1A**



**Attachment 1B**



**Attachment 2**

**Not-for-Profit Hospital Corporation**
Cash Collections vs. Cash Expenditures
In $000s

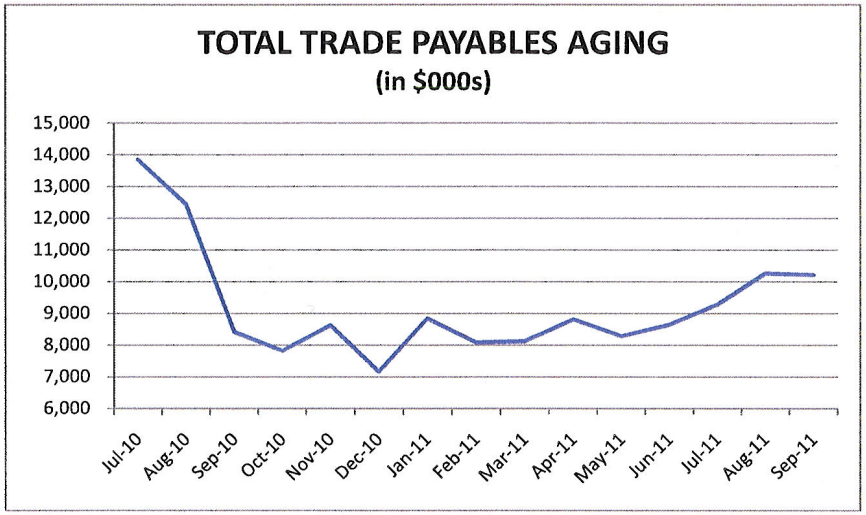
| | | Mar-2010 | Apr-2010 | May-2010 | Jun-2010 | Jul-2010 | Aug-2010 | Sep-2010 | Oct-2010 | Nov-2010 | Dec-2010 | Jan-2011 | Feb-2011 | Mar-2011 | Apr-2011 | May-2011 | Jun-2011 | Jul-2011 | Aug-2011 | Estimated Sept-2011f | *Monthly Average August 2010- August 2011* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Beginning Balance** | 1,294 | 2,685 | 1,305 | 1,260 | 1,124 | (623) | 2,004 | 227 | (1,478) | (1,172) | 2,116 | 1,990 | 2,022 | 3,682 | 2,085 | 4,133 | 2,939 | 2,252 | 2,408 | |
| 1a | Hospital Funds from Operations (incl. professional fees) | 6,843 | 5,379 | 5,475 | 5,745 | 4,706 | 5,659 | 4,793 | 5,319 | 4,734 | 5,579 | 5,317 | 6,522 | 6,612 | 5,607 | 5,260 | 5,301 | 5,303 | 5,731 | 4,766 | *5,518* |
| 1b | SNF Funds from Operations[a] | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 377 | 637 | 475 | 511 | 541 | 687 | 545 | 721 | 493 | 558 | 710 | *427* |
| 1c | Misc. Funds from Operations (incl. rent)[b] | 65 | 115 | 679 | 466 | 235 | 72 | 840 | 318 | 161 | 355 | 248 | 497 | 347 | 291 | 229 | 208 | 314 | 349 | 307 | *325* |
| 1d | ***NFPHC Total Funds from Operations*** | ***6,908*** | ***5,495*** | ***6,155*** | ***6,212*** | ***4,941*** | ***5,731*** | ***5,633*** | ***5,638*** | ***5,272*** | ***6,571*** | ***6,040*** | ***7,531*** | ***7,500*** | ***6,585*** | ***6,034*** | ***6,230*** | ***6,109*** | ***6,638*** | ***5,784*** | ***6,270*** |
| 2 | ***Medicaid DSH Payment[c]*** | **0** | **0** | **0** | **1,217** | **0** | **4,152** | **0** | **0** | **0** | **3,724** | **0** | **0** | **3,724** | **0** | **3,724** | **0** | **0** | **0** | **3,776** | ***1,179*** |
| 3a | Receipts from Chartered Note (debt proceeds)/ Specialty Hospitals of Washington (settlement) | 250 | 325 | 500 | 200 | 0 | 250 | 250 | 250 | 250 | 250 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | *96* |
| 3b | Contingency Fund ($5.1m YTD, FY 2011)[d] | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,179 | 1,774 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 750 | 750 | 645 | *343* |
| 3c | ***NFPHC Funds from Non-operating Sources*** | ***250*** | ***325*** | ***500*** | ***200*** | ***0*** | ***250*** | ***250*** | ***1,429*** | ***2,024*** | ***250*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***0*** | ***750*** | ***750*** | ***645*** | ***439*** |
| 4 | **NFPHC Total Funds** | **7,158** | **5,820** | **6,655** | **7,629** | **4,941** | **10,133** | **5,883** | **7,067** | **7,296** | **10,545** | **6,040** | **7,531** | **11,224** | **6,585** | **9,758** | **6,230** | **6,859** | **7,388** | **10,205** | ***7,888*** |
| 5 | **Total Operating Cash Expenditures** | **5,767** | **7,200** | **6,700** | **7,764** | **6,688** | **7,506** | **7,660** | **8,772** | **6,990** | **7,258** | **6,166** | **7,499** | **9,564** | **8,182** | **7,710** | **7,424** | **7,546** | **7,231** | **9,944** | ***7,654*** |
| 6 | ***Cash Operating Margin excluding DSH ( 1d - 5)*** | ***1,141*** | ***(1,705)*** | ***(545)*** | ***(1,553)*** | ***(1,747)*** | ***(1,775)*** | ***(2,027)*** | ***(3,134)*** | ***(1,718)*** | ***(687)*** | ***(126)*** | ***32*** | ***(2,064)*** | ***(1,597)*** | ***(1,676)*** | ***(1,194)*** | ***(1,437)*** | ***(594)*** | ***(4,160)*** | ***(1,384)*** |
| 7 | ***Cash Operating Margin including DSH (1d + 2 - 5)*** | ***1,141*** | ***(1,705)*** | ***(545)*** | ***(336)*** | ***(1,747)*** | ***2,377*** | ***(2,027)*** | ***(3,134)*** | ***(1,718)*** | ***3,037*** | ***(126)*** | ***32*** | ***1,660*** | ***(1,597)*** | ***2,048*** | ***(1,194)*** | ***(1,437)*** | ***(594)*** | ***(384)*** | ***(206)*** |
| 8 | ***Total Cash Margin (4 - 5)*** | ***1,391*** | ***(1,380)*** | ***(45)*** | ***(136)*** | ***(1,747)*** | ***2,627*** | ***(1,777)*** | ***(1,705)*** | ***306*** | ***3,287*** | ***(126)*** | ***32*** | ***1,660*** | ***(1,597)*** | ***2,048*** | ***(1,194)*** | ***(687)*** | ***156*** | ***261*** | ***233*** |
| | **Ending Balance** | *2,685* | *1,305* | *1,260* | *1,124* | *(623)* | *2,004* | *227* | *(1,478)* | *(1,172)* | *2,116* | *1,990* | *2,022* | *3,682* | *2,085* | *4,133* | *2,939* | *2,252* | *2,408* | *2,670* | |
| | **Additional District Funding** | | | | | | | | | | | | | | | | | | | | |
| 9 | Healthy DC Grant (Amortized, Seven Months, FY 2010)[e] | 843 | 843 | 843 | 843 | 843 | 843 | 843 | | | | | | | | | | | | | |

Notes
a. NFPHC took over SNF Operations in October of 2010
b. Miscellaneous funds as reported in financial statements, includes rent of buildings and equipment
c. The Disproportionate Share Hospital (DSH) payment is received quarterly, but intended as a monthly compensation for care to the indigent.
*NFPHC received its 4th Quarter FY 2011 DSH payment of $3.776 million in September 2011.*
d. Funds were withdrawn from the Hospital Reserve Fund from funds that the District set up using $6 million from FY2010 Contingency Funds.
e Amortized as reflected on FY 2010 Financial Statements.
f Estimates based on month to date and projections. September is a three-payroll month, if Emergency Medicare payment is received revenues would increase by $1million.

Sources
1 UMC Daily Cash reports from UMC Management
2. UMC Daily Cash reports from UMC Management
3a. UMC Daily Cash reports from UMC Management
3b. Bank Statements for Contingency Reserve Account
5. Check Backup Reports from UMC Finance Office, sent September 2011

**Attachment 3**

| MONTH | TOTAL TRADE PAYABLES AGING ($) | | |
|---|---|---|---|
| Jul-10 | 13,848,897.06 | * | |
| Aug-10 | 12,441,068.54 | * | |
| Sep-10 | 8,410,756.68 | * | *Write-off of pre-foreclosure accounts payable* |
| Oct-10 | 7,819,732.51 | * | |
| Nov-10 | 8,616,022.97 | * | |
| Dec-10 | 7,162,713.66 | | *Write-off of pre-foreclosure accounts payable* |
| Jan-11 | 8,833,618.94 | | |
| Feb-11 | 8,080,438.67 | * | |
| Mar-11 | 8,112,497.50 | * | |
| Apr-11 | 8,802,845.25 | * | |
| May-11 | 8,273,662.68 | | |
| Jun-11 | 8,647,860.17 | | |
| Jul-11 | 9,279,377.55 | | |
| Aug-11 | 10,264,765.67 | | |
| 9/26/2011 | 10,211,673.86 | | |




* Does not include payables to personnel-related payments, including to health insurer, retirement fund, and union dues.

Source: Month-end Accounts Payable Aging reports from NFPHC Financial Management

**The Chappelle Group Timeline**

- On July 9, 2010, Patient Financial Services Director gave 30-day notice
- On August 1, 2010, OCFO asked Derrick Hollings to post the position
- Hollings said no applicants, but Hospital HR Director said there were responses, but applicants "not qualified"
- September 15, 2010, Chappelle group entered into sole-source six-month contract with the Hospital
- On March 10, 2011, Hospital modified contract for additional 60 days and sought additional 6-month modification (in violation of Hospital procurement rules)
- On March 14, 2011 in an effort to continue the services, OCFO sent Chappelle a 180-day letter contract under District procurement rules for similar statement of work and identical compensation
- On March 15, 2011, Chappelle proposed a temporary agreement
- On March 15, 2011, OCFO responded that a temporary agreement or an additional 6-month modification violated Hospital and District procurement rules
- On March 15, 2011, the OCFO proposed that the Hospital enter into the agreed-upon Hospital/Chappelle long-term contract and assign it to the OCFO
- On March 15, 2011, Frank DeLisi rejected the proposal
- On March 16, 2011, Chappelle entered into a contract with the Hospital (without OCFO fiscal certification)
- On March 17, 2011, Chappelle rejected the March 14, 2011 proposed letter contract
- On March 24, 2011, the OCFO received two bids for interim PFS managers
- At Frank DeLisi's request, the OCFO did not continue the procurement process but sought to reach agreement with the Hospital regarding a contract with Chappelle
- From mid-March to the end of May, 2011, the OCFO turned numerous drafts of a contract, based almost exclusively on Frank DeLisi's requests for language regarding the level of his participation in controlling the contractor
- In May, 2011, Chappelle requested an increase in the price of the contract
- On July 21, 2011, the Hospital sent the OCFO the sole source determination and findings for the Chappelle contract
- The OCFO procurement office could not accept the sole source justification (the OCFO had received bids from other vendors that were capable of providing quality services at lower prices than proposed by Chappelle
- The OCFO rebid the contract and the new patient financial services director started on September 1, 2011

**Attachment 5**

| | 2009-2010 | 2010-2011 |
|---|---|---|
| October | 6,142,022 | 5,319,728 |
| November | 5,255,080 | 4,734,291 |
| December | 5,618,731 | 5,579,087 |
| January | 4,757,235 | 5,316,855 |
| February | 4,685,468 | 6,511,518 |
| March | 6,715,264 | 6,612,172 |
| April | 5,284,395 | 5,504,436 |
| May | 5,408,648 | 5,181,373 |
| June | 5,621,876 | 4,956,834 |
| July | 4,593,942 | 5,502,648 |
| August | 5,544,601 | 5,584,002 |
| September | 4,774,176 | |