PUBLIC HEARING

The Not-for-Profit Hospital Corporation

Before the Committee on Health

The Honorable David Catania, Chairman

January 20, 2011, 9:30 a.m.
John A. Wilson Building
Council Chambers

Testimony of

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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. I am here to present testimony regarding the current financial status of the Not-for-Profit Hospital Corporation, commonly referred to as United Medical Center or the Hospital. With me today are Associate Chief Financial Officer Deloras Shepherd, who is also the OCFO's representative on the UMC Board, Derrick Hollings, CFO for UMC, and OCFO Deputy General Counsel Steve Lyons.

I want to begin by commending you, Mr. Catania, for your leadership and dedication to the Hospital. United Medical Center (UMC) is the District's only hospital east of the Anacostia River, and provides critical health care services to the surrounding community. Notwithstanding the financial issues that are the topic of my testimony today, I commend your efforts to maintain access to quality care for District residents in need.

As you know, the District took ownership of the Hospital through foreclosure on July 9, 2010, only thirty-two months after the District had provided $29 million in acquisition funds, more than $40 million in capital funds, and more than $25 million in operating funds to Specialty Hospitals of America, its previous owner.

Since the transfer to public ownership, the Hospital has shown improvement. Since taking ownership of the Hospital, the District has made significant efforts to keep the Hospital operational, to improve the Hospital's services to the community and to stabilize its financial position. In particular, as I mentioned during my July 12, 2010 testimony to this Committee, the financial improvements are due largely to an

increase in its share of the Medicaid Disproportionate Share Hospital (DSH, pronounced "dish") payment from $4.8 million/year to $14.9 million/year (an increase from 10% of the total available District pool of funds to 31% of that pool). This increase, which has proven to be greater than anticipated, occurred without the Hospital having to improve its operations or its patient census. The increase, however, has been somewhat offset by a smaller than expected increase from the Medicaid rate plan change (the annual increase is now estimated to be approximately $1 million instead of the $4 to $4.5 million projected by Hospital management last year). I must also mention here that the actual change in the District's Medicaid reimbursement structure is pending federal approval.

In addition, as I noted during last year's testimony to this Committee, there were, and continue to be, various other potential mitigating factors, such as partnerships with the Washington Hospital Center (MedStar), and the Children's National Medical Center which opened its satellite pediatric emergency ward this past September. These partnerships, which, if management projections are realized, could contribute to the Hospital's financial position and ease its risk of becoming a financial burden on the District.

Clearly, the District has made a substantial investment in the Hospital, and the foreclosure and subsequent District control are intended to protect this investment. We must be very clear, however, about the financial implications of District ownership so that our elected leaders and policymakers can properly plan for the on-going impact of District ownership of the Hospital. Although we all hope for the best, to meet the goal of maintaining an operational full-service medical facility east of the

Anacostia River, we must take a realistic view of its financial position in order to meet its financial demands. In doing so, we must consider the potential operational and financial challenges to the hospital's success.

The Hospital's future success in large measure will depend upon careful planning and successful relationship building with key stakeholders including the community, legislators, and providers. The UMC's Management 2015 Vision Statement identifies the following "barriers to success:"

- Poor Public Perception – the hospital does not have adequate facilities, technologies, clinical programs and physician capabilities.

- Revolving Ownership – which has disrupted the continuity required to develop and execute long-range strategic plans (i.e., physician capabilities, facilities improvements, programs and services needed by the community).

- Checkered Financial History – Greater Southeast Hospital and its predecessor organizations have gone through a never-ending series of bankruptcies and foreclosures over the past 10 years which has undermined its operational and financial stability.

- A Corporate Structure – which, in the past, has impaired the Hospital's ability to attract philanthropic sponsorships and stymied community development activities.

- Talent Acquisition – an inability to recruit and retain management and physician leaders in the context of the current strategies and strategic initiatives.

- Program Deficits – an inability to develop clinical programs and services that are needed by the residents east of the Anacostia River, and

- Cash Limitations – cash generated from operations has been inadequate for financing physician recruitment, facilities development, equipment purchases and expanding service offerings. I will go into more detail about the Hospital's limited cash flow later in my testimony.

Additionally, we must examine the following critical financial issues:

First, Liabilities of the former owners of the Hospital: With the foreclosure, the prior Hospital owner's obligations to third parties did not carry forward, and therefore, most of those obligations have been removed from the balance sheet. As projected in my July 12, 2010 testimony to this Committee, it has proven necessary to pay a portion of the $7 to $9 million of outstanding accounts payable to certain vendors who continue to provide critical medical supplies and services to the Hospital. The Office of the Attorney General and Hospital staff worked diligently to negotiate settlements with these critical vendors, but some additional expenditures may be necessary. These include payment plans of as much as $600,000 to $700,000 per month for the remainder of this fiscal year. Finally, although certain accrued payroll benefit and tax liabilities are legally imposed on the former owner of the Hospital,

they cannot be ignored, and, in some cases, are not subject to settlement or are subject to settlement at the sole discretion of the taxing entity.

Second, on-going funding needs: The Hospital continues to suffer significant cash-flow issues. Aside from the increased DSH and Medicaid payments, it has shown no material increase in net patient revenues. Accordingly, the Hospital maintains critically low liquidity measures, including "days cash on hand." Days cash on hand is a standard business indicator which essentially looks at the amount of unencumbered cash in the bank and compares it to a daily expenditure rate. The median days cash on hand for hospitals in the United States is 110 days, according to a 2010 report from the American Hospital Association. The Hospital's available cash on hand since the foreclosure has averaged 6 days. Excluding funds from the Contingency Reserve, it has averaged a negative 2 days (see Appendix A). As a result, the Hospital is unable to pay all bills on a current basis or in accordance with industry standards. In addition, the actual operating results since foreclosure on July 9th is negative $753,000 (see Appendix B).

This concern is evidenced by the fact that, during the first quarter of this fiscal year, the lack of operating cash, when combined with a delayed DSH payment, forced the Hospital to draw $3.6 million of the $6 million that originated from the District's Contingency Reserve Fund. As you recall, the District provided the Hospital $26 million in FY 2010, and the Hospital replenished or repaid $20 million of that to the Contingency Reserve using revenues generated in FY 2010. In the beginning of FY 2011, the remaining $6 million was left with the Hospital as a cash reserve or working capital account. To date, $600,000 of the $3.6 million draw has been repaid

to the Hospital's reserve account, leaving the Hospital with a $3.05 million reserve and $2.95 million as an advance. Without that advance, the Hospital could not have met all of its financial obligations.

Additionally, on January 13th, the Hospital was informed by Specialty Hospitals of Washington (SHW) that it will no longer be making monthly payments of $250,000 as stipulated in the August 10, 2010 purchase service agreement, due to its receipt of vendor claims for services provided to the Hospital prior to the foreclosure. This unanticipated event, which could cost the Hospital as much as $948,000, further strains the Hospital's fragile cash position.

Given the Hospital's continued low cash balance and lack of credit line or emergency funds, it is only prudent to undertake a very careful examination of the Hospital's budget and its underlying assumptions.

The Hospital's FY 2011 internal budget is $123 million. This budget does not include any local funds, but anticipates that the Hospital will spend its own revenues to maintain its operations. The Hospital's operations consist of three major service categories: inpatient, outpatient, and skilled nursing facility (SNF, pronounced "sniff") services, and includes $112.9 million of operating expenses and $4.7 million of capital improvement expenses (some of which are ordinarily paid from operating, not capital, budget). The Hospital forecasts an FY 2011 operating margin of 8.2%, compared to 3.2% for A-rated hospitals, per an analysis conducted by Moody's Investor Services, as outlined in the table below.

Description	Moody's A Rated Hospital	UMC 2011 Budget	Best When?
Maintained Bed Capacity	71%	63%	Higher
Average Length of Stay	5.0	5.1	Lower
Operating Margin	3.2%	8.20%	Higher
Excess Margin	6.4%	4.32%	Higher
Cash-on-hand (days)	196.6	30.2	Higher
Accounts Receivables (days)	50.60	40.6	Lower
Debt-to-capitalization	35.2%	15.6%	Lower
Bad Debt as a % of Net Patient Revenues	5.8%	14.6%	Lower
Source: UMC Management Vision 2015 Document			

Because the OCFO could not verify certain assumptions such as the projected number of obstetric deliveries, adult emergency room visits, and SNF patients in the FY 2011 budget, the OCFO did not certify the budget that the NFPHC Board approved on December 16, 2010. The OCFO's Board representative abstained from the NFPHC Board's vote on the budget.

The Board-approved budget projects FY 2011 Hospital revenues of $123 million. This amount is based largely on projections of new or expanding programs, rather than on the Hospital's performance history. Reaching this total is contingent on many moving parts coming to fruition on certain dates, including, but not limited to:

- A successful expansion of Ob/Gyn services in partnership with Washington Hospital Center (which was expected to have commenced in October but only began this week);

- An increased inpatient, emergency room, and outpatient volume;

- An increased number of patients with more severe medical conditions;

- An improved SNF occupancy level (to almost 100 percent of licensed beds); and

- The provision of ancillary services to non-Hospital providers (for example, the Hospital should benefit from its provision of ancillary medical tests and other services provided to the patients of the Children's National Medical Center pediatric emergency ward).

Third, Financial audits: I am pleased to report that the KPMG audit of the Hospital from July 9, 2010 to September 30, 2010 is expected to be completed in time for the District's FY 2010 Consolidated Annual Financial Report. Further, because the Hospital did not complete a financial audit for its fiscal year ended December 31, 2009, KPMG also has been retained to perform audits for Calendar Year 2009 and for the period January 1, 2010 to July 8, 2010. This information should prove to be extremely valuable in increasing the District's understanding of the Hospital's true and complete financial condition and will enable the District's leaders, rating agencies, potential purchasers and/or health care partners to better assess the financial stability of the Hospital and to make sound policy decisions for the future viability of the Hospital.

Fourth, Need for capital investment: The Hospital requires significant capital improvements. Virtually none of these needs have been addressed since the

foreclosure. The Hospital's current four-year capital plan includes more than $30 million in repairs and improvements, of which approximately $8 million are considered critical life safety items. The budget includes just $4.7 million for capital improvements in FY 2011, which appears insufficient to meet the critical life-safety needs identified (see Appendix C).

In addition, to avoid reductions in Medicare payments beginning in Calendar Year 2015, the Hospital will need to invest in and ensure the "meaningful use" of federally mandated Health Information Technology and Electronic Health Records improvements, but it has included only $355,000 for these improvements in its FY 2011 capital budget.

Because the District's goal is to keep the Hospital operational and improve its facilities, these immediate and critical capital needs must be addressed. At present, the ability to pay for any capital improvements depends almost exclusively on continued strengthening of the Hospital's cash flow situation.

Fifth, Additional programs to enhance Hospital revenues: As I mentioned earlier, the Hospital budget depends on the successful implementation of a number of programs.

These programs include a new Children's National Medical Center pediatric emergency ward, which was funded by a District grant, and opened in September. Although the Children's pediatric emergency room patients are not Hospital patients, and although this new Center will take patients who otherwise would have been

admitted to the Hospital's emergency room, Hospital management hopes that eventually the Children's ward will attract a net increase in the number of patients who will use more ancillary services at UMC.

The Hospital just executed an agreement with the MedStar system (Washington Hospital Center) to accommodate additional childbirths. Once it is implemented, management projects that the new arrangement will significantly increase the OB patient census, partially because UNITY patients will be directed to UMC for Ob/Gyn care. It is hoped that this program will reduce the net financial losses that the Hospital's OB department currently experiences.

Furthermore, as anticipated for FY 2011, the revenues generated from NFPHC's acquisition of the skilled nursing facility continue to be outpaced by the SNF's costs. The FY 2011 budget projects a $900,000 loss in SNF operations, but the amount of the loss may prove larger if the number of residents continues to increase at a lower rate than was projected by Hospital management. The Department of Health Care Finance is working to submit a State Plan Amendment that would provide the SNF with a revised rate.

In addition, the Hospital must meet efficiencies in order to control its expenses. Specifically, the expenses are driven primarily by the wages of its employees and contractors, and by costs controlled by physicians, who, if efficient, can help control these Hospital cost drivers, such as above-average length of stay for inpatients and their utilization of supplies. The Hospital may also begin to realize savings through

the use of group purchasing organizations and of the General Services Administration supply schedule.

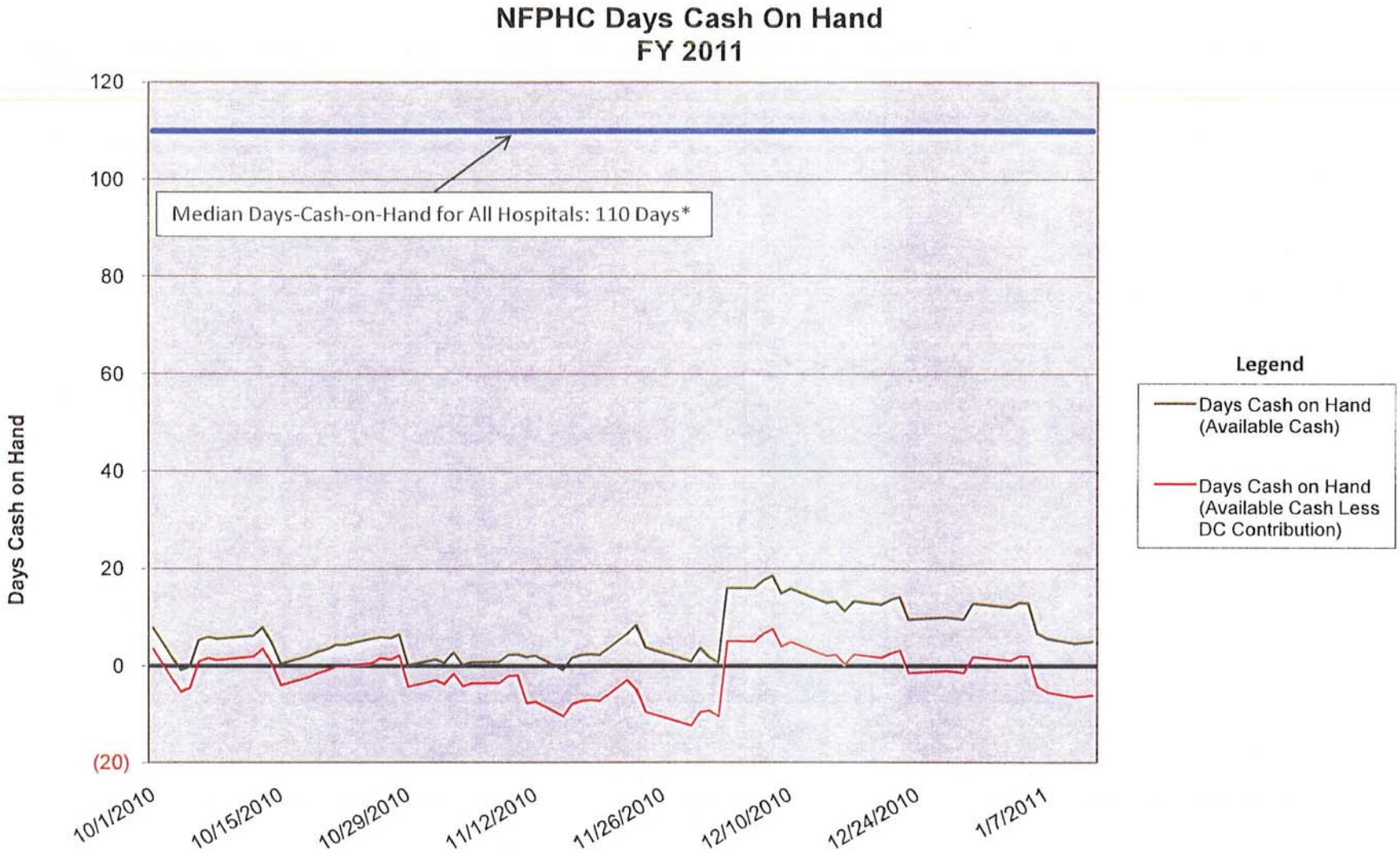
Sixth, Use of Contingency Reserve Funds: In July 2010, the District withdrew $26 million from the District's Contingency Reserve Fund to provide the Hospital appropriations authority to continue operations during FY 2010. This proved vital to keeping the Hospital operating from July 9, 2010 going forward into FY 2011, a period during which costs have continued to grow steadily and, while revenue has also increased somewhat, cash receipts have flowed unevenly. Of the $26 million, $20 million was replenished from the Hospital's FY 2010 revenues. The remaining $6 million was left in place for use by the Hospital as a cash reserve or working capital.

In accordance with District law, the $6 million must be repaid to the District Contingency Fund in full by the end of FY 2012. While the repayment could be deferred, the Hospital's CEO, Frank DeLisi, sent a letter informing then Council Chairman Gray of Mr. DeLisi's plans to replenish $3 million in December 2010, based on the Hospital's projections of increased revenues. If this repayment were made, the Hospital would have had a reserve of approximately 12 days cash-on-hand as of January 3, 2011. Even that reserve is somewhat illusory because it includes the $2.95 million of Contingency Reserve funds. This repayment would leave the Hospital extremely vulnerable should unforeseen events arise. At present, the Hospital has not formally requested the OCFO to transfer the $3 million to the Contingency Reserve Fund, so the amount remains in the Hospital reserve account.

Conclusion: The Hospital should be carefully monitored and managed to ensure that its continued ownership and operation do not adversely affect the District as a whole. I should mention that, in its most recent credit ratings report, Standard and Poor's specifically cited the acquisition of the Hospital and its potential need for further subsidy as factors that could negatively impact their assessment of the District's financial strength. Thus, additional analysis should be conducted to determine the best future course of action for the District as it relates to the Hospital.

This concludes my testimony. I am happy to answer any questions you may have.

Appendix A



*Source: 2010 American Hospital Association Environmental Scan Report

Appendix B

NFPHC Cash Flows
(July 9, 2010 through December 31, 2010)

CASH ANALYSIS	JULY 9 -31	AUG	SEPT	OCT	NOV	DEC	TOTAL	Average Monthly
Receipts from Operations								
Collections	$3,806	$5,726	$5,633	$7,120	$6,027	$6,430	$34,742	$6,051
Payments from Specialty		$250	$250	$250	$250	$250	$1,250	$218
DSH (Received 8/27 and 12/3)		$4,156				$3,724	$7,880	$1,372
Total Receipts	$3,806	$10,132	$5,883	$7,370	$6,277	$10,404	$43,872	$7,641
Cash Disbursements								
Wages and Benefits	$3,014	$4,105	$5,058	$5,699	$4,788	$5,722	$28,386	$4,944
Payments and other expenses	$2,021	$3,202	$1,950	$3,332	$3,133	$2,601	$16,239	$2,828
Total Disbursements	$5,035	$7,307	$7,008	$9,031	$7,921	$8,323	$44,625	$7,772
Operating Result (Cash Basis)	($1,229)	$2,825	($1,125)	($1,661)	($1,644)	$2,081	($753)	($131)
District Contribution from Safety Net Grant		($500)	($652)					
NFPHC Operating Result (excluding Safety Net Grant)	($1,229)	$2,325	($1,777)	($1,661)	($1,644)	$2,081	($1,905)	($332)

Source: July 2010 through November 2010 based on NFPHC Management Reports. December based on NFPHC collection, payment and payroll data.

Appendix C

United Medical Center
Plant, Property and Equipment

Dollars in Thousands

Description	Life	2010	2011	2012	2013	2014	Total
Hospital Capital Budget							
Plant Property and Equipment							
Land	LD	-	-	-	-	-	-
Land improvements	LI	-	-	-	-	-	-
Building and contents	BC	-	-	-	-	-	-
Leasehold improvements	LH	-	3,123	6,560	5,580	1,950	**17,213**
Medical and general equipment	ME	-	188	310	1,300	1,300	**3,098**
Management information systems	IT	-	275	900	2,625	2,675	**6,475**
Contingency		-	1,000	1,000	1,000	1,000	**4,000**
Total Plant, Property and Equipment		-	**4,586**	**8,770**	**10,505**	**6,925**	**30,786**
Hospital Depreciation Expense							
Plant Property and Equipment							
Land	0	-	-	-	-	-	
Land improvements	10	-	-	-	-	-	
Building and contents	30	-	-	-	-	-	
Leasehold improvements	25	-	125	262	223	78	
Medical and general equipment	15	-	13	21	87	87	
Management information systems	10	-	28	90	263	268	
Contingency	15	-	67	67	67	67	
Total Plant, Property and Equipment		-	**165**	**373**	**572**	**432**	
Cummulative Depreciation Expense							
FY 2010 Additional Depreciation		-	-	-	-	-	
FY 2011 Additional Depreciation		-	165	165	165	165	
FY 2012 Additional Depreciation		-	-	373	373	373	
FY 2013 Additional Depreciation		-	-	-	572	572	
FY 2014 Additional Depreciation		-	-	-	-	432	
Additional Depreciation		-	**165**	**538**	**1,110**	**1,543**	

Dollars in Thousands

Description	Life	2010	2011	2012	2013	2014	Total

Executive Summary

Description	2010	2011	2012	2013	2014	Total
Urgent Needs	-	1,036	3,662	3,000	500	8,198
Critical Life Safety	-	512	1,398	1,580	650	4,140
Patient Care	-	1,763	1,810	2,300	2,100	7,973
Information Technology	-	275	900	2,625	2,675	6,475
Contingency	-	1,000	1,000	1,000	1,000	4,000
Total	**-**	**4,586**	**8,770**	**10,505**	**6,925**	**30,786**

Executive Summary

Description	2010	2011	2012	2013	2014	Total
Leasehold Improvements	-	3,123	6,560	5,580	1,950	17,213
Medical and Equipment	-	188	310	1,300	1,300	3,098
Information Technology	-	275	900	2,625	2,675	6,475
Contingency	-	1,000	1,000	1,000	1,000	4,000
Total	**-**	**4,586**	**8,770**	**10,505**	**6,925**	**30,786**

Urgent Needs

Description		2010	2011	2012	2013	2014	Total		
Emergency Department	LH	-	-	2,500	2,500	-	5,000	Discre	
Dietary Equipment Replacement	LH	-	-	302	-	-	302	Discre	
Boiler	LH	-	-	860	-	-	860	**CLS**	860
Roof Replacement	LH	-	461	-	-	-	461	Discre	
Unit Renovation - Level 8	LH	-	500	-	500	-	1,000	Discre	
Clinical Lab Renovations	LH	-	-	-	-	500	500	Discre	
Overhaul Chiller	LH	-	75	-	-	-	75	Discre	
Total - Urgent Needs		**-**	**1,036**	**3,662**	**3,000**	**500**	**8,198**	Discre	**7,338**
									8,198

Dollars in Thousands

Description	Life	2010	2011	2012	2013	2014	Total		
Critical Life Safety									
Description		**2010**	**2011**	**2012**	**2013**	**2014**	**Total**		
Hospital Elevators Phase I	LH	-	-	-	-	-	-	CLS	
MOB - Elevators Phase II	LH	-	-	398	-	-	398	CLS	
Air Handling Phase III	LH	-	-	1,000	1,000	300	2,300	CLS	
OR Air Handler Humidification	LH	-	200	-	-	-	200	CLS	
Deareator	LH	-	-	-	300	-	300	CLS	
Medical Gas Phase I	LH	-	-	-	280	-	280	CLS	
Medical Gas Phase II	LH	-	-	-	-	350	350	CLS	
Fire Protection - Penetration Patch	LH	-	164	-	-	-	164	CLS	
Repairs to Fire Alarm	LH	-	18	-	-	-	18	CLS	
Repair/Replace Fire Doors	LH	-	50	-	-	-	50	CLS	
Loading Dock Sprinklers	LH	-	30	-	-	-	30	CLS	
Nurse Call System	LH	-	50	-	-	-	50	CLS	
Total - Critical Life Safety		**-**	**512**	**1,398**	**1,580**	**650**	**4,140**	CLS	**4,140**
Patient Care									
Description		**2010**	**2011**	**2012**	**2013**	**2014**	**Total**		
Cardiology, Cath Lab	ME	-	-		800	800	1,600	important	
Imaging	ME	-	-	310	-	-	310	important	
Theraphy	ME	-	80	-	-	-	80	important	
Laboratory	ME	-	108	-	-	-	108	important	
Isolation Rooms	LH	-	-	-	-	800	800	important	
Bed Replacement	ME	-	-	-	-	-	-	important	
Surgical Equipment & Renovation	ME	-	-	-	500	500	1,000	important	
OB/GYN Renovations	LH	-	500	1,500	1,000	-	3,000	important	
Pharmacy 797 Code Compliance	LH	-	75	-	-	-	75	important	
Unused	LH	-	-	-	-	-	-	important	
Dietary Equipment Replacement	ME	-	-	-	-	-	-	important	
Primary Care and Clinics	LH	-	1,000	-	-	-	1,000	important	
Total - Patient Care		**-**	**1,763**	**1,810**	**2,300**	**2,100**	**7,973**	important	**7,973**

Dollars in Thousands

Description	Life	2010	2011	2012	2013	2014	Total		
Information Technology									
Description		**2010**	**2011**	**2012**	**2013**	**2014**	**Total**		
Network & infrastructure	IT	-	-	200	200	200	600	Discre	
Clinical Software	IT	-	-	350	500	300	1,150	Discre	
System Upgrades	IT	-	-	100	100	100	300	Discre	
Electronic Medical Record	IT	-	-	-	1,500	1,500	3,000	**CLS**	**3,000**
Hardware & Storage	IT	-	100	100	100	100	400	Discre	
IT/Telecom Infrastructure	IT	-	-	-	-	250	250	Discre	
Scanning and Imaging System	IT	-	-	-	-	-	-	Discre	
Computers & Peripherals	IT	-	175	75	75	75	400	Discre	
Forms Administration	IT	-	-	75	150	150	375	Discre	
Total - Information Technology		**-**	**275**	**900**	**2,625**	**2,675**	**6,475**	**Discre**	**3,475**
								Check Total	6,475
Contingency									
Description		**2010**	**2011**	**2012**	**2013**	**2014**	**Total**		
Contingency		-	1,000	1,000	1,000	1,000	4,000		
Total - Contingency		**-**	**1,000**	**1,000**	**1,000**	**1,000**	**4,000**	Discre	**4,000**

Critical Life Safety
Descreationary

Discretionary	14,813
Critical Life Safety	8,000
Important	7,973
Total	**30,786**