

Business Plan Analysis

University Medical Center, New Orleans

Prepared for:

Louisiana Department of Health and Hospitals

Prepared by:

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Introduction

This report summarizes our analysis of the Business Plan to rebuild the Medical Center of Louisiana New Orleans (MCLNO), which will operate as a non-profit corporation and will be named “University Medical Center” (UMC). Pursuant to a Memorandum of Understanding signed by LSU, the Louisiana Department of Health and Hospitals (DHH) and the state, and by Tulane University, when established, UMC:

- will operate as an Academic Medical Center (AMC),
- will be governed by an eleven member board of directors (the Corporation Board),
- will operate as a major affiliate of Louisiana State University and as part of the LSU system, and would serve as a teaching affiliate of Tulane University, and
- will have other university affiliations as approved by the Corporation Board.

To prepare the analysis, Verité Healthcare Consulting (VHC) developed financial projections for UMC under various scenarios. Together with Berkoff Facilities Strategies and Hogan & Hartson, LLP, VHC also reviewed and commented on plans for the UMC facilities and for UMC governance.

This report briefly describes the proposed project, presents financial projections for the medical center, describes the principal assumptions that underlie the projections, discusses findings from our review of the medical center's facilities plans, and concludes with observations regarding certain risks that may affect the project's success.

The Proposed Project

The Business Plan calls for constructing a new, 424-bed AMC in New Orleans. The project budget would be \$1.2 Billion (not including working capital that we have assumed also will be needed).

Project costs would be funded from three sources: the state of Louisiana, which has committed \$300 million in state general funds to the project, federal FEMA funding for construction costs (\$474.7 million) and also for equipment (\$50.0 million), and borrowing (bond issue) that would fund the remaining project costs and to finance initial working capital needs for the UMC entity.

Clinical, education, and research activities now being provided at the Interim LSU Hospital in New Orleans (formerly known as the Medical Center of Louisiana New Orleans, or “MCLNO”) – including other MCLNO activities that were displaced by hurricanes Katrina and Rita, would be transferred to the new University Medical Center.

Financial Projections

VHC developed financial projections to demonstrate the range of ongoing, state general funds¹ that would be needed to operate UMC successfully (and to provide debt service coverage necessary to qualify for bond financing). The financial projections build on recent financial performance information for the Interim LSU Hospital and incorporate numerous assumptions regarding the populations that UMC would serve, changes to the level of insurance coverage associated with possible federal health reforms, projected UMC market shares, lengths of stay, Medicaid and Medicare reimbursement rates and formulae, staffing levels, project costs, and working capital needs.

Two principal scenarios were prepared:

- **Scenario 1 (Reform)** assumes that federal health reforms are implemented pursuant to recently signed legislation. Under those reforms, portions of uninsured residents of the areas to be served by UMC would be enrolled in Medicaid and private coverage. The overall demand for health services is increased as health care utilization for formerly uninsured consumers becomes aligned with "use rates" characteristic of Medicaid and commercially insured populations.

The allotment of federal Medicaid Disproportionate Share Hospital (DSH) funds to Louisiana would be reduced according to a schedule published in the legislation. UMC's Medicare DSH funds would be reduced by 75 percent compared to amounts that would be available without the federal reforms. Base payment rates both for Medicare and for Medicaid are assumed to inflate less rapidly under the reform scenario as well.

Federal health reforms are assumed to begin having a meaningful impact on coverage on January 1, 2014.

- **Scenario 2 (No Reform)** assumes that no federal health reforms are implemented. Known changes to Medicaid and Medicare payment policy are reflected in the results (e.g., the impact of the Medicaid "DSH audit rule" which reduces the amount of Medicaid DSH funds available to LSU-State and other Louisiana hospitals).

Table 1 indicates the amount of state general funds needed by UMC under the two scenarios. In the analysis, UMC is assumed to begin operating in new ambulatory care facilities in February of 2013 and in the new hospital buildings in June, 2014.

¹ The projections measure both "unmatched" state funds that are directly appropriated to the medical center and also the amount of state funds needed to match federal Medicaid Disproportionate Share Hospital revenue at UMC.

**Table 1: Projected State General Fund Required by ILH/UMC, Fiscal Years
Ending June 30, 2008-2016 (\$millions)**

\$ in Millions	Actual		Budgeted	Projected					
	2008	2009	2010	2011	2012	2013	2014	2015	2016
Unmatched State General Fund Support									
Scenario 1 (Reform)	\$ 48.7	\$ 50.6	\$ 26.1	\$ 63.4	\$ 65.5	\$ 68.1	\$ 78.3	\$ 74.1	\$ 70.5
Scenario 2 (No Reform)	\$ 48.7	\$ 50.6	\$ 26.1	\$ 63.4	\$ 65.2	\$ 67.7	\$ 78.9	\$ 75.2	\$ 85.7
State General Fund as % of Expense									
Scenario 1 (Reform)	14.6%	12.1%	6.6%	15.9%	16.1%	16.5%	14.5%	12.0%	9.9%
Scenario 2 (No Reform)	14.6%	12.1%	6.6%	15.9%	16.1%	16.4%	14.4%	12.0%	12.1%
State General Fund as % of Revenue									
Scenario 1 (Reform)	14.3%	12.1%	7.1%	16.8%	17.0%	17.2%	15.7%	12.9%	10.5%
Scenario 2 (No Reform)	14.3%	12.1%	7.1%	16.8%	16.9%	17.1%	15.5%	12.8%	12.8%
SGF Including State Medicaid DSH Match									
Scenario 1 (Reform)	\$ 88.6	\$ 96.2	\$ 72.2	\$ 110.1	\$ 112.7	\$ 113.9	\$ 124.1	\$ 115.0	\$ 116.5
Scenario 2 (No Reform)	\$ 88.6	\$ 96.2	\$ 72.2	\$ 110.1	\$ 112.5	\$ 113.4	\$ 133.9	\$ 134.6	\$ 145.1

Source: Actual ILH Financial Performance and projections prepared by VHC.

For reference, **Table 2** indicates the amount of state general funds historically spent at MCLNO/ILH between 2000 and 2009,

**Table 2: Historical State General Fund Required MCLNO/ILH, Fiscal Years
Ending June 30, 2000-2009 (\$millions)**

Year	Unmatched State General Funds	State Medicaid DSH Funds	Total
2000	\$ 1.1	\$ 77.9	\$ 78.9
2001	0.5	75.2	75.7
2002	1.0	74.4	75.3
2003	14.5	71.5	86.0
2004	21.6	60.2	81.8
2005	13.9	58.2	72.1
2006	37.5	33.3	70.8
2007	36.4	34.0	70.4
2008	48.7	39.8	88.6
2009	50.6	45.6	96.2

Source: LSU records.

Based on the assumptions described in this report, the results presented in Table 1 indicate that:

- During fiscal years 2011 through 2013, the Interim LSU Hospital in New Orleans is likely to require \$63 to \$68 million in unmatched state general fund resources annually during its 2011 through 2013 fiscal years – an increase from \$26 million budgeted for 2010 – and an amount averaging about 16 percent of operating expense. The increase from 2010 to 2011 primarily is due to the negative impact

of the "DSH Audit Rule" on Medicaid Disproportionate Share Hospital funds. Under this audit rule, beginning in 2011 Medicaid DSH funds no longer will be available for "under-insured" patients (those who have coverage but the benefits or payments do not cover the full cost of their care).

During that time period, the Interim LSU Hospital is projected to require \$110 to \$113 million in state funds, including amounts needed to match federal Medicaid DSH funds spent at the hospital.

- Assuming that federal health reforms are implemented (**Scenario 1**), during the 2014-2016 time frame UMC will require approximately \$70-80 million in unmatched annual state general fund appropriation – an amount representing **11 to 16** percent of operating revenue. UMC would require \$115-\$124 million in state funds including state Medicaid DSH matching funds.
- Importantly - under reform, federal Medicaid DSH allotments would be reduced pursuant to the following schedule:

Table 3: Federal Medicaid DSH Allotments Under Health Reform
(\$ millions)

Year	DSH Reduction	Federal U.S.-Wide DSH Allotment	Reduction %
2010	\$ -	\$ 11,400.0	0.0%
2014	\$ 500.0	\$ 11,400.0	-4.4%
2015	600.0	11,400.0	-5.3%
2016	600.0	11,400.0	-5.3%
2017	1,800.0	11,400.0	-15.8%
2018	5,000.0	11,400.0	-43.9%
2019	5,600.0	11,400.0	-49.1%
2020	4,000.0	11,400.0	-35.1%

- Medicaid DSH allotments U.S.-wide are scheduled to be reduced by \$0.5 billion in 2014 – and increasing to \$5.6 billion in 2019. Note that the largest reductions are not scheduled to occur until 2018. The projections for UMC in Table 1 extend only through 2016.
- The impact of the federal reductions on any given state is highly uncertain. The Secretary of Health and Human Services is to develop a methodology to distribute the federal DSH reductions to the states. Most likely, “high DSH” states like Louisiana would receive the largest reductions to their allotments of federal Medicaid DSH funds.

However, the actual impact of the reduced federal Medicaid DSH allotments after 2018 on revenue available to UMC will depend on numerous factors, including the need for Medicaid DSH spending in those years versus the total state-wide DSH cap. **Table 4** projects Louisiana’s Medicaid “DSH cap” assuming that

reductions occur under health reform and also projects total state-wide spending after the impact of the DSH audit rule and no increases in spending needs once reforms begin to yield coverage expansions.

Table 4: Louisiana and UMC Medicaid DSH Under Health Reform
(\$ millions)

Year	Federal Allotment		Louisiana DSH Cap			Estimated State-Wide Spending	Room Under DSH Cap	Medicaid DSH at UMC
	Reduction Amount	Reduction %	Federal Allotment	State Match	Total			
2010	\$ -	0%	\$ 750.3	\$ 359.4	\$ 1,109.7	\$ 929.0	\$ 180.7	\$ 163.2
2014	\$ (45.0)	-6.0%	\$ 705.2	\$ 329.3	\$ 1,034.5	\$ 777.8	\$ 256.8	\$ 144.0
2015	(52.5)	-7.0%	697.7	319.7	1,017.4	777.8	239.6	130.1
2016	(52.5)	-7.0%	697.7	319.5	1,017.3	777.8	239.5	146.7
2017	(127.5)	-17.0%	622.7	285.2	907.9	777.8	130.1	146.7
2018	(337.6)	-45.0%	412.6	189.0	601.6	601.6	-	113.5
2019	(375.1)	-50.0%	375.1	171.8	546.9	546.9	-	103.2
2020	(300.1)	-40.0%	450.2	206.1	656.3	656.3	-	123.8

In 2010, the Interim LSU Hospital is to receive approximately 18 percent of state-wide Medicaid DSH resources. The state is projected to spend \$929 million in Medicaid DSH funds – an amount \$180.7 million below the total “DSH cap” of \$1.1 billion.

The amount of “room under the DSH cap” is projected to increase in 2011 due to the state-wide impact of the DSH audit rule. State-wide spending in 2014 is projected to be about \$778 million and to remain level as coverage expands. In 2014, the Louisiana DSH cap is assumed to fall by 6 percent to \$1.0 billion – leaving \$256.8 million of “room under the DSH cap” at that time. Accordingly, there would be no need to reduce Medicaid DSH revenue for UMC or other facilities.

In this projection, 2018 would be the first year when we project that state-wide Medicaid DSH spending would be affected because in that year the DSH cap would fall to around \$602 million while projected spending needs would be \$778 million. If in that year, UMC continues to receive 18 percent of the state-wide DSH resources, its Medicaid DSH revenue would fall to \$113.5 million. **Accordingly, the need for unmatched, state general funds for UMC would increase by \$33-\$34 million.**

On or before 2018, Louisiana may consider various policy options such as concentrating the Medicaid DSH resources in fewer facilities (which may be logical due to the impact of coverage expansions on other non-state hospitals). If the state decides to increase UMC’s share of state-wide DSH funding in 2008 to 25 percent or more, there would be minimal or no impact on Medicaid DSH revenue for the medical center.

If no such policy options are implemented, the amount of unmatched state general funds for UMC beginning in 2018 could exceed \$100 million annually.

- Assuming that federal health reforms do not pass (**Scenario 2**), the amount of state general fund needed by UMC in the 2014 to 2016 time frame would average \$79 to \$86 million, or **13 to 16 percent** of operating revenue. While UMC would be operating in a new building (with new debt service, depreciation expense, and other carrying costs), we assume that the new governing board would be able to implement several operational improvements that would substantially offset these costs.

Data from the National Association of Public Hospitals indicate that in 2007, about **17 percent** of the operating revenue for the nation's largest public hospitals was comprised of state and/or local general fund support. Several well known public hospitals that operate as major teaching facilities received general fund support at levels above this overall average, including the Grady Health System (24 percent), Jackson Memorial in Miami (25 percent), Cook County in Chicago (44 percent), and Parkland in Dallas (44 percent).

Caveats. These results are based on numerous assumptions. The assumptions (and underlying data) have been reviewed with staff at DHH and LSU for reasonableness. However, future projections involve uncertainty. The assumptions and the financial projections are likely to vary from the values presented in this report, and the variations may be material.

The assumptions underlying the projections are described in more detail below.

Assumptions

The financial projections were assembled by analyzing and projecting the following variables.

Demographics for the three parishes that constitute the primary service area for MCLNO/ILH/UMC: Jefferson, Orleans, and St. Bernard. The original business plan for a replacement MCLNO facility indicated that by 2016, approximately 798,406 persons would be living in the three parishes. In June 2008, VHC worked with Phase 2 Consulting (the authors of that original plan), DHH, and other stakeholders to reassess the plan. That review indicated that the original business plan had underestimated the population of Orleans Parish. Accordingly, the Phase 2 Business Plan was amended to add 30,000 persons to the projected population of Orleans Parish for 2016.

After reviewing recently published demographic data, we believe the 2016 population estimate for Orleans Parish should be increased again to at least 352,191 persons. The total population of the three-parish region is estimated to be 850,400 by 2016 - an increase of over 50,000 persons compared to the values in the original business plan and an increase of 22,000 persons compared to the plan that was amended in mid-2008 (**Table 5**).

Table 5: Updated Demographic Data Used in Business Plan Analysis

Parish	Projected Population in 2016		
	Original Phase 2 (2007)	Mid-2008 Update	VHC Analysis
Jefferson	449,740	449,740	453,006
Orleans	303,740	333,740	352,191
St. Bernard	44,926	44,926	45,407
Total	798,406	828,406	850,604

Sources: Updated June/July 2008 Business Plan and VHC estimates. Revised 2010 and 2016 population applies growth rates published by the State of Louisiana to updated 2008 census figures.

The upward revisions to population figures suggest greater need for the beds and other services planned for UMC.

Estimates regarding the number of uninsured residents of these areas that would obtain Medicaid or commercial coverage under proposed federal health reforms. The June 2008 Business Plan update found that the number (and percent of people) uninsured in Region 1 (New Orleans) had fallen between 2005 and 2007. More recently published data suggest a slight increase in the uninsured through the end of 2008. This slight increase most likely is associated with weakness in the economy, among other factors (**Table 6**).

Table 6: Estimated Number (and Percent) Uninsured, Region 1

Uninsured, Region 1	2003	2005	2007	2008 Q4 Forecast
Uninsured Percentage				
Children	9.60%	7.40%	9.00%	8.70%
Non-Elderly Adults	20.90%	23.20%	21.20%	22.10%
Number of Uninsured				
Children	25,169	19,376	15,845	14,434
Non-Elderly Adults	128,240	142,414	89,962	98,252
Total	153,409	161,790	105,807	112,686

Source: “Louisiana’s Uninsured Population: Regional and Parish-level Estimates, Fourth Quarter 2008 Update”, The Public Policy Research Lab, Sponsored by The Louisiana Department of Health and Hospitals.

Overall, approximately 16.4 percent of the area's total population was uninsured in 2005 (total uninsured persons divided by all children, non-elderly adults, and elderly adults combined); 15.9 percent in 2008. The financial projections estimate the number of

uninsured between 2008 and 2016 with and without the implementation of federal health reforms.

- In **Scenario 2 (No Reform)** the 15.9 percent metric is projected to decline slightly to 15.7 percent by 2016. This occurs due to aging of the population, whereby more Region 1 residents would qualify for Medicare benefits.
- In **Scenario 1 (Reform)**, we relied on an analysis prepared by Mercer for DHH. Under proposed federal health reforms, uninsured persons (not already eligible for Medicaid) and in households with incomes up to 133 percent of the federal poverty guidelines would be eligible for Medicaid. By 2016, we assume that 90 percent of those newly eligible for Medicaid benefits would enroll. Due to various mandates, we also assume that 50 percent of uninsured people who would not be newly eligible for Medicaid (because their incomes are too high or for other reasons) would obtain coverage through their employers or as individuals.

Under these assumptions, the percent of the population uninsured is projected to fall from 15.9 percent in 2009 to approximately 6 percent in the 2014-2016 time period.

Use rates (discharges per 1,000 persons), by payer source (Medicare, Commercial, Medicaid, Uninsured). The analysis assumes that inpatient discharge rates (number of discharges occurring for residents of the service area per 1,000 persons) have declined between 2005 and 2008, but that these rates remain constant at 127.1 per 1,000 (Medicare and commercial), 184.3 (Medicaid), and 75.6 (Uninsured) during the 2008 through 2016 time frame. In **Scenario 1 (Reform)**, as uninsured residents obtain coverage through Medicaid or commercial sources, their use of inpatient services increases to levels characteristic of the other Medicaid and commercially-insured populations. These assumptions yield the following total number of discharges for residents of the three parish service area.

- In 2005, the area's residents experienced 131,180 discharges (from all hospitals in Louisiana).
- In 2008, we estimate the total number of discharges for area residents to be approximately 100,800.
- For **Scenario 1 (Reform)** the total number of discharges is projected to be 116,383.
- For **Scenario 2 (No Reform)** the total is projected to be 109,201.
- The difference between Scenarios 1 and 2 (7,182 or 6.6 percent) results from the assumed effects of coverage on how Region 1 residents are likely to use health care services.

The medical center's market share of inpatient discharges (by payer source). In 2005, MCLNO maintained an overall market share of 13.1 percent: 2.6 percent for

Medicare and commercial discharges, 21.5 percent for Medicaid, and 63.3 percent for uninsured consumers. In 2009, we estimate that the Interim LSU Hospital's market shares were 2.8 percent (Medicare and commercial), 17.3 percent (Medicaid), and 55.0 percent (Uninsured). These estimates are based on actual volumes at the medical center.

We assume that these market share values remain constant until the new facility is open (mid-2013, or at the beginning of the fiscal year ending July 1, 2014). Once the new facility is operational, market shares would increase - to 5.2 percent (Medicare and commercial), 29 percent (Medicaid), and 63 percent (Uninsured). These market share increases are based on detailed analysis conducted by LSU that assumes that various faculty practices now operating across Louisiana would be located at the new UMC once operational. The shares also reflect growth in the medical center's Level I Trauma service, relied upon by all types of insured and uninsured patients. On an overall basis, UMC would have a market share of 16.1 percent in **Scenario 2 (No Reform)** and a market share of 13.8 percent in **Scenario 1 (Reform)**. The difference is due to substantially fewer patients being uninsured in **Scenario 1**.

The assumed increases in market shares for the medical center, particularly those for commercially insured (and Medicare) patients have raised concerns by several observers. They suggest that:

- Private patients will be unwilling to choose the University Medical Center for cultural and operational reasons, and due to the hospital's downtown location.
- LSU specialists that currently practice in other hospitals will have referral relationships disrupted when/if they move their practices to the UMC.
- The organization needs to undertake massive cultural change that may prove elusive.
- Competing hospitals will work hard to maintain their market shares of Medicare and commercial patient business, creating headwinds for UMC.
- It is unwise or unfair for the State to build up programs that compete with community hospitals that already offer services and that have been suffering financial distress.

Those who believe market share gains for the medical center are feasible suggest that:

- LSU has conducted a careful analysis, faculty member by faculty member, program by program, DRG by DRG, and has identified specific programs that can be relocated to UMC without posing significant competitive challenges to area community hospitals. These include programs that draw patients from across the State and the region and nation. The specific programs have been identified.
- The amount of private patient volume planned for the medical center represents only a modest increase in admissions (increasing from a 2-3 percent share to a 5-6

percent share – roughly 2,000 admissions on an annual basis). That leaves 94-95 percent of a growing Medicare/Commercial market available to other hospitals.

- LSU faculty now operate at numerous hospital and office sites. When they are practicing together at the UMC, opportunities for natural, faculty to faculty “internal referrals” will return and emerge.

VHC considered these points and concluded that the market share increases are modest and achievable if UMC and the Corporate Board are provided the flexibility and authorities to develop and implement effective strategic plans.

The number of patients who would travel from outside of the three-parish primary service area to the medical center ("inmigration"). In 2005, approximately 3,860 of MCLNO's discharges (18 percent) were from people living outside the three-parish primary service area. By 2008, we estimate that the "inmigration percentage" had fallen to 10 percent. The original business plan (and mid-2008 update) assumed that over 20 percent of the new UMC's discharges would originate from people living outside the three-parish area; however in this analysis we have lowered this assumption to 15 percent - or a total of about 2,800 inpatients (**Scenario 1 Reform**) or 3,100 inpatients (**Scenario 2 No Reform**). This adjustment considers the impact of the evolving collaboration in Baton Rouge between Earl K. Long Medical Center and Our Lady of the Lake. The analysis regarding that collaboration is assuming market share gains for the same populations that historically have relied on MCLNO in New Orleans.

Average lengths of stay for medical center inpatients. The analysis assumes that average lengths of stay for the medical center's patients will decline by approximately 0.5 days for adult and pediatrics services (between 2009 and 2013) and by 1.8 days for psychiatric services (also between 2009 and 2013). Lengths of stay have been decreasing in recent years, and conversations with medical center leadership indicate that operational improvements will continue to result in declines for the next few years. For **Scenario 1 Reform**, and after accounting for changes in UMC payer mix, the overall length of stay for the medical center (all patients and services combined) is projected to increase. This occurs because lengths of stay for insured patients historically have been longer than stays for uninsured patients.

Facility occupancy. UMC now is planned to have 424 licensed beds (364 for adult and pediatric services, 60 for acute psychiatry)². In 2009, the Interim LSU Hospital reported an average daily census of 206.9 inpatients. On the basis of the above assumptions, we project that by 2016,

- UMC would achieve an average daily census of 323.6 inpatients and an occupancy rate of 76.3 percent (for **Scenario 1 Reform**).
- In 2016, average daily census would be 321.3 and occupancy would be 75.8 percent for **Scenario 2 No Reform**.

² The original business plan called for 484 beds. VHC worked with Phase 2 and other stakeholders to revise the plan in mid-2008, and the number of beds planned for the facility was reduced to 424.

The overall volume of outpatient care at the medical center. In 2008, 28 percent of the Interim LSU Hospital's gross patient charges was generated by outpatients. In 2009, this percentage increased to 34 percent. We assume continued increases through 2013 - to 37 percent.

Medicaid payment. The medical center receives two types of Medicaid payment: fee-for-service reimbursement for inpatient and outpatient care provided to Medicaid patients and Medicaid Disproportionate Share Hospital (DSH) funding. The amount of payment received is assumed to vary substantially under the two scenarios.

Under both scenarios, the Medicaid DSH Audit Rule is assumed to reduce DSH payments to the medical center by 19 percent. This reduction is based on an assessment prepared by LSU.

- **Scenario 1 (Reform).** As previously discussed, we have assumed that the reductions in federal Medicaid DSH allotments scheduled in federal health reform legislation will not affect projected Medicaid DSH resources for UMC until 2018.

In the reform scenario, we also assume that Medicaid fee-for-service rates would increase by 2.0 percent annually (from 2011 through 2016) - 1.0 percent lower than the rates assumed in **Scenario 2 (No Reform)**. This reflects a commitment by the American Hospital Association to encourage cost containment as a component of federal reforms.

- **Scenario 2 (No Reform).** We assume that Medicaid fee-for-service rates would increase by 3.0 percent annually during the 2012 through 2016 time frame. Reflecting DHH budget constraints, no increase is assumed for 2012. Medicaid DSH funds are projected to continue at levels that would be generated by the medical center's Medicaid DSH cost report - with reductions assumed due to the DSH Audit Rule.

Medicare payment. Medicare revenue for the medical center is projected based on current and known changes to payment policy. For inpatient services, base payment rates for **Scenario 1 Reform** are increased by 2.0 percent annually; 3.0 percent annually under **Scenario 2 No Reform**. The analysis assumes that the number of full-time equivalent interns and residents at the medical center remains at approximately 300 during the 2010 through 2014 time frame; the number then increases to 500 for fiscal year 2016 - as trainees are repatriated to UMC from hospitals where programs were relocated after the hurricanes. Historically, 550 interns and residents were training at MCLNO before the storms. Direct and indirect medical education payments are projected for the medical center based on current and anticipated formulae.

Payment rates from commercial payers. In 2009-2010, we estimate that the Interim LSU Hospital has been receiving payments from commercial payers that are below cost (approximately 70 percent of cost). Through the oversight of the new Corporate Board, greater effort placed into negotiating with commercial payers, and due to operational improvements at the medical center, we assume that the commercial "payment to cost" ratio will increase from the 0.7 level to 1.0 by 2014 and to 1.10 by 2016 (indicating a 10

percent margin would be earned by the medical center from this payer source - a level lower than typical hospital experience).

Project cost and financing assumptions. The project construction budget for UMC is \$1.2 Billion. Project costs would be funded from three sources: the state of Louisiana, which has committed \$300 million in state general funds to the project, federal FEMA funding for construction costs (\$474.7 million) and also for equipment (\$50.0 million), and borrowing (bond issue) that would fund the remaining project costs and to finance initial working capital needs for the UMC entity.

In this analysis, we assumed that the bond issue would finance \$375.3 million in project construction cost (\$1.2 Billion minus equity provided by the state and FEMA). We also have assumed that UMC also borrows \$150 million for its initial working capital needs. This assumption is based on the following concerns:

- The year-end 2009 balance sheet for the Interim LSU Hospital indicates that the medical center has a working capital deficit (current liabilities greater than current assets) of approximately \$51.5 million. That deficit does not result from the costs associated with the proposed project, but will need to be addressed at some point during the next several years under any future scenarios. If (or when) UMC assumes responsibility for the Interim LSU Hospital balance sheet, it should not inherit this working capital deficiency.
- The business plan calls for substantial growth once UMC begins operating in new facilities. This also indicates the need for working capital funds, because it typically takes 30 to 60 days to collect "accounts receivable" from third party payers. In the meantime, UMC will need to meet its payroll and other obligations. UMC also will need to establish an inventory of supplies, pharmaceuticals, and similar items.

Accordingly, we have assumed that the organization will need to borrow an additional \$150 million to meet these needs. This need had not been identified in earlier business planning efforts.

Debt service on the bond issue would be approximately \$36 million annually (assuming a 30 year amortization and interest costs based on a 5.5 percent rate). The new UMC facility also would generate \$44.7 million in depreciation expense.

Staffing levels, average wage, and benefit levels at the medical center. LSU retained Alvarez & Marsal (A&M) to analyze the cost and revenue performance of the Interim LSU Hospital. Results of that work were published in March 2009. The A&M study found:

- The Interim LSU Hospital operates the only Level I Trauma Center in the region.
- The hospital's costs have been 20-25 percent higher than benchmark facilities (based on data published by the Association of American Medical College, or "AAMC" - see **Table 7**).

**Table 7: Benchmark Analysis: Interim LSU Hospital
and other Academic Medical Centers**

Benchmark Variables	Integrated AMC	Other Teaching Hospitals	LSU Interim Hospital	Integrated AMC %
Admissions	26,543	13,035	13,194	
ALOS	6.00	4.80	5.80	
Total FTEs	4,179.00	1,394.00	2,482.50	
FTE per Adjusted Occupied Bed	6.00	4.80	8.20	-27%
Cost per Patient Day	\$ 3,766	\$ 2,794	\$ 5,031	-25%
Cost per Adjusted Patient Day	\$ 2,497	\$ 1,685	\$ 3,354	-26%
Cost per Adjusted Admission	\$ 14,995	\$ 8,256	\$ 19,581	-23%

Source: Alvarez & Marsal, March 2009

In **Table 7**, "ALOS" is average length of stay. "FTE" denotes "full-time equivalent" employees. "FTE per Adjusted Occupied Bed" is an overall productivity measure. At 6.00, the typical Integrated Academic Medical Center was staffed at levels 27 percent below the 8.20 level at the Interim LSU Hospital.

LSU responded to the A&M recommendations and has reduced staffing levels at the Interim LSU Hospital (as well as implementing other changes). With salary and benefit costs representing a large proportion of total operating expense for the hospital, future staffing levels are a major variable in projected financial performance (and state general fund requirements). For this analysis, we have assumed that the medical center's staffing levels would decline from the 8.20 level (2008) to 7.0 in 2010 and 6.0 in 2013.

In recent years, employee benefits expenses at the Interim LSU Hospital have averaged 39 to 40 percent of salary expense, a comparatively high level. In this analysis, we assume that as a new, non-profit entity, UMC and the new Corporation Board would modify employee benefit programs and reduce their costs to 33 percent of salary expense by 2015.

Inflation factors for salaries and wages, operating services, supplies, and professional services (payments to medical school faculty and other clinicians to provide services at the medical center, including supervision of health professionals in training). The analysis assumes inflation factors averaging 4.0 percent annually. For example, the average salary per FTE would increase by 4.0 percent each year between 2010 and 2016.

We understand that in addition to reducing the number of FTE staff (per adjusted occupied bed), LSU also is examining the staffing mix at the Interim LSU Hospital and that strategies for staffing the new UMC include adding staff with a mix of skills that would help improve the cost effectiveness of hospital operations. The 4.0 percent annual

salary inflation factor thus appears reasonable if the organization also is implementing staffing mix changes during the next several years.

The analysis also assumes that there will be limited or no growth in total professional services costs during the 2014 through 2016 time period. Resources needed to assure faculty supervision and clinic service would moderate due to the changing payer mix of the medical center (increased numbers of commercial and Medicare patients). The changing mix of patients by payer category at UMC also would be reflected in a changing payer mix for the faculty physician practices affiliated with the medical center. The Corporate Board also would exercise its fiduciary responsibilities and would assure that the professional services costs borne by UMC would be carefully negotiated.

Ongoing, routine capital expenditures. The projections also assume that the Interim LSU Hospital (and UMC once operational) will spend approximately \$10 million on routine capital items including equipment replacement and renovations. The hospital, in total, is anticipated to report over \$50 million in annual depreciation expense. The difference (\$50 million in depreciation - a non-cash item, and the \$10 million in capital expenditures) would not be funded with state general funds. In other words, UMC would not be "funding depreciation" during its initial years of operation using state or other resources.

Review of the Medical Center's Facilities Plans

VHC asked Marlene Berkoff, an experienced health care facilities planner and analyst to review the facilities plans for the new University Medical Center. Her findings and recommendations are summarized below.

The size of the UMC project is within contemporary norms:

- Both the hospital and the ambulatory care buildings, and their component rooms and departments, are programmed and planned at sizes within norms as defined by codes, guidelines and other recent hospital and ambulatory care developments for comparable health care facilities.
- The only way to significantly reduce the size of the buildings would be to eliminate some whole departments or functional program elements.
- **Recommendation:** Identify program elements that might potentially be eliminated or postponed if need arises, and analyze impact on development and business plan.

The timing and schedule for the projects are a concern; there are several potentials for delay:

- Several factors might impact the current schedule for development of the UMC project. The most significant are:
 - Land acquisition

- Relocation of utilities and underground infrastructure elements
- Archeological findings
- While these factors are recognized and major resources are being dedicated to resolving issues related to them, there are too many to ignore the risk they pose to the schedule, and ultimately to costs and operations.
- **Recommendation:** Analyze the potential impacts of delays of 6 months and 1 year, and develop options for addressing this eventuality should it occur.

The current cost estimates may be affected by potential delays and external factors:

- Although detailed investigations were not performed, the magnitude of the construction costs appears in line compared to health care projects of similar scope for comparable facilities.
- While most associated project costs have been included in current estimates, it is not clear if all have been; i.e., costs of street closures, traffic re-routing during construction, other “external” factors.
- Construction and design contingencies appear adequate, but additional contingencies for costs of potential delays do not appear to be fully addressed.
- **Recommendation:** Review all elements of Project Cost to ensure completeness; construct a “worst case” or “bad case” scenario and analyze its impact on the overall project budget and business plan; and define actions that might be taken if absolutely necessary.

VA sharing of services requires final resolution: impacts facility costs, medical services, operations and schedule:

- Discussions of shared services with the VA have taken place but it appears final decisions have not been reached, especially about the Central Plant.
- Current plans do not provide a physical link, or a budget for one, between the VA and UMC hospitals. This may present an obstacle to sharing medical services that might hold promise for reducing redundancies and costs. Two design teams currently are working to clarify linkage between the two facilities.
- Resolution of these issues could impact the design team’s work on construction documents, and may have cost and operational impacts as well.
- **Recommendations:** Review joint VA / UMC planning issues and resolve them as soon as possible, including space, cost and operational impacts.

- Make final decisions about the Central Plant and a bridge link, and factor these into the budget and business plan.

Re-Use of old Charity Hospital not cost-effective or operationally efficient:

- Review of studies on re-use of the old Charity Hospital reveal a number of serious drawbacks that could affect schedule, project cost, adaptation to contemporary medical technologies and long-term operational efficiencies. Primary factors are:
 - Still many unknowns in existing building construction and condition
 - Limitations imposed by structural building configuration, both height and plan configuration of building wings and form
 - Limited parking and campus site space
- **Recommendation:** Abandon the concept of re-use of Charity for LSU Hospital replacement, and concentrate on most effective actions for sale or re-use of the structure.

Project Risks

Through the proposed University Medical Center project, Louisiana appears committed to developing a world-class health sciences center in New Orleans. From a financial feasibility standpoint, the following appear to be the most significant risks associated with the project.

1. Independence and Fiduciary Responsibilities of the Corporation Board

In our opinion, the agreement to operate UMC as a Public Benefit Corporation under a fiduciary operating board is a positive development for the feasibility of the Business Plan. It clarifies the governance model and the preliminary financing structure for the University Medical Center, and can afford UMC with the cultural change and operational flexibility needed to achieve the vision of a world-class health sciences center. The proposed governance and corporate structure also allows UMC to manage resources without many of the constraints associated with public ownership.

However, there are several agreements that still need to be developed: the Cooperative Endeavor Agreement, agreements allowing UMC to use land that would be owned by LSU, Academic Affiliation Agreements, perhaps a contract between the State and UMC for uninsured care, and others that are likely to influence the extent to which UMC can benefit from the flexibility afforded by the Public Benefit Corporation structure. We believe the ability to achieve the projected financial results could be impeded if UMC loses operational flexibility or independence as these additional agreements are crafted.

A board that operates with independence, with the primary interests of UMC in mind, and with fiduciary responsibilities would be more likely to assure the organization's financial success.

2. Continued Operational Improvements at the Interim LSU Hospital

The A&M analysis indicates that operating costs at the Interim LSU Hospital have been 20 to 25 percent higher than benchmark facilities. Continued effort to implement the A&M recommendations is warranted - e.g., to achieve "FTEs per adjusted occupied bed" of 6.0 or less.

3. Forming the Corporate Board

We believe there is merit in forming the Corporate Board as early as practicable. If there are delays in forming the Corporate Board until late in the construction and strategic planning process, this new governing body will be in the position of inheriting numerous decisions that already have been made, making it more difficult for the board to assume its fiduciary responsibilities (and to provide a relevant track record to lenders / Wall Street). Candidates for senior leadership (including the UMC Chief Executive Officer) are likely to want to see a well functioning, supportive, authoritative governing body in place before accepting positions.

4. Completing the Construction Project On-Time and On-Budget

If project completion is delayed, costs are likely to increase; contingency planning is warranted.

5. Competitive Reactions from Other Hospitals and Health Systems

Business planning for UMC has been conducted in public. Other organizations are well aware of the plans to increase the organization's share of commercial and Medicare patients, among other strategic initiatives. Another reason to form the Corporate Board is to engage that group in supporting tactics that protect UMC's interests during the next several years. Forming the Corporate Board also can improve the ability to conduct strategic planning in private.

6. Ongoing Capital Development

As a Public Benefit Corporation that also receives state general funds, UMC will need to be able to generate positive earnings and/or have other sources of capital to meet ongoing needs - including obtaining new technologies as they emerge. Historically (due in large part to the mechanics of the Medicaid DSH program), LSU-State hospitals have not been afforded ready access to capital.

7. Federal Medicaid DSH Allotment Reductions

As previously mentioned, under health reform the Secretary of Health and Human Services is to develop a methodology to distribute reductions to federal Medicaid DSH allotments to the states. Most likely, "high DSH" states like Louisiana would receive the largest reductions to their allotments of federal Medicaid DSH funds. Reductions to Louisiana's federal Medicaid DSH allotment greater than the amounts would affect the amount of Medicaid revenue available for UMC.

1	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
Key Variables Under Health Reform											
Uninsured Moving to Medicaid											
0-133 Percent of Poverty											
134-150 Percent of Poverty											
Remaining Uninsured to Private Coverage											
Average Payment Rate Increases											
Medicaid											
Medicare											
Adjustments to DSH											
National Federal Allotment Reductions (\$mm)											
Total National Federal Allotment											
Reduction to LA Federal DSH Allotment											
Medicare DSH Payments											
Inflation in State-Wide DSH Spending											
Actual Impacts on UMC DSH											
Medicaid DSH											
Medicare DSH											
Key Variables Assuming No Reform											
Uninsured Moving to Medicaid											
0-133 Percent of Poverty											
134-150 Percent of Poverty											
Remaining Uninsured to Private Coverage											
Average Payment Rate Increases											
Medicaid											
Medicare											
Adjustments to DSH											
National Federal Allotment Reductions (\$mm)											
Total National Federal Allotment											
Federal Medicaid DSH Cap											
Medicare DSH Payments											
Inflation in State-Wide DSH Spending											
Actual Impacts on UMC DSH											
Medicaid DSH											
Medicare DSH											
Scenario =====											
1 1 = Reform, 2 = No Reform											
Variables Used in Scenario											
Uninsured Moving to Medicaid											
0-133 Percent of Poverty											
134-150 Percent of Poverty											
Remaining Uninsured to Private Coverage											
Average Payment Rate Increases											

1	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
	Medicaid			31.3%	0.4%	0.0%	0.0%	0.0%	2.0%	2.0%	2.0%
	Medicare			3.3%	0.5%	1.0%	2.0%	2.0%	2.0%	2.0%	2.0%
	Inflation in State-Wide DSH Spending					0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Adjustments to DSH										
	National Federal Allotment Reductions (\$mm)								\$ 500	\$ 600	\$ 600
	Total National Federal Allotment								\$ 11,400	\$ 11,400	\$ 11,400
	Federal Medicaid DSH Cap			0.0%	0.0%	0.0%	0.0%	0.0%	-6.0%	-7.0%	-7.0%
	Medicare DSH Payments			0.0%	0.0%	0.0%	0.0%	0.0%	-37.5%	-75.0%	-75.0%
	Inflation in State-Wide DSH Spending					2.0%	2.0%	2.0%	0.0%	0.0%	0.0%
	Actual Impacts on UMC DSH										
	Medicaid DSH			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Medicare DSH			0.0%	0.0%	0.0%	0.0%	0.0%	-37.5%	-75.0%	-75.0%
Service Area Population (Jefferson, Orleans, St. Bernard)											
	Total People	970,784	785,756	804,114	823,436	827,866	832,322	836,803	841,310	845,842	850,400
	Uninsured Moving to Medicaid										
	0-133 Percent of Poverty								0%	40%	80%
	134-150 Percent of Poverty								0%	0%	0%
	Remaining Uninsured to Private Coverage								0%	20%	50%
	Distribution by Payer										
	Private Coverage	52.2%	52.7%	52.6%	52.6%	52.5%	52.4%	52.4%	55.0%	57.7%	57.4%
	Medicaid/LaCHIP	17.0%	16.3%	16.3%	16.3%	16.3%	16.3%	16.4%	18.7%	21.1%	21.7%
	Medicare	14.4%	15.2%	15.2%	15.3%	15.4%	15.4%	15.5%	15.6%	15.7%	15.7%
	Uninsured	16.4%	15.9%	15.9%	15.8%	15.8%	15.8%	15.8%	10.7%	5.5%	5.2%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Number of Uninsured	159,672	124,716	127,519	130,467	130,938	131,411	131,886	89,889	46,361	44,029
Service Area Discharges											
	Medicare/Commercial	86,416	67,744	69,332	71,003	71,401	71,801	72,203	75,463	78,907	79,019
	Medicaid	32,050	23,599	24,164	24,757	24,911	25,065	25,221	29,063	32,927	34,033
	Uninsured	12,714	9,434	9,646	9,869	9,905	9,941	9,976	6,800	3,507	3,331
		131,180	100,777	103,141	105,630	106,216	106,806	107,400	111,326	115,341	116,383
Discharge Rates per 1,000											
	Medicare/Commercial	133.79	127.10	127.10	127.10	127.10	127.10	127.10	127.10	127.10	127.10
	Medicaid	193.98	184.28	184.28	184.28	184.28	184.28	184.28	184.28	184.28	184.28
	Uninsured	79.63	75.64	75.64	75.64	75.64	75.64	75.64	75.64	75.64	75.64
Change in Discharge Rates											
		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
UMC Market Shares											
	Medicare/Commercial	2.58%	2.55%	2.81%	2.81%	2.81%	2.81%	2.81%	3.61%	4.40%	5.20%
	Medicaid	21.49%	15.20%	17.25%	17.25%	17.25%	17.25%	17.25%	21.17%	25.08%	29.00%
	Uninsured	63.30%	49.45%	55.00%	55.00%	55.00%	55.00%	55.00%	57.67%	60.33%	63.00%
		13.09%	9.90%	11.07%	11.07%	11.06%	11.06%	11.05%	11.49%	12.01%	13.81%
"Inmigration" Discharges											
		3,858	1,109	1,484	1,595	1,602	1,610	1,773	2,083	2,444	2,837

1	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
MCLNO Payer Mix (Discharges)											
Medicare/Commercial		13%	17%	17%	17%	17%	17%	17%	21%	25%	26%
Medicaid		40%	36%	36%	37%	37%	37%	37%	48%	60%	61%
Uninsured		47%	47%	46%	46%	46%	46%	46%	31%	15%	13%
Total Discharges											
Adult and Pediatrics			10,512	11,684	12,030	12,089	12,148	12,348	13,425	14,660	17,011
Psychiatry			575	1,233	1,270	1,276	1,282	1,304	1,466	1,650	1,922
Total		17,168	11,087	12,917	13,300	13,365	13,430	13,651	14,891	16,310	18,933
Average Lengths of Stay											
ALOS Adjustment											
Adult and Pediatrics				(0.12)	(0.10)	(0.10)	(0.10)	(0.10)	-	-	-
Psychiatry				(0.98)	(0.20)	(0.20)	(0.20)	(0.20)	-	-	-
Adult and Pediatrics			5.44	5.33	5.23	5.13	5.03	4.93	5.31	5.68	5.74
Psychiatry			11.77	10.79	10.59	10.39	10.19	10.00	10.32	10.62	10.67
Average Daily Census											
Adult and Pediatrics			156.7	170.5	172.2	169.8	167.4	166.8	195.2	228.2	267.4
Psychiatry			18.5	36.5	36.8	36.3	35.8	35.7	41.4	48.0	56.2
Total			175.3	206.9	209.1	206.2	203.2	202.5	236.6	276.2	323.6
Total Beds			230.0	230.0	230.0	230.0	230.0	230.0	424.0	424.0	424.0
Occupancy			76.2%	90.0%	90.9%	89.6%	88.3%	88.0%	55.8%	65.2%	76.3%
Adjusted Patient Days by Payer											
Medicare			9,261	11,561	11,722	11,654	11,581	11,637	15,792	20,397	24,122
Medicaid			37,037	45,572	46,383	46,301	46,206	46,627	66,696	90,601	108,267
Insured/Commercial			6,447	7,397	7,511	7,478	7,443	7,490	10,165	13,129	15,526
Other (Uninsured)			29,085	36,386	36,649	36,150	35,633	35,501	25,665	14,012	13,895
			81,830	100,916	102,265	101,583	100,863	101,255	118,318	138,138	161,810
Revenue Assumptions											
Change in Gross Charges/Day				-2.6%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Change in Medicaid Rates				31.3%	0.4%	0.0%	0.0%	0.0%	0.0%	2.0%	2.0%
Medicaid DSH, pre Reform											
Total Hospital Expense		\$ 339.6	\$ 390.2	\$ 375.6	\$ 377.6	\$ 386.1	\$ 393.1	\$ 511.5	\$ 585.0	\$ 678.2	
Allowable Hospital Expense		\$ 288.4	\$ 349.0	\$ 335.9	\$ 337.7	\$ 345.4	\$ 351.6	\$ 457.5	\$ 523.2	\$ 606.5	
Percent Allowable		85%	89%	89%	89%	89%	89%	89%	89%	89%	89%
Adjustments (Other Payers)		\$ (143.7)	\$ (181.9)	\$ (172.7)	\$ (174.2)	\$ (178.5)	\$ (182.2)	\$ (278.9)	\$ (361.9)	\$ (424.6)	
% of Allowable Expense		-50%	-52%	-51%	-52%	-52%	-52%	-61%	-69%	-70%	
Net DSH pre Audit Rule/Reform		\$ 144.7	\$ 167.1	\$ 163.2	\$ 163.6	\$ 166.9	\$ 169.4	\$ 178.5	\$ 161.3	\$ 181.9	
Impact of Audit Rule		0%	0%	0%	-19%	-19%	-19%	-19%	-19%	-19%	
UMC DSH Before Reform Impacts		\$ 144.7	\$ 167.1	\$ 163.2	\$ 131.9	\$ 134.6	\$ 136.6	\$ 144.0	\$ 130.1	\$ 146.7	
State-Wide DSH Funds (Post-Reform)											
Aggregate DSH Allotment Reductions (by FFY)								\$ 500	\$ 600	\$ 600	
Total U.S. DSH Allotments								\$ 11,400	\$ 11,400	\$ 11,400	
Percent Reduction, U.S.-Wide								4.4%	5.3%	5.3%	
Assumed Reduction in LA Federal Allotment								6.0%	7.0%	7.0%	
LA DSH Funds in Scenario											
Federal Allotment				\$ 750.3	\$ 750.3	\$ 750.3	\$ 750.3	\$ 705.2	\$ 697.7	\$ 697.7	
State Share				\$ 359.4	\$ 411.0	\$ 405.6	\$ 377.4	\$ 329.3	\$ 319.7	\$ 319.5	
State-wide DSH Cap				\$ 1,109.7	\$ 1,161.2	\$ 1,155.8	\$ 1,127.7	\$ 1,034.5	\$ 1,017.4	\$ 1,017.3	

1	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
State-Wide DSH Spending											
	Estimated State-Wide Spending				\$ 929.0	\$ 747.6	\$ 762.5	\$ 777.8	\$ 777.8	\$ 777.8	\$ 777.8
	Change in State-Wide Spending					-19.5%	2.0%	2.0%	0.0%	0.0%	0.0%
	Room under DSH Cap				\$ 180.7	\$ 413.6	\$ 393.3	\$ 349.9	\$ 256.8	\$ 239.6	\$ 239.5
	Impact of Reform on UMC DSH				0%	0%	0%	0%	0%	0%	0%
	Projected UMC Medicaid DSH	\$ 154.4	\$ 160.4	\$ 163.2	\$ 131.9	\$ 134.6	\$ 136.6	\$ 144.0	\$ 140.0	\$ 130.1	\$ 146.7
Note: State-Wide DSH Spending											
	Impact of Audit Rule				\$ 929.00	\$ 747.58	\$ 762.53	\$ 777.78	\$ 777.78	\$ 777.78	\$ 777.78
					\$ -	\$ (200.00)	\$ -	\$ -	\$ -	\$ -	\$ -
	Federal Share				\$ 628.10	\$ 483.01	\$ 494.96	\$ 517.46	\$ 530.21	\$ 533.40	\$ 533.48
	State Share				\$ 300.90	\$ 264.57	\$ 267.57	\$ 260.32	\$ 247.57	\$ 244.38	\$ 244.30
Medicare Assumptions											
	Medicare Discharges	1,097	1,334	1,374	1,382	1,389	1,413	1,918	2,477	2,929	
	Interns and Residents	202.82	282.40	300.00	300.00	300.00	300.00	300.00	400.00	500.00	
	Base Payment Updates	0.0%	3.3%	1.8%	1.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
	Case Mix Index	1.39	1.39	1.39	1.39	1.39	1.39	1.43	1.48	1.52	
	Interns and Residents/Beds	0.32	0.32	0.44	0.44	0.44	0.44	0.29	0.29	0.37	
	Impact of Reform on Medicare DSH		0.0%	0.0%	0.0%	0.0%	0.0%	-37.5%	-75.0%	-75.0%	
Private Payers											
	Revenue	\$ 23.2	\$ 21.7	\$ 18.9	\$ 21.9	\$ 24.0	\$ 26.0	\$ 46.3	\$ 61.4	\$ 75.3	
	Estimated Cost	\$ 26.2	\$ 30.7	\$ 29.0	\$ 29.3	\$ 30.0	\$ 30.6	\$ 46.3	\$ 58.5	\$ 68.5	
	Payment/Cost Ratio	0.88	0.71	0.65	0.75	0.80	0.85	1.00	1.05	1.10	
Project Cost Assumptions											
	Total Project Cost	\$ 1,200.0									
	Offsetting Equity										
	State of Louisiana	\$ 300.0									
	FEMA	\$ 474.7									
	FEMA Equipment	\$ 50.0									
	Borrowing Needed	\$ 375.3									
	Bond Issue Factor	1.00									
	Borrowing for Working Capital	\$ 150.0									
	Estimated Bond Issue	\$ 525.3									
	Annual Debt Service	5.50%	\$36.1								
	Bond Issue Amortization										
	Principal Payments	\$ -	\$ -	\$ -	\$ -	\$ 7.3	\$ 7.7	\$ 8.1	\$ 8.5	\$ 9.0	
	Interest Payments	\$ -	\$ -	\$ -	\$ -	\$ 28.9	\$ 28.5	\$ 28.1	\$ 27.6	\$ 27.2	
	Depreciation Expense on Project	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 44.3	\$ 44.3	\$ 44.3	
Operating Expense Assumptions											
	Full-Time Equivalent Employees	2,035.23	2,577.07	2,261.24	2,109.01	2,040.92	1,964.47	2,244.95	2,670.77	3,159.89	
	Interns and Residents	202.82	282.40	300.00	300.00	300.00	300.00	300.00	400.00	500.00	

1	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
	FTEs Net of I&R		1,832.41	2,294.67	1,961.24	1,809.01	1,740.92	1,664.47	1,944.95	2,270.77	2,659.89
	Adjusted, Occupied Beds		224.2	276.5	280.2	278.3	276.3	277.4	324.2	378.5	443.3
	Net FTEs/AOB		8.17	8.30	7.00	6.50	6.30	6.00	6.00	6.00	6.00
	Employee Benefits Factor		39.7%	38.8%	38.8%	38.8%	38.8%	38.8%	35.0%	33.0%	33.0%
	Inflation Factors										
	Salaries and Wages			2.1%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
	Operating Services			-1.5%	-5.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
	Supplies			18.1%	-5.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
	Professional Services			-6.7%	-5.0%	4.0%	4.0%	4.0%	-15.0%	-15.0%	-15.0%
	Non-Project Capital Spending	\$	12.3	\$ 29.1	\$ 5.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0

Estimated Revenue Collected (Before State Appropriation)

Medicaid	\$ 68.3	\$ 135.9	\$ 112.8	\$ 112.6	\$ 112.4	\$ 113.4	\$ 165.5	\$ 229.3	\$ 279.5
Medicaid DSH	\$ 154.4	\$ 160.4	\$ 163.2	\$ 131.9	\$ 134.6	\$ 136.6	\$ 144.0	\$ 130.1	\$ 146.7
Medicare	\$ 27.4	\$ 29.4	\$ 27.3	\$ 29.2	\$ 30.0	\$ 31.1	\$ 39.4	\$ 49.9	\$ 63.7
Commercial/Private Pay	\$ 23.2	\$ 21.7	\$ 18.9	\$ 21.9	\$ 24.0	\$ 26.0	\$ 46.3	\$ 61.4	\$ 75.3
Overcollections Fund	\$ -	\$ 1.5	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Miscellaneous	\$ 18.1	\$ 17.0	\$ 18.5	\$ 19.1	\$ 19.7	\$ 20.6	\$ 25.0	\$ 30.4	\$ 37.0
Poolings	\$ 0.5	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 291.9	\$ 366.0	\$ 340.8	\$ 314.8	\$ 320.7	\$ 327.7	\$ 420.1	\$ 501.1	\$ 602.3

Operating Expenses

Salary Expense	\$ 108.6	\$ 140.4	\$ 128.1	\$ 124.3	\$ 125.1	\$ 125.2	\$ 148.8	\$ 184.1	\$ 226.5
Employee Benefits	\$ 43.1	\$ 54.5	\$ 49.7	\$ 48.2	\$ 48.5	\$ 48.6	\$ 52.1	\$ 60.7	\$ 74.7
Operating Services	\$ 43.9	\$ 53.3	\$ 51.3	\$ 53.0	\$ 54.7	\$ 57.2	\$ 69.5	\$ 84.3	\$ 102.7
Supplies	\$ 46.0	\$ 67.0	\$ 64.5	\$ 66.7	\$ 68.8	\$ 71.9	\$ 87.3	\$ 106.0	\$ 129.2
Professional Services	\$ 79.4	\$ 91.4	\$ 88.0	\$ 90.9	\$ 93.9	\$ 98.0	\$ 97.3	\$ 96.6	\$ 96.2
Interest Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 28.1	\$ 27.6	\$ 27.2
Amortization of Financing Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 5.0	\$ 5.0	\$ 5.0
Total Depreciation Expense	\$ 10.6	\$ 13.4	\$ 13.7	\$ 14.4	\$ 15.4	\$ 13.0	\$ 50.3	\$ 51.3	\$ 52.3
Other Expense	\$ 1.1	\$ (0.7)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Expense Adjustments (e.g., VA)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 332.8	\$ 419.3	\$ 395.3	\$ 397.5	\$ 406.5	\$ 413.8	\$ 538.4	\$ 615.8	\$ 713.8

Gain/Loss (non-cash)

	(40.9)	(53.4)	(54.5)	(82.7)	(85.8)	(86.1)	(118.3)	(114.6)	(111.5)
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Adjustments to Cash Expense

Depreciation	\$ (10.6)	\$ (13.4)	\$ (13.7)	\$ (14.4)	\$ (15.4)	\$ (13.0)	\$ (50.3)	\$ (51.3)	\$ (52.3)
Interest Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (28.1)	\$ (27.6)	\$ (27.2)
Amortization Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (5.0)	\$ (5.0)	\$ (5.0)
Non-Project Capital Spending	\$ 12.3	\$ 29.1	\$ 5.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0
Interest Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 28.1	\$ 27.6	\$ 27.2
Principal Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8.1	\$ 8.5	\$ 9.0
Working Capital Deficiency	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 51.5	\$ -	\$ -
Other Working Capital Needs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Retention of Funded Depreciation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Move and Interruption	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other	\$ 1.9	\$ (45.8)	\$ (14.9)	\$ (14.9)	\$ (14.9)	\$ (14.9)	\$ (14.9)	\$ (14.9)	\$ (14.9)
Total	\$ 3.6	\$ (30.2)	\$ (23.6)	\$ (19.3)	\$ (20.3)	\$ (17.9)	\$ (0.6)	\$ (52.7)	\$ (53.2)

Cash Expense

	\$ 336.4	\$ 389.2	\$ 371.8	\$ 378.2	\$ 386.1	\$ 395.9	\$ 537.7	\$ 563.1	\$ 660.6
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1	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
Cash Flow Surplus/(Deficit)		\$ (44.5)	\$ (23.2)	\$ (31.0)	\$ (63.4)	\$ (65.5)	\$ (68.1)	\$ (117.6)	\$ (61.9)	\$ (58.3)	
State General Funds											
Directly appropriated funds		\$ 13.9	\$ 48.7	\$ 50.6	\$ 26.1	\$ 63.4	\$ 65.5	\$ 68.1	\$ 78.3	\$ 74.1	\$ 70.5
DSH/UCC Matching Funds											
Allowable UCC Cost		\$ 200.99	\$ 154.4	\$ 160.4	\$ 163.2	\$ 131.9	\$ 134.6	\$ 136.6	\$ 144.0	\$ 130.1	\$ 146.7
Adjustment		-	(9.74)	(1.33)	(21.15)	-	-	-	-	-	-
Actual Amounts		201.0	\$ 144.7	\$ 159.1	\$ 142.1	131.9	134.6	136.6	144.0	130.1	146.7
State UCC Match Rate		28.96%	27.53%	28.69%	32.39%	35.39%	35.09%	33.47%	31.83%	31.42%	31.41%
FMAP for UCC		71.04%	72.47%	71.31%	67.61%	64.61%	64.91%	66.53%	68.17%	68.58%	68.59%
State UCC Match		\$ 58.21	\$ 39.84	\$ 45.64	\$ 46.02	\$ 46.69	\$ 47.22	\$ 45.73	\$ 45.83	\$ 40.87	\$ 46.08
Total State Funds		\$ 72.1	\$ 88.6	\$ 96.2	\$ 72.2	\$ 110.1	\$ 112.7	\$ 113.9	\$ 124.1	\$ 115.0	\$ 116.5
SGF Needed for Coverage Ratio											
Gain/Loss					(82.7)	(85.8)	(86.1)	(118.3)	(114.6)	(111.5)	
Depreciation Expense					14.4	15.4	13.0	50.3	51.3	52.3	
Interest Expense					\$ -	\$ -	\$ -	\$ 28.1	\$ 27.6	\$ 27.2	
Amortization Expense					\$ -	\$ -	\$ -	\$ 5.0	\$ 5.0	\$ 5.0	
EBITDA					(68.3)	(70.4)	(73.1)	(34.9)	(30.7)	(27.1)	
Bond Issue Principal and Interest								\$ 36.1	\$ 36.1	\$ 36.1	
EBITDA Needed		1.2 Times						\$ 43.4	\$ 43.4	\$ 43.4	
SGF Needed		\$ 48.7	\$ 50.6	\$ 26.1	\$ 63.4	\$ 65.5	\$ 68.1	\$ 78.3	\$ 74.1	\$ 70.5	
SGF as Percent of Expense		14.6%	12.1%	6.6%	15.9%	16.1%	16.5%	14.5%	12.0%	9.9%	

\$ in Millions	Actual		Budgeted	Projected						
	2008	2009	2010	2011	2012	2013	2014	2015	2016	
Unmatched State General Fund Support										
Scenario 1 (Reform)	\$ 48.7	\$ 50.6	\$ 26.1	\$ 63.4	\$ 65.5	\$ 68.1	\$ 78.3	\$ 74.1	\$ 70.5	
Scenario 2 (No Reform)	\$ 48.7	\$ 50.6	\$ 26.1	\$ 63.4	\$ 65.2	\$ 67.7	\$ 78.9	\$ 75.2	\$ 85.7	
State General Fund as % of Expense										
Scenario 1 (Reform)	14.6%	12.1%	6.6%	15.9%	16.1%	16.5%	14.5%	12.0%	9.9%	
Scenario 2 (No Reform)	14.6%	12.1%	6.6%	15.9%	16.1%	16.4%	14.4%	12.0%	12.1%	
State General Fund as % of Revenue										
Scenario 1 (Reform)	14.3%	12.1%	7.1%	16.8%	17.0%	17.2%	15.7%	12.9%	10.5%	
Scenario 2 (No Reform)	14.3%	12.1%	7.1%	16.8%	16.9%	17.1%	15.5%	12.8%	12.8%	
SGF Including State Medicaid DSH Match										
Scenario 1 (Reform)	\$ 88.6	\$ 96.2	\$ 72.2	\$ 110.1	\$ 112.7	\$ 113.9	\$ 124.1	\$ 115.0	\$ 116.5	
Scenario 2 (No Reform)	\$ 88.6	\$ 96.2	\$ 72.2	\$ 110.1	\$ 112.5	\$ 113.4	\$ 133.9	\$ 134.6	\$ 145.1	

2	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
Key Variables Under Health Reform											
Uninsured Moving to Medicaid											
0-133 Percent of Poverty											
134-150 Percent of Poverty											
Remaining Uninsured to Private Coverage											
Average Payment Rate Increases											
Medicaid											
Medicare											
Adjustments to DSH											
National Federal Allotment Reductions (\$mm)											
Total National Federal Allotment											
Reduction to LA Federal DSH Allotment											
Medicare DSH Payments											
Inflation in State-Wide DSH Spending											
Actual Impacts on UMC DSH											
Medicaid DSH											
Medicare DSH											
Key Variables Assuming No Reform											
Uninsured Moving to Medicaid											
0-133 Percent of Poverty											
134-150 Percent of Poverty											
Remaining Uninsured to Private Coverage											
Average Payment Rate Increases											
Medicaid											
Medicare											
Adjustments to DSH											
National Federal Allotment Reductions (\$mm)											
Total National Federal Allotment											
Federal Medicaid DSH Cap											
Medicare DSH Payments											
Inflation in State-Wide DSH Spending											
Actual Impacts on UMC DSH											
Medicaid DSH											
Medicare DSH											
Scenario =====											
2 1 = Reform, 2 = No Reform											
Variables Used in Scenario											
Uninsured Moving to Medicaid											
0-133 Percent of Poverty											
134-150 Percent of Poverty											
Remaining Uninsured to Private Coverage											
Average Payment Rate Increases											

2	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
	Medicaid			31.3%	0.4%	0.0%	0.0%	0.0%	3.0%	3.0%	3.0%
	Medicare			3.3%	0.5%	1.0%	3.0%	3.0%	3.0%	3.0%	3.0%
	Inflation in State-Wide DSH Spending					0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Adjustments to DSH										
	National Federal Allotment Reductions (\$mm)								\$ -	\$ -	\$ -
	Total National Federal Allotment								\$ 11,400	\$ 11,400	\$ 11,400
	Federal Medicaid DSH Cap			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Medicare DSH Payments			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Inflation in State-Wide DSH Spending					3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
	Actual Impacts on UMC DSH										
	Medicaid DSH			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Medicare DSH			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Service Area Population (Jefferson, Orleans, St. Bernard)											
	Total People	970,784	785,756	804,114	823,436	827,866	832,322	836,803	841,310	845,842	850,400
	Uninsured Moving to Medicaid										
	0-133 Percent of Poverty										
	134-150 Percent of Poverty										
	Remaining Uninsured to Private Coverage										
	Distribution by Payer										
	Private Coverage	52.2%	52.7%	52.6%	52.6%	52.5%	52.4%	52.4%	52.3%	52.3%	52.2%
	Medicaid/LaCHIP	17.0%	16.3%	16.3%	16.3%	16.3%	16.3%	16.4%	16.4%	16.4%	16.4%
	Medicare	14.4%	15.2%	15.2%	15.3%	15.4%	15.4%	15.5%	15.6%	15.7%	15.7%
	Uninsured	16.4%	15.9%	15.9%	15.8%	15.8%	15.8%	15.8%	15.7%	15.7%	15.7%
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Number of Uninsured	159,672	124,716	127,519	130,467	130,938	131,411	131,886	132,361	132,838	133,316
Service Area Discharges											
	Medicare/Commercial	86,416	67,744	69,332	71,003	71,401	71,801	72,203	72,607	73,014	73,423
	Medicaid	32,050	23,599	24,164	24,757	24,911	25,065	25,221	25,377	25,534	25,693
	Uninsured	12,714	9,434	9,646	9,869	9,905	9,941	9,976	10,012	10,048	10,085
		131,180	100,777	103,141	105,630	106,216	106,806	107,400	107,996	108,597	109,201
Discharge Rates per 1,000											
	Medicare/Commercial	133.79	127.10	127.10	127.10	127.10	127.10	127.10	127.10	127.10	127.10
	Medicaid	193.98	184.28	184.28	184.28	184.28	184.28	184.28	184.28	184.28	184.28
	Uninsured	79.63	75.64	75.64	75.64	75.64	75.64	75.64	75.64	75.64	75.64
	Change in Discharge Rates		0%	0%	0%	0%	0%	0%	0%	0%	0%
UMC Market Shares											
	Medicare/Commercial	2.58%	2.55%	2.81%	2.81%	2.81%	2.81%	2.81%	3.61%	4.40%	5.20%
	Medicaid	21.49%	15.20%	17.25%	17.25%	17.25%	17.25%	17.25%	21.17%	25.08%	29.00%
	Uninsured	63.30%	49.45%	55.00%	55.00%	55.00%	55.00%	55.00%	57.67%	60.33%	63.00%
		13.09%	9.90%	11.07%	11.07%	11.06%	11.06%	11.05%	12.74%	14.44%	16.14%
	"Inmigration" Discharges	3,858	1,109	1,484	1,595	1,602	1,610	1,773	2,241	2,767	3,110

2	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
MCLNO Payer Mix (Discharges)											
Medicare/Commercial		13%	17%	17%	17%	17%	17%	17%	19%	21%	22%
Medicaid		40%	36%	36%	37%	37%	37%	37%	39%	41%	42%
Uninsured		47%	47%	46%	46%	46%	46%	46%	42%	39%	36%
Total Discharges											
Adult and Pediatrics			10,512	11,684	12,030	12,089	12,148	12,348	14,469	16,663	18,709
Psychiatry			575	1,233	1,270	1,276	1,282	1,304	1,549	1,804	2,042
Total		17,168	11,087	12,917	13,300	13,365	13,430	13,651	16,019	18,467	20,752
Average Lengths of Stay											
ALOS Adjustment											
Adult and Pediatrics				(0.12)	(0.10)	(0.10)	(0.10)	(0.10)	-	-	-
Psychiatry				(0.98)	(0.20)	(0.20)	(0.20)	(0.20)	-	-	-
Adult and Pediatrics			5.44	5.33	5.23	5.13	5.03	4.93	5.02	5.10	5.15
Psychiatry			11.77	10.79	10.59	10.39	10.19	10.00	10.09	10.16	10.22
Average Daily Census											
Adult and Pediatrics			156.7	170.5	172.2	169.8	167.4	166.8	199.1	232.6	264.1
Psychiatry			18.5	36.5	36.8	36.3	35.8	35.7	42.8	50.2	57.2
Total			175.3	206.9	209.1	206.2	203.2	202.5	242.0	282.8	321.3
Total Beds			230.0	230.0	230.0	230.0	230.0	230.0	424.0	424.0	424.0
Occupancy			76.2%	90.0%	90.9%	89.6%	88.3%	88.0%	57.1%	66.7%	75.8%
Adjusted Patient Days by Payer											
Medicare			9,261	11,561	11,722	11,654	11,581	11,637	15,194	18,874	22,414
Medicaid			37,037	45,572	46,383	46,301	46,206	46,627	58,238	70,260	81,735
Insured/Commercial			6,447	7,397	7,511	7,478	7,443	7,490	9,780	12,148	14,427
Other (Uninsured)			29,085	36,386	36,649	36,150	35,633	35,501	37,791	40,148	42,073
			81,830	100,916	102,265	101,583	100,863	101,255	121,003	141,430	160,648
Revenue Assumptions											
Change in Gross Charges/Day				-2.6%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Change in Medicaid Rates				31.3%	0.4%	0.0%	0.0%	0.0%	0.0%	3.0%	3.0%
Medicaid DSH, pre Reform											
Total Hospital Expense		\$ 339.6	\$ 390.2	\$ 375.6	\$ 377.6	\$ 386.1	\$ 393.1	\$ 520.7	\$ 596.2	\$ 674.2	
Allowable Hospital Expense		\$ 288.4	\$ 349.0	\$ 335.9	\$ 337.7	\$ 345.4	\$ 351.6	\$ 465.7	\$ 533.2	\$ 603.0	
Percent Allowable		85%	89%	89%	89%	89%	89%	89%	89%	89%	
Adjustments (Other Payers)		\$ (143.7)	\$ (181.9)	\$ (172.7)	\$ (174.2)	\$ (178.5)	\$ (182.2)	\$ (251.4)	\$ (297.9)	\$ (345.6)	
% of Allowable Expense		-50%	-52%	-51%	-52%	-52%	-52%	-54%	-56%	-57%	
Net DSH pre Audit Rule/Reform		\$ 144.7	\$ 167.1	\$ 163.2	\$ 163.6	\$ 166.9	\$ 169.4	\$ 214.3	\$ 235.4	\$ 257.4	
Impact of Audit Rule		0%	0%	0%	-19%	-19%	-19%	-19%	-19%	-19%	
UMC DSH Before Reform Impacts		\$ 144.7	\$ 167.1	\$ 163.2	\$ 131.9	\$ 134.6	\$ 136.6	\$ 172.8	\$ 189.8	\$ 207.6	
State-Wide DSH Funds (Post-Reform)											
Aggregate DSH Allotment Reductions (by FFY)								\$ 500	\$ 600	\$ 600	
Total U.S. DSH Allotments								\$ 11,400	\$ 11,400	\$ 11,400	
Percent Reduction, U.S.-Wide								4.4%	5.3%	5.3%	
Assumed Reduction in LA Federal Allotment								6.0%	7.0%	7.0%	
LA DSH Funds in Scenario											
Federal Allotment				\$ 750.3	\$ 750.3	\$ 750.3	\$ 750.3	\$ 750.3	\$ 750.3	\$ 750.3	\$ 750.3
State Share				\$ 359.4	\$ 411.0	\$ 405.6	\$ 377.4	\$ 350.3	\$ 343.7	\$ 343.6	
State-wide DSH Cap				\$ 1,109.7	\$ 1,161.2	\$ 1,155.8	\$ 1,127.7	\$ 1,100.6	\$ 1,094.0	\$ 1,093.8	

2	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
State-Wide DSH Spending											
	Estimated State-Wide Spending				\$ 929.0	\$ 756.9	\$ 779.6	\$ 803.0	\$ 827.1	\$ 851.9	\$ 877.4
	Change in State-Wide Spending					-18.5%	3.0%	3.0%	3.0%	3.0%	3.0%
	Room under DSH Cap				\$ 180.7	\$ 404.3	\$ 376.3	\$ 324.7	\$ 273.5	\$ 242.1	\$ 216.4
	Impact of Reform on UMC DSH				0%	0%	0%	0%	0%	0%	0%
	Projected UMC Medicaid DSH	\$ 154.4	\$ 160.4	\$ 163.2	\$ 131.9	\$ 134.6	\$ 136.6	\$ 172.8	\$ 189.0	\$ 189.0	
Note: State-Wide DSH Spending											
	Impact of Audit Rule				\$ 929.00	\$ 756.87	\$ 779.58	\$ 802.96	\$ 827.05	\$ 851.86	\$ 877.42
					\$ -	\$ (200.00)	\$ -	\$ -	\$ -	\$ -	\$ -
	Federal Share				\$ 628.10	\$ 489.01	\$ 506.02	\$ 534.21	\$ 563.80	\$ 584.21	\$ 601.82
	State Share				\$ 300.90	\$ 267.86	\$ 273.55	\$ 268.75	\$ 263.25	\$ 267.66	\$ 275.60
Medicare Assumptions											
	Medicare Discharges	1,097	1,334	1,374	1,382	1,389	1,413	1,845	2,292	2,722	
	Interns and Residents	202.82	282.40	300.00	300.00	300.00	300.00	300.00	400.00	500.00	
	Base Payment Updates	0.0%	3.3%	1.8%	1.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
	Case Mix Index	1.39	1.39	1.39	1.39	1.39	1.39	1.43	1.48	1.52	
	Interns and Residents/Beds	0.32	0.32	0.44	0.44	0.44	0.44	0.29	0.29	0.37	
	Impact of Reform on Medicare DSH		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Private Payers											
	Revenue	\$ 23.2	\$ 21.7	\$ 18.9	\$ 21.9	\$ 24.0	\$ 26.0	\$ 44.3	\$ 56.6	\$ 70.1	
	Estimated Cost	\$ 26.2	\$ 30.7	\$ 29.0	\$ 29.3	\$ 30.0	\$ 30.6	\$ 44.3	\$ 53.9	\$ 63.7	
	Payment/Cost Ratio	0.88	0.71	0.65	0.75	0.80	0.85	1.00	1.05	1.10	
Project Cost Assumptions											
	Total Project Cost	\$ 1,200.0									
	Offsetting Equity										
	State of Louisiana	\$ 300.0									
	FEMA	\$ 474.7									
	FEMA Equipment	\$ 50.0									
	Borrowing Needed	\$ 375.3									
	Bond Issue Factor	1.00									
	Borrowing for Working Capital	\$ 150.0									
	Estimated Bond Issue	\$ 525.3									
	Annual Debt Service	5.50%	\$36.1								
	Bond Issue Amortization										
	Principal Payments	\$ -	\$ -	\$ -	\$ -	\$ 7.3	\$ 7.7	\$ 8.1	\$ 8.5	\$ 9.0	
	Interest Payments	\$ -	\$ -	\$ -	\$ -	\$ 28.9	\$ 28.5	\$ 28.1	\$ 27.6	\$ 27.2	
	Depreciation Expense on Project	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 44.3	\$ 44.3	\$ 44.3	
Operating Expense Assumptions											
	Full-Time Equivalent Employees	2,035.23	2,577.07	2,261.24	2,109.01	2,040.92	1,964.47	2,289.09	2,724.87	3,140.79	
	Interns and Residents	202.82	282.40	300.00	300.00	300.00	300.00	300.00	400.00	500.00	

2	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016
FTEs Net of I&R			1,832.41	2,294.67	1,961.24	1,809.01	1,740.92	1,664.47	1,989.09	2,324.87	2,640.79
Adjusted, Occupied Beds			224.2	276.5	280.2	278.3	276.3	277.4	331.5	387.5	440.1
Net FTEs/AOB			8.17	8.30	7.00	6.50	6.30	6.00	6.00	6.00	6.00
Employee Benefits Factor			39.7%	38.8%	38.8%	38.8%	38.8%	38.8%	35.0%	33.0%	33.0%
Inflation Factors											
Salaries and Wages				2.1%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Operating Services				-1.5%	-5.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Supplies				18.1%	-5.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Professional Services				-6.7%	-5.0%	4.0%	4.0%	4.0%	-15.0%	-15.0%	-15.0%
Non-Project Capital Spending		\$	12.3	\$ 29.1	\$ 5.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0

Estimated Revenue Collected (Before State Appropriation)

Medicaid	\$ 68.3	\$ 135.9	\$ 112.8	\$ 112.6	\$ 112.4	\$ 113.4	\$ 145.9	\$ 181.3	\$ 217.3
Medicaid DSH	\$ 154.4	\$ 160.4	\$ 163.2	\$ 131.9	\$ 134.6	\$ 136.6	\$ 172.8	\$ 189.0	\$ 189.0
Medicare	\$ 27.4	\$ 29.4	\$ 27.3	\$ 29.2	\$ 30.2	\$ 31.5	\$ 40.6	\$ 53.8	\$ 69.8
Commercial/Private Pay	\$ 23.2	\$ 21.7	\$ 18.9	\$ 21.9	\$ 24.0	\$ 26.0	\$ 44.3	\$ 56.6	\$ 70.1
Overcollections Fund	\$ -	\$ 1.5	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Miscellaneous	\$ 18.1	\$ 17.0	\$ 18.5	\$ 19.1	\$ 19.7	\$ 20.6	\$ 25.6	\$ 31.1	\$ 36.8
Poolings	\$ 0.5	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 291.9	\$ 366.0	\$ 340.8	\$ 314.8	\$ 320.9	\$ 328.2	\$ 429.2	\$ 511.8	\$ 582.9

Operating Expenses

Salary Expense	\$ 108.6	\$ 140.4	\$ 128.1	\$ 124.3	\$ 125.1	\$ 125.2	\$ 151.7	\$ 187.8	\$ 225.1
Employee Benefits	\$ 43.1	\$ 54.5	\$ 49.7	\$ 48.2	\$ 48.5	\$ 48.6	\$ 53.1	\$ 62.0	\$ 74.3
Operating Services	\$ 43.9	\$ 53.3	\$ 51.3	\$ 53.0	\$ 54.7	\$ 57.2	\$ 71.0	\$ 86.3	\$ 102.0
Supplies	\$ 46.0	\$ 67.0	\$ 64.5	\$ 66.7	\$ 68.8	\$ 71.9	\$ 89.3	\$ 108.6	\$ 128.3
Professional Services	\$ 79.4	\$ 91.4	\$ 88.0	\$ 90.9	\$ 93.9	\$ 98.0	\$ 99.6	\$ 98.9	\$ 95.5
Interest Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 28.1	\$ 27.6	\$ 27.2
Amortization of Financing Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 5.0	\$ 5.0	\$ 5.0
Total Depreciation Expense	\$ 10.6	\$ 13.4	\$ 13.7	\$ 14.4	\$ 15.4	\$ 13.0	\$ 50.3	\$ 51.3	\$ 52.3
Other Expense	\$ 1.1	\$ (0.7)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Expense Adjustments (e.g., VA)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 332.8	\$ 419.3	\$ 395.3	\$ 397.5	\$ 406.5	\$ 413.8	\$ 548.1	\$ 627.6	\$ 709.7

Gain/Loss (non-cash)

	(40.9)	(53.4)	(54.5)	(82.7)	(85.6)	(85.6)	(118.9)	(115.7)	(126.8)
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Adjustments to Cash Expense

Depreciation	\$ (10.6)	\$ (13.4)	\$ (13.7)	\$ (14.4)	\$ (15.4)	\$ (13.0)	\$ (50.3)	\$ (51.3)	\$ (52.3)
Interest Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (28.1)	\$ (27.6)	\$ (27.2)
Amortization Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (5.0)	\$ (5.0)	\$ (5.0)
Non-Project Capital Spending	\$ 12.3	\$ 29.1	\$ 5.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0	\$ 10.0
Interest Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 28.1	\$ 27.6	\$ 27.2
Principal Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8.1	\$ 8.5	\$ 9.0
Working Capital Deficiency	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 51.5	\$ -	\$ -
Other Working Capital Needs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Retention of Funded Depreciation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Move and Interruption	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other	\$ 1.9	\$ (45.8)	\$ (14.9)	\$ (14.9)	\$ (14.9)	\$ (14.9)	\$ (14.9)	\$ (14.9)	\$ (14.9)
Total	\$ 3.6	\$ (30.2)	\$ (23.6)	\$ (19.3)	\$ (20.3)	\$ (17.9)	\$ (0.6)	\$ (52.7)	\$ (53.2)

Cash Expense

	\$ 336.4	\$ 389.2	\$ 371.8	\$ 378.2	\$ 386.1	\$ 395.9	\$ 547.5	\$ 574.9	\$ 656.4
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2	1 = Reform, 2 = No Reform	2005	2008	2009	2010	2011	2012	2013	2014	2015	2016	
Cash Flow Surplus/(Deficit)		\$	(44.5)	(23.2)	(31.0)	(63.4)	(65.2)	(67.7)	(118.2)	(63.0)	(73.5)	
State General Funds												
Directly appropriated funds		\$	13.9	48.7	50.6	26.1	63.4	65.2	67.7	78.9	75.2	85.7
DSH/UCC Matching Funds												
Allowable UCC Cost		\$	200.99	154.4	160.4	163.2	131.9	134.6	136.6	172.8	189.0	189.0
Adjustment			-	(9.74)	(1.33)	(21.15)	-	-	-	-	-	-
Actual Amounts			201.0	144.7	159.1	142.1	131.9	134.6	136.6	172.8	189.0	189.0
State UCC Match Rate			28.96%	27.53%	28.69%	32.39%	35.39%	35.09%	33.47%	31.83%	31.42%	31.41%
FMAP for UCC			71.04%	72.47%	71.31%	67.61%	64.61%	64.91%	66.53%	68.17%	68.58%	68.59%
State UCC Match		\$	58.21	39.84	45.64	46.02	46.69	47.22	45.73	55.02	59.38	59.36
Total State Funds		\$	72.1	88.6	96.2	72.2	110.1	112.5	113.4	133.9	134.6	145.1
SGF Needed for Coverage Ratio												
Gain/Loss						(82.7)	(85.6)	(85.6)	(118.9)	(115.7)	(126.8)	
Depreciation Expense						14.4	15.4	13.0	50.3	51.3	52.3	
Interest Expense						\$ -	\$ -	\$ -	\$ 28.1	\$ 27.6	\$ 27.2	
Amortization Expense						\$ -	\$ -	\$ -	\$ 5.0	\$ 5.0	\$ 5.0	
EBITDA						(68.3)	(70.2)	(72.6)	(35.5)	(31.8)	(42.3)	
Bond Issue Principal and Interest									\$ 36.1	\$ 36.1	\$ 36.1	
EBITDA Needed		1.2 Times							\$ 43.4	\$ 43.4	\$ 43.4	
SGF Needed		\$	48.7	50.6	26.1	63.4	65.2	67.7	78.9	75.2	85.7	
SGF as Percent of Expense			14.6%	12.1%	6.6%	15.9%	16.1%	16.4%	14.4%	12.0%	12.1%	

\$ in Millions	Actual		Budgeted	Projected														
	2008	2009	2010	2011	2012	2013	2014	2015	2016									
Unmatched State General Fund Support																		
Scenario 1 (Reform)	\$	48.7	\$	50.6	\$	26.1	\$	63.4	\$	65.2	\$	67.7	\$	78.9	\$	75.2	\$	85.7
Scenario 2 (No Reform)	\$	48.7	\$	50.6	\$	26.1	\$	63.4	\$	65.2	\$	67.7	\$	78.9	\$	75.2	\$	85.7
State General Fund as % of Expense																		
Scenario 1 (Reform)		14.6%		12.1%		6.6%		15.9%		16.1%		16.4%		14.4%		12.0%		12.1%
Scenario 2 (No Reform)		14.6%		12.1%		6.6%		15.9%		16.1%		16.4%		14.4%		12.0%		12.1%
State General Fund as % of Revenue																		
Scenario 1 (Reform)		14.3%		12.1%		7.1%		16.8%		16.9%		17.1%		15.5%		12.8%		12.8%
Scenario 2 (No Reform)		14.3%		12.1%		7.1%		16.8%		16.9%		17.1%		15.5%		12.8%		12.8%
SGF Including State Medicaid DSH Match																		
Scenario 1 (Reform)	\$	88.6	\$	96.2	\$	72.2	\$	110.1	\$	112.5	\$	113.4	\$	133.9	\$	134.6	\$	145.1
Scenario 2 (No Reform)	\$	88.6	\$	96.2	\$	72.2	\$	110.1	\$	112.5	\$	113.4	\$	133.9	\$	134.6	\$	145.1