

EXECUTIVE SUMMARY

Site And Facility Masterplan
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Consolidation Of
Charity And University Hospitals
Medical Center Of Louisiana
New Orleans

19-610-03B-13 Part 01

Site Code: 1-36-036



nbbj

KaufmanHall

Conclusion

Due to years of deferred maintenance, lack of reinvestment in facilities, and changes in privacy regulation, MCLNO is housed in hopelessly outmoded facilities. Without action, MCLNO will likely lose its facility accreditation. The loss of this accreditation will cause MCLNO to fail to meet its mission of providing healthcare access to the uninsured, resulting in the redistribution of the area's medically indigent to New Orleans' other hospitals at a potentially higher cost to the state, and could possibly cause the evaporation of key health profession educational programs in New Orleans.

To avoid this, a new University Hospital must be constructed. A strategic vision for MCLNO in 2013 finds that it will continue to fulfill its dual role of providing a site for medical education and clinical care, remain the primary health-care services resource in the region for the uninsured, function as the trauma provider for all patients in the region and remain the tertiary-care provider for the uninsured throughout the state. Further, MCLNO will expand the volume of insured patients through focused programmatic development efforts and a marketing strategy centered on building market share of Medicare and Medicaid populations within the African-American community in the core market and New Orleans East. In addition, MCLNO will provide a state-of-the-art academic medical center with leading medical technology and clinical information systems to achieve the best possible patient outcomes; improve hospital and clinic operations with leading information technology to ensure timely and accurate revenue collection processes and maximize other operational efficiencies; and maintain a sound financial position and an ability to generate the capital necessary to sustain operations into the future.

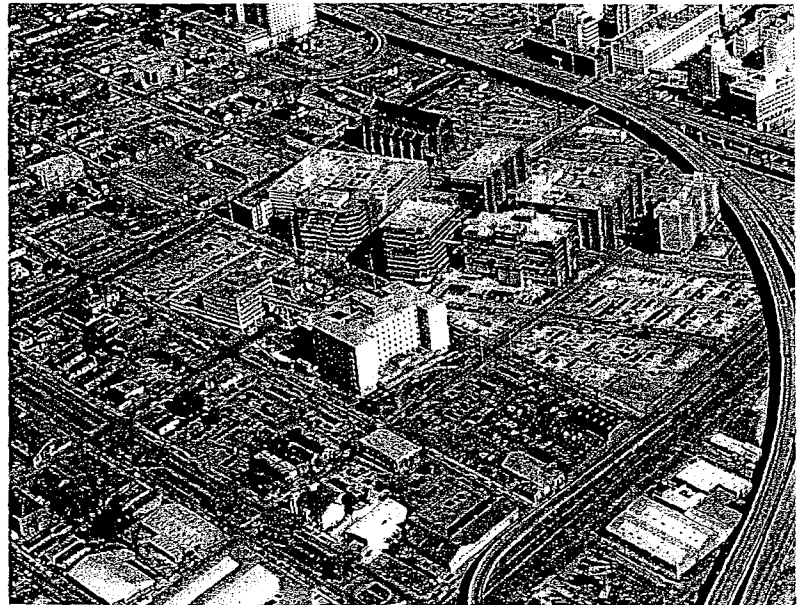
The Planning Team recommends that LSU HCSD seriously consider locating the replacement facility north of Tulane, with an address facing Canal Street. Such a location will allow for the necessary future expansion of this facility, open additional space for the LSU Health Sciences Center, provide a better image and better transportation access, and tie directly into the ongoing urban redevelopment efforts of the community and the city of New Orleans. The construction of new state-of-the-art healthcare delivery facilities will further maximize the potential operational efficiencies of the consolidation of Charity and University inpatient

and outpatient facilities. Despite some higher first costs, the facility in the North Option configuration will allow for a more seamless and less expensive long-term delivery of outpatient and inpatient services with a simultaneous opening date, also enabling earlier access to care.

Study Background

In November 2003, the Medical Center of Louisiana at New Orleans (MCLNO) commissioned ADAMS Management Services Corporation (ADAMS) to direct strategic and financial planning services and campus master planning services for new and consolidated inpatient and outpatient facilities. ADAMS orchestrated separate selection processes whereby a strategic/financial planning firm, Kaufman Hall, and a campus master planning firm, NBBJ, were incorporated into the Planning Team. The study was ordered in response to facility and accreditation threats due to dilapidated facilities.

The total MCLNO campus is composed of a variety of buildings, including two major inpatient facilities – University and Charity hospitals. Charity Hospital was constructed in 1938 and is comprised of approximately 1,000,000sf. In addition to the main building, there are numerous ancillary buildings on campus that total approximately 250,000sf of space. University



Hospital was constructed in 1972 and consists of approximately 364,000sf.

Between the two facilities, MCLNO provides medical education for Louisiana State University (LSU) and Tulane University and normally staffs between 450 and 500 inpatient beds. MCLNO is a critical resource for the city of New Orleans and the state of Louisiana through both its role as a site for medical education and the delivery of clinical care. MCLNO patient volumes are one of the largest in the state of Louisiana, though the majority of MCLNO's current patient base is uninsured. Approximately 350,000 visits are made to MCLNO outpatient clinics each year. MCLNO emergency rooms experience over 160,000 patient visits annually.

A Comprehensive Healthcare Facilities Study (HFS) was undertaken in early 2003, at the request of LSU Health Care Services Division (HCSID), to examine each of the (then) ten hospitals in the Charity system. At MCLNO, the HFS team discovered poor privacy and infection control environments, particularly within the Charity facility. The study indicated that many of the buildings and their systems were in overall poor condition, with major repairs required. There was an apparent unsafe operational functionality of the existing facilities. The HFS team found that the Charity Hospital structure was no longer suited for healthcare services delivery. Preliminary analysis of University Hospital facilities suggest that its best long-term usage would be primarily for non-clinical activities.

MCLNO has been a repeated victim of historic budget cuts and deferred maintenance. Between calendar year (CY) 2003 and CY 2004, MCLNO inpatient discharges decreased by nearly 17 percent (4,500 cases), primarily due to a reduction in scale and scope of services. While MCLNO captured over 60 percent of the area's estimated "self-pay/indigent" cases in CY 2004, overall area cases in this category decreased by 12 percent (1,758 cases), indicating that many patients either sought care outside the service area or did not have access to care and their need went unmet. In that same time frame, MCLNO lost market share across all "paying patient" categories (Medicare, Medicaid, BCBS, commercial/managed care and other government), further inhibiting its ability to maintain future financial stability.

The indigent population that MCLNO does serve constitutes a disproportionate share of its payor mix, financially hampering its ability to provide additional access to care. Despite the constraints and relative lack of resources, the MCLNO staff and physicians provide some of the highest and best outcomes in the region. Despite the best efforts of the staff, operating two campuses and outdated/threatened facilities is inherently inefficient. The consolidation of services at a single site would undoubtedly present substantial cost-saving opportunities.

External Threats to MCLNO

Even with excellent outcomes and exceptional patient care, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has threatened MCLNO with the possibility of revoking its accreditation. JCAHO last visited MCLNO in 2002, with a follow-up visit scheduled for December 2005. During the 2002 visit, JCAHO charged MCLNO with rectifying the lack of compliance with applicable laws and regulations, particularly with respect to privacy issues and patient rights. The 2002 JCAHO report specifically states: "(MCLNO) leadership needs to strongly consider seeking from the state a more modern facility to improve patient safety, environmental safety, patient privacy and infection control." Without facility accreditation, MCLNO will not be able to draw Medicaid or Medicare funds, thereby severely impacting the access to care that it could provide.

Other than replacement, the only option would be to ultimately close MCLNO and redistribute medical education and patients throughout the private hospitals in the region. This would have a negative impact on the medical education component due to the absence of sufficient clinical mass at any one site, present access challenges for patients, and shift the uncompensated care burden to private hospitals and physicians.

Study Vision

ADAMS and the Planning Team undertook a comprehensive planning effort that included LSU officials, as well as external participants such as local community leaders, working with various committees and subcommittees. A Project Vision for the new facility soon became apparent. The vision included the planning and creation of a new, sustainable state-of-the-art medical center that responds to the missions of patient care, education, research and clinical research in a setting that builds on the synergy of LSU and Tulane, is a destination of healthcare choice for all, improves both clinical outcomes and financial performance and establishes centers of excellence that complement existing community resources.

Strategic and Financial Planning Process

The Planning Team began the strategic and financial planning effort by analyzing the current revenue structure of MCLNO and identifying opportunities for improvement. The team was given a variety of planning objectives around which to build the financial model; they are as follows:

- Support the replacement of University and Charity hospitals
- Maintain uncompensated care and teaching roles at current levels
- Avoid extensive added state funding
- Allow MCLNO to operate on an enterprise basis
- Do not require unrealistic assumptions
- Support the gradual rationalization of the delivery system

A financial model was developed to test various operating models to seek the best balance between mission fulfillment, operating results, risk and outside support requirements, as well as other issues. The "Shreveport Model" served as the inspiration for the new facility, serving both paying and indigent patients and enhancing the patient care mission while improving the education base. A financial plan was specified that could support this preferred operating configuration.

Financial Plan

An initial financial planning effort was undertaken in 2004 and later updated in 2005. The proposed financial plan is achievable, based on the support of several key constituencies. Specifically, relatively dedicated utilization and admissions support will be required from the LSU faculty. Additionally, state funding should be maintained with incremental growth. Finally, as MCLNO seeks to expand its primary care network in partnership with the City of New Orleans, ongoing support from local government will be required.

The essential elements of the financial plan include realizing significant savings as a result of consolidation of the two existing facilities, increasing the external support base by 3% annually, increasing the gross charge rates by 6% annually from FY 2007 – FY 2011 and growing them 4% annually thereafter, gradually improving the commercial collection rate from FY 2007 to FY 2011 to 85% and holding it there after as well as capturing an additional 2,000 paying patient discharges by FY 2011 as a result of opening the new facility.

Key programs include the enhancement of the Level I Trauma Center and post-trauma-related services, the enhancement of geriatric services, the enhancement of already strong disease management capabilities in order to better manage the health status of at-risk populations, the potential joint partnership with the City of New Orleans in the establishment of satellite primary care clinics throughout the city and the expansion of clinical research opportunities.

The success of the financial plan is also based on successful operations initiatives, capital requirements and external funding. Recommended operational changes include improving the charge structure and paying patient collections to industry norms. The improvement of patient flow, management process and IT/business system infrastructure is also recommended, along with maintaining productivity at least consistent with current levels.

From a strategic standpoint, infrastructure improvements, faculty support, physician network, revised clinic operations and public outreach efforts should be well in place prior to the opening of the new hospital. With respect to capital requirements and external funding, a plan for facility upkeep and reinvestment in equipment is suggested, as well as the obtaining of sufficient state UCC funding and outside funding to assure long-term viability.

A financial plan consistent with the strategic and operating plan described above is summarized below. It results in adequate cash and debt service outcomes in the years after project completion:

(\$ in Millions)					Projected					
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Net Patient Revenue	\$618.9	\$641.7	\$667.1	\$694.4	\$724.5	\$756.4	\$824.0	\$858.0	\$884.3	\$911.5
Excess Income	\$28.9	\$63.4	\$66.6	\$70.2	\$76.1	\$82.2	\$57.8	\$42.3	\$41.5	\$39.6
Operating EBIDA	\$57.7	\$58.3	\$60.4	\$63.4	\$68.1	\$72.8	\$121.1	\$123.7	\$123.3	\$122.4
Unrestricted Cash	\$10.3	\$45.0	\$91.6	\$146.6	\$208.9	\$278.1	\$301.5	\$332.8	\$360.7	\$393.7
Long-Term Debt	\$30.7	\$21.5	\$15.8	\$965.3	\$960.3	\$940.1	\$924.2	\$907.4	\$889.5	\$870.6
External Support	\$307.3	\$316.5	\$326.0	\$335.8	\$345.9	\$356.3	\$367.0	\$378.0	\$389.3	\$401.0
Profitability / Cash Flow										
EBIDA Margin	9.1%	8.9%	8.9%	8.9%	9.2%	9.4%	14.4%	14.1%	13.7%	13.2%
Excess Margin	9.8%	9.4%	9.5%	9.6%	10.0%	10.3%	6.7%	4.7%	4.4%	4.1%
Debt Service Coverage	7.10	7.41	7.82	13.23	17.03	18.73	1.91	2.10	2.12	2.12
Liquidity / Leverage										
Days Cash on Hand	7	27	54	83	113	145	142	150	158	167
Cash to Debt	33.5%	208.9%	578.4%	15.2%	21.8%	29.6%	32.6%	36.7%	40.5%	45.2%
Debt to Capitalization	81.7%	23.4%	10.4%	82.3%	77.2%	72.0%	68.6%	66.1%	63.7%	61.4%
Other										
Compensation Ratio	31.7%	32.1%	32.1%	32.0%	31.9%	31.8%	31.6%	31.8%	32.1%	32.3%
Average Age of Plant	21.9	20.2	19.6	18.9	18.3	17.9	8.5	6.3	7.0	7.6

The patient care goals from 2005 - 2014 include a commitment to care for the current market share of the area indigent and a modest annual growth (1.3%) of paying patients to assure some stability for the future of MCLNO.

Patient by Financial Class	FY 2005	FY 2014	FY 2014	FY05 to FY14 Target
	Actual	Baseline	Target	CAGR
Medicare	1,810	1,746	2,029	1.3%
Medicaid	9,576	9,236	10,735	1.3%
Pending Medicaid (MAP)	792	764	888	1.3%
Commercial	1,260	1,215	1,412	1.3%
"Paying" Patient Sub-Total	13,438	12,961	15,064	1.3%
Free Care	3,039	2,931	2,922	(0.4%)
Self Pay	6,188	5,967	5,948	(0.4%)
Prisoner	711	686	684	(0.4%)
"Non-Paying" Patient Sub-Total	9,938	9,584	9,553	(0.4%)
Total	23,374	22,545	24,617	0.6%

Campus Master Planning Process

Once a financial model was generally agreed upon, inpatient and outpatient projections were developed and a good understanding of the service area market was gained, the Planning Team began campus master planning the new facility. The volume projections, resultant occupancy targets and expected length of stay were the early indicators of the necessary patient bed complement and resulting diagnostic/treatment and support services needed. Particular emphasis was placed on shifting the care site from inpatient and hospital to outpatient and ambulatory services in response to contemporary healthcare approaches and economical use of scarce capital dollars. Room utilization was estimated for 2003 usage and then projected forward for the 2013 planning horizon based on target utilization assumptions. The Planning Team also solicited feedback from a wide spectrum of community leaders and internal stakeholders. The Team worked closely with the future users of the proposed building, MCLNO staff, to develop a department-level space program that shed additional light on the detail of the new facility. Clinic and procedure room utilization were examined by area.

The Team initiated a functional facility assessment from an architectural perspective to analyze the relative capabilities for inpatient and/or ambulatory care with regard to several of the existing campus buildings. A group of MCLNO officials and representatives of the Planning Team also visited John H. Stroger, Jr. Hospital of Cook County in Chicago, Illinois to capitalize on lessons learned during their recent completion of a facility of similar size and scope.

The balances developed indicated the need for a 560-bed tertiary-care Level I Trauma Center with 15 additional beds for clinical research activities. Further, an outpatient clinic area (whether a separate building in the North Option or the reuse of University Hospital in the South Option) would require approximately 275 exam rooms for use in 2014.

Key planning assumptions included consolidation of services and staffing efficiencies, integration of improved technology and separation of public versus staff/patient circulation. Key functional relationships that the team sought included all private patient rooms for infection control, safety and a quality experience. Maternal Child Services will be located in distinct inpatient/outpatient zones. The Emergency Department will have five zones – trauma, major acute, fast-track, pediatric and a walk-in clinic. Ambulatory services will include clinics and ambulatory surgery in one location with standardized processes. An Interventional Procedure area will co-locate interventional radiology, cardiology and surgery, and there will be a new prisoner care center for ambulatory care and inpatient access. Finally, the plan was constructed so that the new facility would meet or exceed all anticipated JCAHO and ACGME standards.

In addition, a 17,000sf clinical research unit was planned that allowed 15 inpatient and extended-stay beds, 10 outpatient treatment bays, lab processing, drug storage, metabolic kitchen and associated office space.

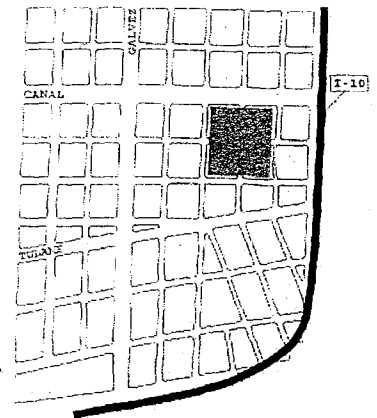
The team also identified a number of selected opportunities for innovation in the new University Hospital, including off-site registration, person-to-person medical communication, electronic medical records and bed status, point-of-care testing, ED immediate triage and room assignment, flexible OR and procedure rooms and a pediatrics unit located adjacent from the ED for staff coverage.

External to the building proper, the team developed a transportation analysis, including a review of traffic volumes, street data, sidewalk inventories and curb use utilization. The team further reviewed parking facilities and capacities, proximity of historic districts, applicable flood elevations, existing LSU property ownership and analyzed utility availability and capacity.

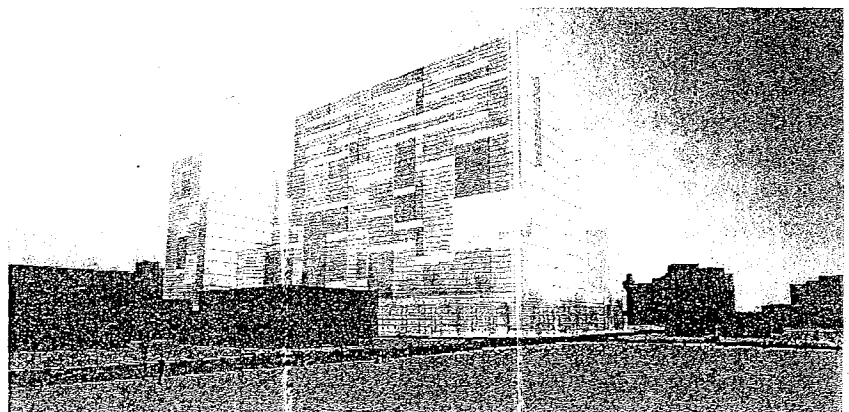
As part of an Urban Development Study, the Planning Team developed six separate urban campus development strategies that were discussed fully with the Executive Planning Committee. The goals of the recent Canal Street Corridor Study were acknowledged and taken into account in the different strategies, as well as the LSU Biotech Study. The Planning Team sees this area having the potential for a vital, urban health science and patient care district fully integrated into a revitalized commercial and residential fabric.

NORTH OPTION

Of the six urban redevelopment scenarios presented, LSU HCSD further commissioned NBBJ with fully evaluating two different sites: an area north of Tulane Avenue (North Option) and a site directly west of the existing University Hospital (South Option). The sites were evaluated through five- and ten-year development plans, building stacking diagrams and floor-by-floor block plans, the construction of a new ambulatory clinics building versus the re-use of the existing University Hospital and subsequent cost estimates.



The North Option produced a 16-floor inpatient structure with three floors of parking and an adjacent eight-floor ambulatory clinics building. In the North Option, the new ambulatory clinics building would be developed on campus in conjunction with the new inpatient facility.

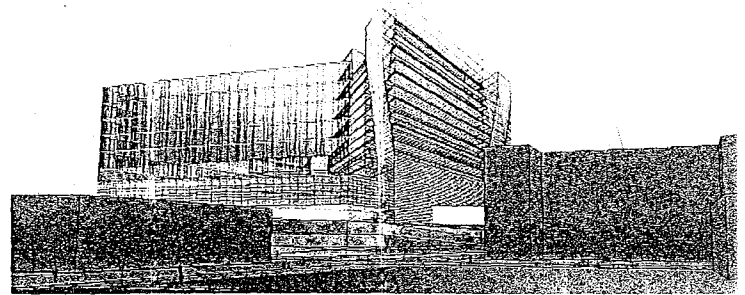


NORTH OPTION

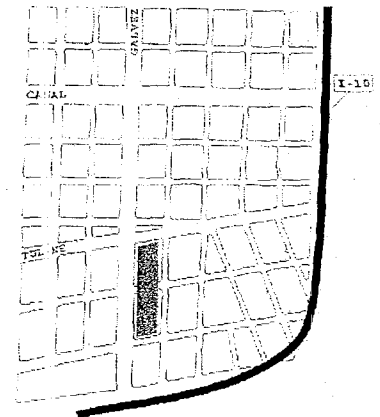
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The South Option was forced to occur on a more compact footprint, necessitating a 17-level structure on four floors of parking and a connection to the existing University Hospital. In this option, University Hospital would be renovated to house the ambulatory clinics function. In the South Option, the renovation of University Hospital would occur only after substantial completion of the new inpatient facility.

SOUTH OPTION



The Planning Team further analyzed several sites on which the new hospital could be located within the North and South Options. The sites were: south of Tulane Avenue, north of Tulane - facing Tulane and north of Tulane - facing Canal. The analysis pointed most favorably toward the location north of Tulane and facing Canal Street with regard to the following: match of cost with LSU budget, adequate area for full renewal, direct transportation access, available utilities, site acquisition cost and complexity, zoning considerations, site issues and the attractive safe location.



Project Costs and Schedule

SOUTH OPTION

Once the space programs were finalized, cost estimates for the North and South Options were developed.

For the South Option, a cost estimate of \$753.0M was developed, including the 17-story, 1.4 million sf, 560-bed hospital, an additional 330,000 sf of structured parking and support services under the hospital and 40,000sf of renovation in the existing University Hospital for ambulatory clinics use. It was generally felt that the constrained nature and location of the South Option site would provide an

image challenge for the new facility. The South Option has a lower first cost because of a greater re-use of the existing University Hospital. However, occupying the older facility will limit options for clinic design and could impact operational efficiencies, resulting in higher future operating costs.

Regarding the North Option, a cost estimate of \$775.0M was developed, including the 16-story, 1.3 million sf, 560-bed hospital, an additional 470,000sf of structured parking and support services and a 300,000sf specialty clinic/office building. It was the general consensus of the participants in the planning process that the North Option presented a better image and allowed future growth for the facility. Despite a higher first cost, the Planning Team was of the opinion that the North Option would prove to provide lower initial and long-term operating costs.

Early on in the planning process, direction was taken from LSU Health Sciences Center to pursue the South Option, and the figure of \$750.0M was subsequently presented to the 2005 State Legislature. Therefore, the capital cost estimates used in the financial plans are \$753.0 million.

The above cost figures do not include the cost of land acquisition, although MCLNO did initiate a high-level property appraisal by SRSA Commercial Real Estate of the different areas for background information. The above cost figures also do not include the provision of utilities to the site. However, the figures do include escalation of project costs at 5% per year until the baseline projected start of construction in October 2007, based on a draft construction schedule that was prepared in October 2004. The above figures also include a sitework allowance.

Construction Delivery Method

Once the nature of the facility was better understood, the October 2004 baseline schedule was amended and extended in June 2005 to allow for additional cost estimating and Owner review among the various design stages, as well as additional time in the construction schedule. Additionally, once it was understood that an authorization to proceed with the design of the new facility would not be forthcoming from the 2005 Legislature, but more likely

the 2006 Legislature, the baseline schedule was further delayed by twelve months. These changes created a later construction start date, and therefore additional escalation cost, as well as a later hospital opening date. Specifically, the construction bid date for both options in the traditional delivery approach was forwarded twenty-two months to July 2009.

The design and construction schedules for pursuing either site option are almost identical, with the exception of the renovation of University Hospital, which falls exclusively in the South Option. It would be reasonable to expect that site acquisition may be more involved in the North Option. On the other hand, the pursuit of at least a limited renovation of University Hospital in the South Option extends the overall project schedule.

With respect to the traditional design-bid-build approach incorporating linear programming, the schedule revisions resulted in approximately \$70.0M in additional escalation costs for both options. The opening date of the proposed inpatient facility in both options was moved to August 2013, and the final Owner move-in into the renovated University Hospital outpatient space (South Option) became November 2014.

	Baseline	Traditional Bid-Build with Linear Programming	
		South Option	North Option
Lump Sum Contract Award	October 1, 2007	July 20, 2009	July 20, 2009
Variance in Months from Baseline	-	(22.0)	(22.0)
Begin Operations at New Inpatient Facilities	September 15, 2010	August 13, 2013	August 13, 2013
Variance in Months from Baseline	-	(35.0)	(35.0)
Begin Operations at New Outpatient Facilities	September 15, 2010	November 6, 2014	August 13, 2013
Variance in Months from Baseline	-	(49.0)	(35.0)
Total Projected Escalation from Baseline			
	-	(70,500,000)	(73,600,000)

At Facility Planning & Control's (FP&C) request, the Team examined alternative construction delivery methods for potential time and cost savings. The Team analyzed the projected time and escalation savings between a traditional design-bid-build approach and a fast-track design and construction approach. The Team also scrutinized other potential time/cost savings factors, such as beginning the operational and space programming effort prior to the selection of a Project Architect.

With respect to the fast-track design with accelerated programming approach, the schedule revisions resulted in approximately \$50.0M in additional escalation costs for both options (a \$20.0M savings over the traditional delivery method). The opening date of the proposed inpatient facility in both options was moved to July 2012 (a time savings of over a year from the traditional approach), and the final Owner move-in into the renovated University Hospital outpatient space (South Option) became October 2013.

	Fast-Track with Accelerated Programming		
	Baseline	South Option	North Option
Lump Sum Contract Award	October 1, 2007	March 8, 2009	March 8, 2009
Variance in Months from Baseline	-	(17.0)	(17.0)
Begin Operations at New Inpatient Facilities	September 15, 2010	July 23, 2012	July 23, 2012
Variance in Months from Baseline	-	(22.0)	(22.0)
Begin Operations at New Outpatient Facilities	September 15, 2010	October 16, 2013	July 23, 2012
Variance in Months from Baseline	-	(37.0)	(22.0)
Total Projected Escalation from Baseline	-	(49,000,000)	(51,160,000)

The Planning Team recommends that LSU HCSD/FP&C initiate operational and functional programming, along with IT planning, in July 2006 after the 2006 State Legislature session ends, concurrent with site acquisition activities and incorporate a fast-track construction delivery method. When compared with the traditional approach with a later programming start, this would avoid an additional \$20.0M in escalation cost in both options and allow the new facility to open almost thirteen months earlier. Therefore, by employing this approach, the cost for the proposed facility would be approximately \$800.0M - \$825.0M, as opposed to \$825.0M - \$850.0M.

Financing Plan

Based on the cost estimates for the proposed University Hospital inpatient and outpatient facilities for the South Option at \$753.0M, the following table compares the projected 2013 financial results under the financial plan and subsequent update to Standard & Poor's (S&P) BBB rated medians:

\$ Millions	S&P BBB	MCLNO Fiscal 2013	
		Plan	Update
Net Patient Revenue		\$ 707	\$ 884
External Support		\$ 273	\$ 389
Unrestricted Cash		\$ 270	\$ 361
Long Term Debt		\$ 508	\$ 890
Debt Service Coverage	2.6x	1.9x	2.1x
Days Cash on Hand	110	138	167
Cash to Debt	71%	53%	45%

There are issues that surface when considering the project financing. The State of Louisiana has indicated that any financing for the proposed hospital must be independent of the state debt cap. Even though the projected 2013 results

above compare favorably to the S&P medians, the sheer amount of the financing and the resulting 2008 - 2009 financial profile would make stand-alone financing a challenge.

It would appear that the best financing option for LSU HCSD would be FHA-insured financing through the HUD 242 program. The chief challenge in pursuing HUD 242 financing would be the customary requirement for 10% equity contribution from its borrowers. LSU HCSD should retain a qualified financial adviser/investment banker to assist in evaluating future choices.