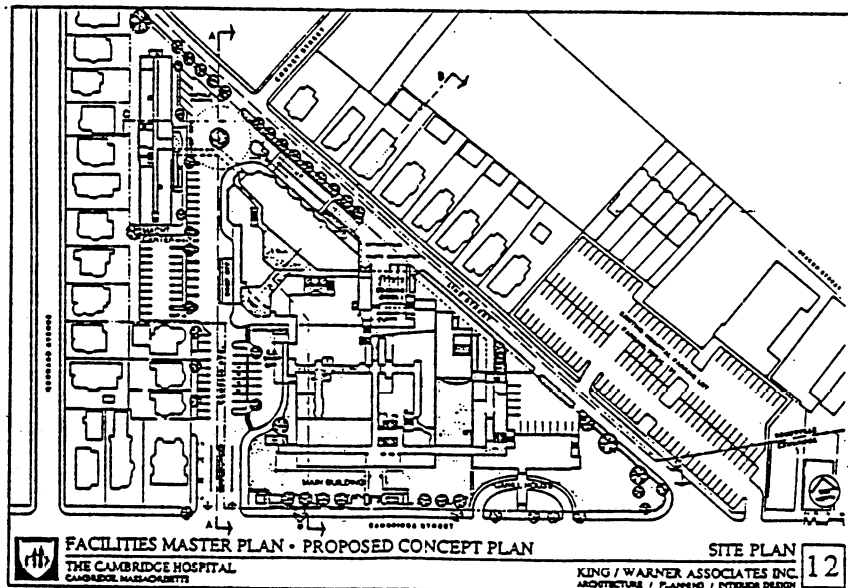


The Cambridge Hospital

FACILITIES MASTER PLAN CHRONOLOGY

" Although we are still dependent on the City for a portion of our operating budget, our deficit has decreased substantially over the past five years, and from a fiscal perspective we are healthier than ever. Through all our years of change, our mission of serving the community, of providing advanced, high quality, compassionate care, has remained the same. Given we intend to serve the community for many years to come, we have started to plan for our future with this Facilities Master Planning process."

- John G. O'Brien



Site plan showing location of new building.

June 1990 Chiefs of Service, Board and administrators attend planning meeting. Discuss need for improved space for ambulatory services. Dr. David Link, Chief of Pediatrics, motions to build an ambulatory building. It is unanimously accepted and discussion of potential facilities concepts begins.

"Cambridge is showing some successes that aren't being replicated by other municipal hospitals...I think anyone in the hospital business who is able to keep their hospital going at all is something approaching a management wizard, and that's especially true of the municipals." - Robert Downing, spokesperson, Massachusetts Hospital Association, Cambridge Chronicle

June 1990 - Feb. 1991 Hospital develops program statements that document volume projections and space needs for each ambulatory service. King/Warner Architects explores potential building sites on hospital campus.

February 1991 Strategic Planning Meeting culminates in presentation of facilities direction with new ambulatory building and parking garage on site of existing boiler plant.

July 1991 The Cambridge Hospital reports surplus for fiscal year ending June 30, 1991, for first time in its 73-year history.

September 1991 Facilities Master Planning process formally launched. Plan will address facilities directions for main hospital campus including a new building for ambulatory services and renovations to existing services. Steering Committee and four subcommittees-- *Strategy and Program, Building, Finance, and External Relations* - are charged.

February 1992 City Councillors meet with hospital administrators to review progress of facilities master planning process.

March 1992 City Manager appoints Community Advisory Committee for Hospital Facilities Plan (CAC), composed of 10 residents of neighboring streets in Cambridge and Somerville.

Fifty members of City leadership, medical staff, Board, and hospital administration attend off-site Facilities Planning retreat. Review Facilities Master Plan project which has evolved after

"Current shortages of space have been causing programs to be capped in size, and have created long delays in patient scheduling...the new space has been programmed to provide greatly improved integration of care across services and within specialties." - Steven T. Lacy, MD, Chair, Strategy and Program Subcommittee

May 1992 Hospital representatives present facilities project at annual meeting of Mid-Cambridge Neighborhood Association (MCNA).

June 1992 Town Meeting held at Hospital to present building project to hospital staff.

Meeting of City Council Subcommittee on Health and Hospitals. Public Notices printed in Cambridge Chronicle and Boston Globe about Hospital's intention to file application to State Determination of Need (DON) office.

July 1992 Hospital reports surplus for second year in row. Ernst & Young begins financial feasibility study of Hospital Facilities Project.

Hospital files DON application with State Department of Public Health for project with maximum capital expenditure of \$57M.

Project includes development of six-story ambulatory building, three-level underground parking garage, two-level addition onto main building, and renovation of existing services.

"The design is based on projections that ambulatory care will increase from 104,981 now to 268,255 patients in the year 2000, or 4.7% a year, and that discharges will go from about 6200 patients a year to 7140... department heads say they need at least 25% more space just to continue with existing services." - Cambridge Chronicle

Environmental Notification Form filed with State Office of Environmental Affairs.

Hospital convenes informational neighborhood meeting in Macht auditorium. Cambridge and Somerville residents in attendance.

"John O'Brien, the Hospital Administrator, acknowledged that the work will be a major imposition on nearby residents, but promised that City and Hospital officials will work with them to make things as bearable as possible." - Cambridge TAB

Seven Ten Taxpayer Groups file with State DON Office, representing the following constituencies: Hospital Governing Board, Hospital medical staff (2 groups), Cambridge and Somerville residents (3 groups), and the Pine Street Inn of Boston.

August 1992 State Office of Environmental Affairs reviews Hospital project at public meeting. It is determined that a full Environmental Impact Report will not be required.

September 1992 Hospital is one of forty-nine hospitals nationwide awarded "distinguished recognition" in the Hospital Community Benefits Standards Program.

October 1992 Neighbors at Mid-Cambridge Neighborhood Association Meeting (MCNA) endorse resolution to reduce size of project to scale more compatible with surrounding residential area:

"The MCNA supports the core mission of the Cambridge Hospital of providing access to quality health care to all Cambridge residents, regardless of their ability to pay, and recognizes the need for the Hospital to modernize. However, unanswered questions and concerns about neighborhood and financial impacts, future state and national health care policy and the apparent breadth of the Hospital's program cause us to oppose any expansion which exceeds the floor area permitted by current zoning on the site."

MCNA also convenes study committee to develop more detailed recommendations.

Ernst & Young presents preliminary findings of Financial Feasibility Study to Steering Committee and Governing Board. Based on E&Y's recommendations and MCNA motion, Strategy and Program subcommittee charged with developing downsized project in next sixty days.

November - December 1992 Project downsized to approximately \$40M project cost.

December 1992 City Council Subcommittee on Health and Hospitals meets to discuss Hospital Facilities Master Plan. Medical staff members Katharine Kosinski, MD, Tom Workman, MD, and David Bor, MD and Board Chairperson Richard de Filippi, PhD, speak to need for project. Ernst & Young presents results of Financial Feasibility study. Many community members present.

Meeting scheduled to reconvene in early 1993.

"Based upon the volume and financial forecast, it appears the Hospital can support the proposed Project as currently configured. Therefore we recommend that management continues their building program planning efforts." - Ernst & Young Financial Feasibility Study

January 1993 Request for Proposal for Design Services available for Prospective Applicants.

City/Hospital holds briefing for prospective applicants for design services. City Manager charges Design Selection Committee.

February 1993 Informational presentation of Hospital Project to Mid-Cambridge Neighborhood Conservation District Commission.

Meeting of City Council Subcommittee on Health and Hospitals for continued discussion of Hospital project. Informational meetings and hospital tours for individual City Councillors.

Community Advisory Committee meeting with expanded membership (6 new MCNA members).

Proposals for Design Services due.

March 1993 Public meeting to discuss Project.

April 1993 City Council meeting to approve Hospital project and authorize loan.

Future purview of Determination of Need process outlined in report of HosPAC Commission.

Contract Awarded for Design Services. Hospital begins schematic design, design development, and construction documentation.

Hospital continues to work closely with Community Advisory Committee and working subcommittees (e.g. Design Review, Traffic & Parking, Construction).

Future approvals will include: MCNCDC review, BZA variance, possible DON public hearing/approval, relief on parking freeze.

December 1994 Scheduled date for Groundbreaking based on December 1992 implementation plan.

THE CAMBRIDGE HOSPITAL
Financial Feasibility Study

Cambridge City Council
Subcommittee of Health and Hospitals
Presentation

December 18, 1992

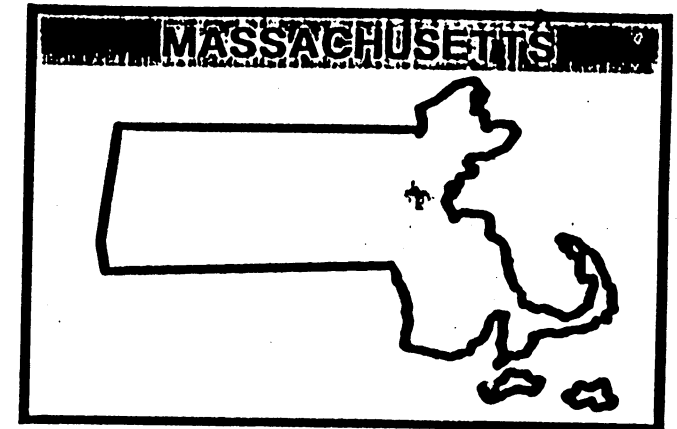
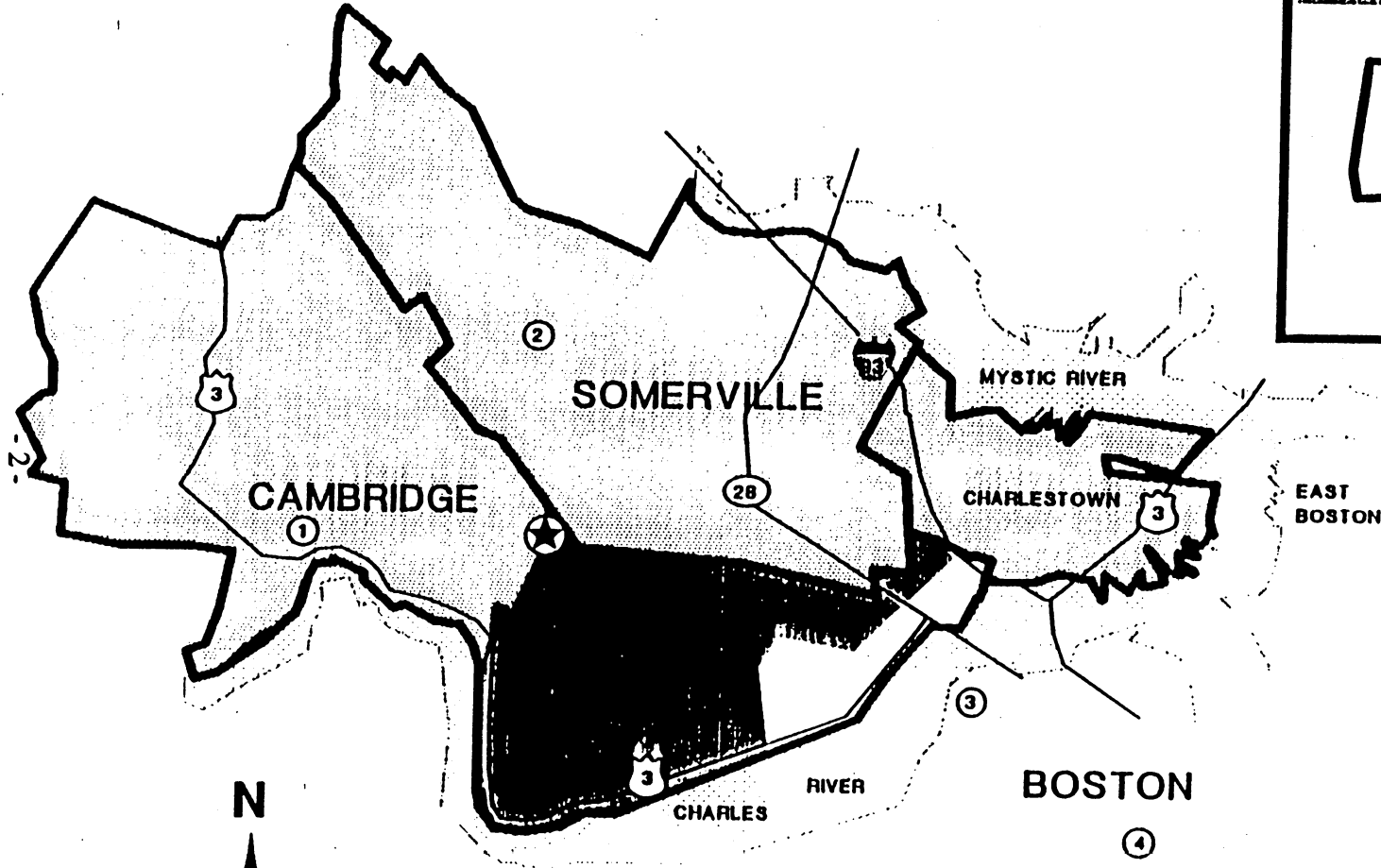
 **ERNST & YOUNG**

THE CAMBRIDGE HOSPITAL Financial Feasibility Study

Demand Methodology Overview

- **Define Hospital service area**
- **Define Hospital services**
 - **Age**
 - **Diagnosis/Service**
- **Review historical trends in:**
 - Use-rates -- Service area patient discharges from all hospitals per 1,000 population**
 - Market Share -- Percentage of total hospital discharges from Cambridge Hospital.**
- **Assess internal and external factors:**
 - **Anticipated environmental changes**
 - **Medical staff structure and support**
 - **Program plans**
 - **Competitor initiatives**

**THE CAMBRIDGE HOSPITAL
FINANCIAL FEASIBILITY STUDY
SERVICE AREA DEFINITION**



KEY

- CAMBRIDGE HOSPITAL
- MT. AUBURN HOSPITAL
- SOMERVILLE HOSPITAL
- MASS GENERAL HOSPITAL
- NEW ENG. MEDICAL CENTER
- PRIMARY SERVICE AREA
- SECONDARY SERVICE AREA
- TOWN LINES
- MAJOR HIGHWAYS



**THE CAMBRIDGE HOSPITAL
Financial Feasibility Study**

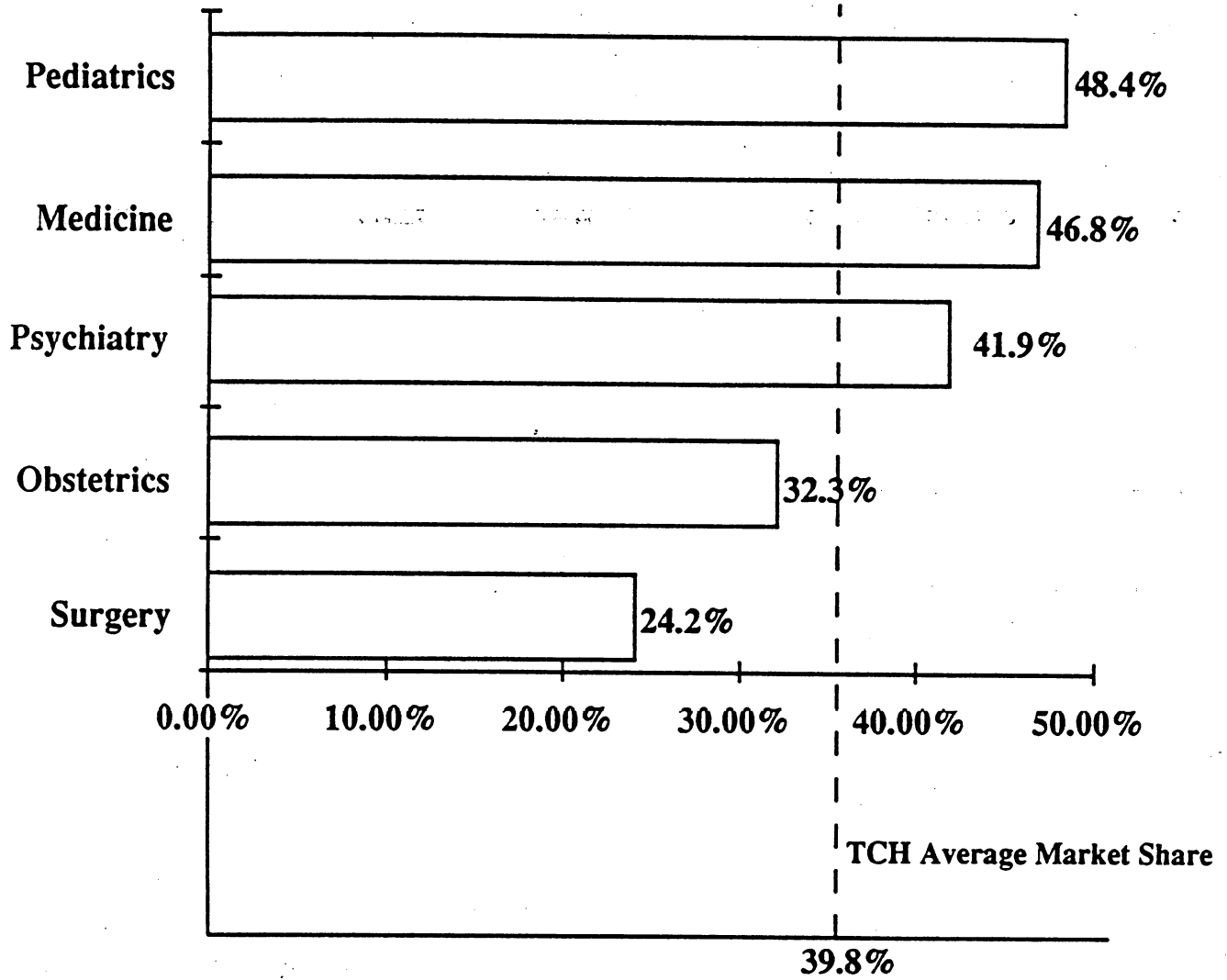
Population Trends, by Age Group

	<u>1980</u>	<u>1990</u>	<u>% Change 1980-1990</u>	<u>2000</u>	<u>% Change 1990-2000</u>
PSA					
0-14	6,273	5,074	(19.1%)	4,689	(7.6%)
15-44	25,701	24,726	(3.8)	20,288	(17.9)
45-64	6,643	7,010	5.5	11,019	57.2
65+	<u>4,792</u>	<u>5,774</u>	<u>20.5</u>	<u>5,742</u>	<u>(0.5)</u>
Total	<u><u>43,409</u></u>	<u><u>42,584</u></u>	<u><u>(1.9)</u></u>	<u><u>41,738</u></u>	<u><u>(2.0)</u></u>
SSA					
0-14	21,018	16,557	(21.2%)	16,032	(3.2%)
15-44	78,973	85,890	8.8	70,857	(17.5)
45-64	24,368	17,781	(27.0)	30,427	71.1
65+	<u>18,290</u>	<u>23,722</u>	<u>29.7</u>	<u>24,545</u>	<u>3.5</u>
Total	<u><u>142,649</u></u>	<u><u>143,950</u></u>	<u><u>0.9%</u></u>	<u><u>141,861</u></u>	<u><u>(1.5%)</u></u>

Source: Metropolitan Area Planning Council (MAPC)

THE CAMBRIDGE HOSPITAL Financial Feasibility Study

PSA Market Share — 1990



THE CAMBRIDGE HOSPITAL Financial Feasibility Study

Physician Interview Summary

Key Issues:

- High level of commitment and support
- Identified Strengths:
 - Unique mission
 - Medical staff
 - Top administration
- Identified Weaknesses:
 - Physical plant
 - Attitudes
 - Parking
- Image
- Optimistic About Growth
- Supportive of Project

THE CAMBRIDGE HOSPITAL
Financial Feasibility Study

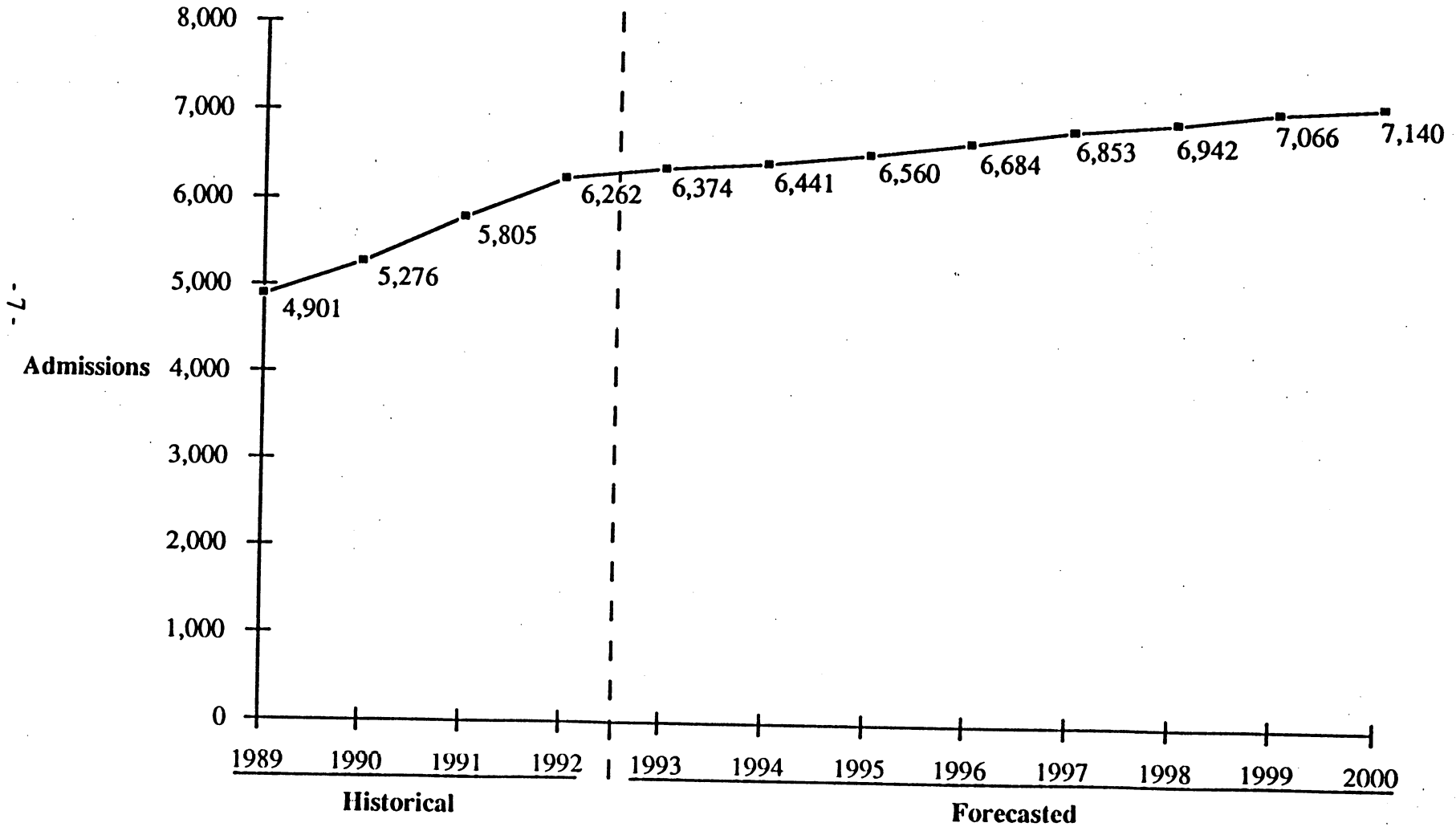
Outpatient Volume Projections

	<u>1987</u>	<u>1992</u>	<u>1987-1992</u> <u>Annual %</u> <u>Change</u>	<u>Revised</u> <u>Forecast</u>	<u>1992-2000</u> <u>Annual %</u> <u>Change</u>
Emergency	20,442	24,036	3.3%	30,255	2.9%
Psych Emergency	1,911	3,626	13.7%	6,000	6.5%
NHC's	25,428	46,193	12.7%	61,000	3.5%
Ambulatory Care Building					
Women's Health	2,229	4,723	(8.9%) (A)	5,800	2.7%
CDC	927	1,169	4.7%	1,600	4.0%
Primary Care Center	10,606	14,042	5.8%	20,700	5.0%
Cambridge Pediatrics	5,537	8,361	8.6%	15,000	7.6%
Pediatric Specialties	1,538	362	(25.1%)	1,000	13.5%
Child Psych		972		2,500	12.4%
Zinberg		3,531		12,500	17.1%
Med Specialties	3,178	15,407	8.8% (A)	18,700	2.5%
Surgical Specialties	10,538	17,908	15.0% (A)	27,200	5.4%
Cardiology		<u>5,000</u>	5.0% (A)	<u>8,000</u>	6.1%
Subtotal	<u>34,553</u>	71,475		113,000	5.9%
Macht Building	19,074	34,104	12.3%	50,000	4.9%
Outpatient Addiction	2,417	4,135	11.4%	5,000	2.4%
SDC	1,156	1,962	11.2%	3,000	5.5%
Total	<u><u>104,981</u></u>	<u><u>185,531</u></u>	12.1%	<u><u>268,255</u></u>	4.7%

(A) Reflects 1992 - Budgeted 1993 growth as
1992 data includes estimates of private patients

THE CAMBRIDGE HOSPITAL Financial Feasibility Study

Historical and Forecasted Inpatient Discharges



Note: Discharges excluding newborns

THE CAMBRIDGE HOSPITAL

Financial Feasibility Study

Financial Statement Preparation Methodology

Demand

Net Revenue

- Payor Mix
- Reimbursement by Payer
- Other Operating Revenue
- Bad Debt/Free Care Uncompensated Care Receipts

Operating Expenses

- Historical Analysis by Cost Center
- Function Areas: Salaries; Fringes; Supplies; Physician Compensation
- Fixed/Variable Relationships

Capital Expenses

- Existing Long Term Debt
- Project Costs
- Project Financing
- Normal Capital Additions

Financial Statements/Cash Flow

- Balance Sheet Analysis
- Transfer from City
- Project Funds Flow

THE CAMBRIDGE HOSPITAL
Financial Feasibility Study

Preliminary Financial Forecast

	Historical	Forecasted			
	1992 (000's)	1994 (000's)	1996 (000's)	1998 (000's)	2000 (000's)
Net Revenue	\$69,271	\$77,218	\$87,714	\$100,885	\$115,078
Expenses					
Operating Expenses	65,488	73,563	83,939	95,719	107,544
Depreciation and Amortization	<u>2,556</u>	<u>3,502</u>	<u>4,571</u>	<u>6,411</u>	<u>7,274</u>
Operating Income (Loss)	1,227	153	(796)	(1,245)	260
Interest Expense	933	683	787	1,552	1,402
Non Operating Revenue	<u>-</u>	<u>969</u>	<u>986</u>	<u>1,009</u>	<u>1,420</u>
Net Income (Loss) Before Operating Transfers	294	439	(597)	(1,788)	278
City Transfer	<u>9,003</u>	<u>8,822</u>	<u>8,822</u>	<u>8,822</u>	<u>8,822</u>
Net Income	<u>\$9,297</u>	<u>\$9,261</u>	<u>\$8,225</u>	<u>\$7,034</u>	<u>\$9,100</u>

THE CAMBRIDGE HOSPITAL
Financial Feasibility Study

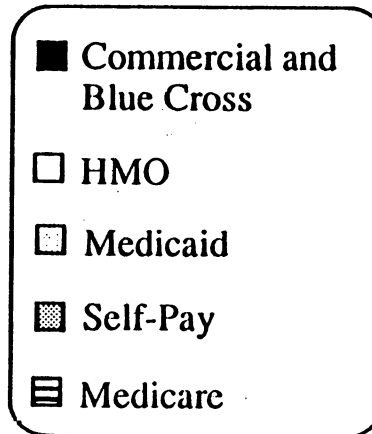
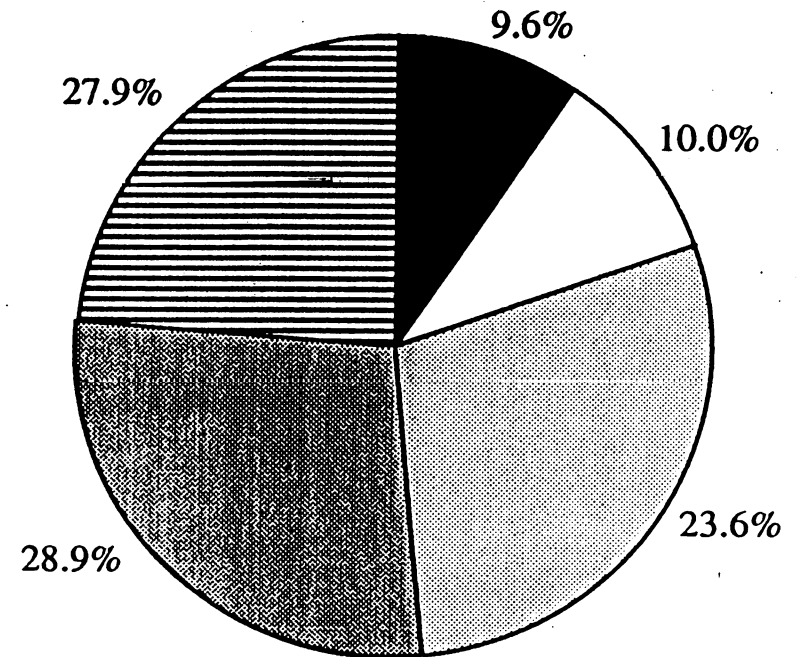
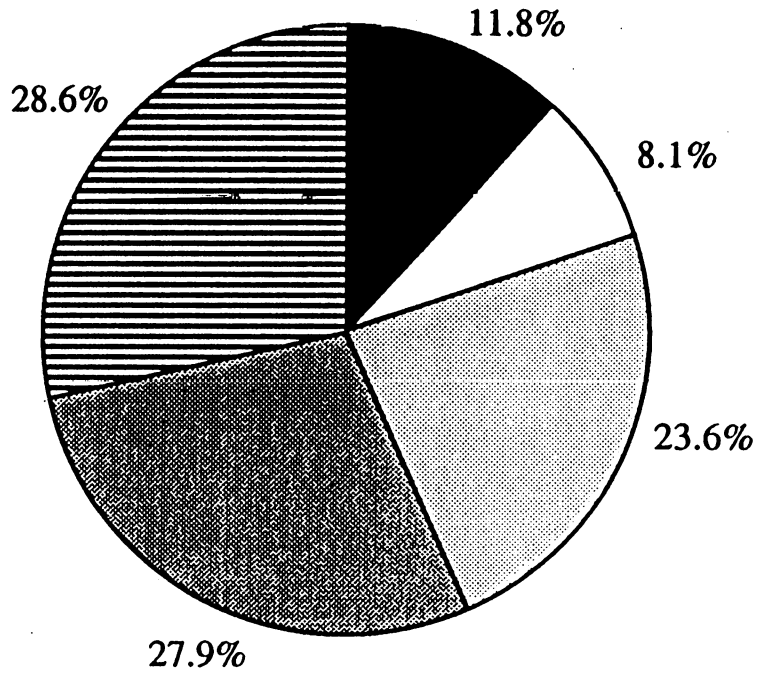
Cash Balances Reflect City Transfer

	<u>Cash</u> (000's)	<u>Due from Other Funds</u> (000's)
Historical		
1989		\$ 3,550
1990		1,155
1991	\$14,563	3,037
1992	9,742	14,828
Estimated		
1993	10,552	20,000
Forecasted		
1994	17,142	20,000
1995	21,754	14,536
1996	26,810	6,373
1997	32,883	722
1998	39,166	124
1999	46,527	--
2000	54,965	--

(A) Reflects amount in cash plus due from other funds

THE CAMBRIDGE HOSPITAL
Financial Feasibility Study

Payor Mix - Gross Revenue



THE CAMBRIDGE HOSPITAL Financial Feasibility Study

Significant Revenue and Expense Assumptions

Patient Service Revenue

- Primarily paid on a per discharge/day basis.
- Payment per discharge increased annually as follows:

Medicare and Medicaid	2.5 - 3.7%
HMOs	4.5 - 5.0%
Commercial Payers	5.0 - 6.0%

- Uncompensated care pool receipts increased as a function of volume and inflation.

Other Operating Revenue

- Other operating revenue declines due to decreased funding from DMH.

Non Operating Revenue

- Interest earnings on cash balances of 3% annually.

City Transfer

- Maintained at gross level of \$8.8 million annually.
- Net transfer declines slightly.

THE CAMBRIDGE HOSPITAL
Financial Feasibility Study

Significant Revenue and Expense Assumptions

Operating Expenses

- Non-physician FTE's increased from 889 in 1992 to 1,041 in 2000.
- Salary increase — 4% annually.
- Fringes — Increased from 21% of salary expense to 27% of salary expense.
- Supplies and Other — split into fixed/variable with variable inflated 4% annually and fixed inflated 6% annually.
- Physician compensation increase — 6% annually.

**THE CAMBRIDGE HOSPITAL
Financial Feasibility Study**

Staffing Levels

	Historical	Forecasted				
	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1996</u>	<u>1998</u>	<u>2000</u>
FTE's (Ex. MD's)	889	950	946	980	1020	1041
Per Occupied Bed	7.03	7.07	7.14	7.25	7.34	7.35
Per Adjusted Occupied Bed	4.91	4.82	4.83	4.85	4.83	4.75
FTE's (Inc. MD's)	956	1016	1024	1047	1087	1109
Per Occupied Bed	7.54	7.56	7.73	7.75	7.83	7.84
Per Adjusted Occupied Bed	5.26	5.16	5.23	5.18	5.15	5.06

THE CAMBRIDGE HOSPITAL Financial Feasibility Study

Significant Revenue and Expense Assumptions

Capital Expenses

- Existing long-term debt paid off by 2000.
- Normal capital additions equal \$43 million between 1993-2000.
- Project debt — 20 year term; 7% interest rate; 5% earnings rate.

**THE CAMBRIDGE HOSPITAL
Financial Feasibility Study**

Proposed Financing Plan

Source of Funds (in 000's)

Bond Proceeds	\$19,252
Equity - Hospital Enterprise Fund	<u>20,000</u>
Total	<u>\$39,252</u>

Uses of Funds (in 000's)

Site Development, Ambulatory Care Building, Parking Garage	\$15,309
Renovations - Emergency Room, Laboratory, Labor and Delivery	14,488
Renovations - Surgical suite, ICU, Macht building, Routine care areas	<u>7,557</u>
	37,354
Net Capitalized Interest	1,233
Financing Fees	<u>665</u>
Total	<u>\$39,252</u>

**THE CAMBRIDGE HOSPITAL
Financial Feasibility Study**

Non-Project Capital Additions

Historical

1989	\$ 2,779
1990	13,283
1991	4,959
1992	5,930

Estimated

1993	8,208
------	-------

Forecasted

1994	3,000
1995	5,500
1996	5,250
1997	4,625
1998	5,125
1999	5,625
2000	6,125

1993—2000	\$43,458
-----------	----------

THE CAMBRIDGE HOSPITAL
Financial Feasibility Study

Significant Revenue and Expense Assumptions

Balance Sheet

- Days in A/R — 1992 level of 60 days.
- Due from other funds reflect project equity.
- Accrued salary — 1992 level of 8.5% of salary and fringes.
- Accounts payable — 1992 level of 12.2% of other operating expenses.
- Due to third party reduced to reflect payments from uncompensated care pool and third party settlements.

THE CAMBRIDGE HOSPITAL Financial Feasibility Study

Risk Factors

- **Volume**
- **Productivity**
- **State and Local Government Funding**
- **Project Delays and/or Modifications**
- **Management Retention**

THE CAMBRIDGE HOSPITAL
Financial Feasibility Study

Controlling Risk

- **Project Phasing**
- **Physician Hospital Organization (Part B Billings)**
- **Salary Increases - Productivity Improvements**
- **Case-Mix Intensity Management**
- **Hospital Affiliations/Negotiations**
- **State Lobbying Efforts**

**THE CAMBRIDGE HOSPITAL
Financial Feasibility Study**

Sensitivity Analysis

	<u>Annual Impact</u>	
	<u>1994</u>	<u>2000</u>
	<u>(000's)</u>	<u>(000's)</u>
<u>Expense Reduction:</u>		
Salary Increase 1% Reduction	<371>	<3,795>
Physician Compensation 1% Reduction	<96>	<1,109>
Fixed Supplies 1% Reduction	<56>	<590>
Variable Supplies 1% Reduction	<65>	<703>
<u>Revenue Enhancement:</u>		
Medicare Case Mix Index 1.16 — 1.25		1,178

THE CAMBRIDGE HOSPITAL

Financial Feasibility Study

Financial Ratios Comparison

	<u>Cambridge Hospital</u>			<u>S&P</u> <u>"AA" Rated</u> <u>1990</u>	<u>S&P</u> <u>"AA" Rated</u> <u>1991</u>	<u>MHA</u> <u>1990</u>	<u>Desired</u> <u>Position</u>
	<u>1991</u>	<u>1992</u>	<u>2000</u>				
Capital Structure Ratios							
Debt Service Coverage	4.15	4.22	6.57	3.40	3.38	2.31	Higher
Long Term Obligations to Capitalization	27.1%	19.3%	13.0%	N/A	33.3%	N/A	Lower
Fixed Asset Financing	54.2%	41.3%	26.2%	63.9%	61.6%	71.4%	Lower
Long Term Obligations to Equity	42.8%	28.8%	16.9%	61.3%	N/A	105.2%	Lower
Profitability Ratios							
Operating Margin	.2%	.5%	.3%	3.1%	5.1%	.4%	Higher
Excess Margin	17.6%	14.8%	8.7%	N/A	7.8%	1.9%	Higher
Capital Expense	6.3%	5.9%	9.1%	9.0%	10.7%	N/A	Lower
Liquidity Ratio							
Days Cash on Hand	103.88	60.64	71.25	27.70	134.51	11.40	Higher
Days in Accounts Receivable	62.90	60.19	60.03	77.11	79.69	72.79	Lower

THE CAMBRIDGE HOSPITAL

Financial Feasibility Study

Definitions:

Debt Service Coverage — Excess revenues over expenses plus depreciation and interest/principal and interest.

Long Term Obligations to Capitalization — Long term liabilities/total liabilities and fund equity.

Fixed Asset Financing — Long term liabilities/net fixed assets.

Long Term Obligations to Equity — Long term debt/equity.

Operating Margin — Net income before transfer/net revenues.

Excess Margin — Excess of revenue over expenses/total revenue.

Capital Expense — Depreciation and interest/total expense less depreciation and interest.

Days Cash on Hand — Cash/operating expenses minus depreciation/365

Days in Accounts Receivable — Accounts receivable/net revenue/365

City of Cambridge

The Health and Hospital Committee held a public meeting on February 3, 1993, beginning at 8:00 a.m. in the Sullivan Chamber, City Hall, for the purpose of continuing discussion of the Cambridge Hospital facilities master plan. Present at the meeting were: Councillor Francis H. Duehay, Chair of the Committee; Councillor Sheila T. Russell; Councillor Walter J. Sullivan; Councillor Timothy J. Toomey, Jr.; Councillor William H. Walsh; Councillor Alice K. Wolf; Dr. Melvin Chalfen, Commissioner of Health and Hospitals; City Manager Robert W. Healy; Richard de Filippi, Chair of the Hospital Governing Board; and John O'Brien, Hospital Administrator.

Councillor Duehay convened the meeting and explained that this was a continuation of the December 18, 1993 meeting. He then introduced City Manager Robert W. Healy who updated the committee on the ongoing design process. He has a ten person design selection committee who will review the design proposals and complete their selection process. By the middle of March he hopes that an architect has been proposed and that he can come to the Council with a request for an appropriation so that he can sign a design contract in April. At the same time the Neighborhood Advisory Committee has been meeting and making good progress.

Councillor Wolf asked about the determination of need process at the state. John O'Brien said that the entire determination of need process is going through major changes, with new applicable laws. It is not clear that a determination of need will be required, but there is not expected to be any delay on account of this process.

At this point, John O'Brien introduced Cambridge Hospital administrative staff, medical staff and Board members in attendance and outlined the history of the facilities planning process. This history is summarized in the attached Facilities Master Plan Chronology.

John O'Brien noted that the process of meeting with the community has become more intensive. Key issues that have emerged are traffic and parking and construction impacts. The Community Advisory Committee, in conjunction with the Mid-Cambridge Neighborhood Association, has suggested additional community members and additional technical support to the advisory group. The hospital staff is committed to a process which results in community support. If the loan authorization and selection and approval for the architect all go on schedule, the construction would commence in late 1994.

Councillor Wolf asked whether the community process involved input from consumers, for example, hospital users. John O'Brien

said that such a forum had not been developed, although feedback from hospital users is presented to the Board on a quarterly basis. Councillor Wolf suggested that consumer input could be useful.

John O'Brien then introduced Linda Chin, Associate Administrator for Planning and Marketing. Ms. Chin said that the design proposals, in response to the request for proposals (RFP), are due tomorrow. The RFP was a very rigorous one. A great deal of emphasis has been placed on demonstrated experience working with community members on such issues as design review and construction impact.

The downsized project is a \$40 million capital expenditure. Originally it was conceived as a \$57 million dollar project. Downsizing occurred as a result of the financial feasibility study and input from Mid-Cambridge Neighborhood Association. With the downsizing, the building will be 312,000 square feet. It would need to be 308,000 to not require a variance in the floor area ratio (FAR), so in addition to the variance for nonconformity, they will be seeking a variance for FAR. The new plans have cut the building two stories and reduced one level of parking.

Ms. Chin then summarized the functional configuration and design improvements in the new plan, such as a new integration of women's health care services, improvements in the intensive care units and improvements to privacy for patients. She explained the decisions involving the underground parking. Patient parking is necessary and the underground parking will assist in preserving neighborhood aesthetics. Ms. Chin noted that the project is very tightly designed.

Dr. Kathy Kosinski noted that the issue of privacy is raised now by patients on a daily basis. These issues are addressed in all of the aspects of the space renovations.

Carol Cerf, Health Policy Board, said that the hospital is currently unable to serve all the physical therapy patients who need care because there is no space. Margaret Coleman, physician in the Pediatrics Department, said there is currently a six week wait for these services.

Barbara Ackermann, Health Policy Board, said that it is hard to get surgeons to come to the Cambridge Hospital because there are space issues with the surgical floor and related back up space. Space is needed to keep attracting good physicians. Robert Healy said that there are currently excellent physicians who are on staff believing that there will be improvements. It is important to reinforce the support and faith they have shown by moving forward on this plan in the timeframe that has been established.

Margaret Coleman said that the physical plant has been a major impediment to attracting and retaining HMO and insured patients. Councillor Duehay asked what proof there was that HMO and insured patients would select Cambridge Hospital, even after improvements. John O'Brien said that currently 30% to 40% of City of Cambridge employees select Cambridge Hospital. He added that with managed care, individuals will have less choice over where they get their care. Councillor Duehay said that he believes this will require enormous negotiation efforts at many levels to assure that Cambridge Hospital gets these insured patients; improvement of facilities will not be enough.

Councillor Wolf asked how Cambridge Hospital is positioning itself to compete in a managed care environment. John O'Brien said that there will be much more networking with other hospitals to provide community care. He expects that over the next three years, there will be a transition to capitate rates. Cambridge Hospital is well positioned for that change, although in the short term there will be issues because the payors' focus will be cost containment. In the year 2000, the hospital's debt will be similar to what it is today.

Councillor Wolf asked what is going to happen during the construction phase. What will be the fiscal effects and the effects on the public vis a vis competition. John O'Brien said that the parking and new addition will be constructed in eighteen months and that will open the facility up for new patients.

Dr. Steve Lacy said that the issue of phasing is a worrisome issue. There has been some remodeling and there will be additional evening hours and other accommodations to try to keep volume up during construction.

Councillor Wolf asked whether the number of substance abuse beds are adequate. John O'Brien said that that issue is being watched carefully. David Bor, Acting Chief of Medicine, said that it is unclear what model the third party payors will be interested in. They are going in two different directions: hospitalization for those medically impaired and ambulatory services for those needing only de-tox services. Laurie Berry, Ambulatory Care, said that there is increased interest by payors in having "simple" detox occur outside of hospitals.

In response to a question by Councillor Toomey regarding parking, Linda Chin said that 200 spaces are proposed in the underground parking facility, an addition of 77 spaces over the current 123. The hospital will need relief from the parking freeze. If that is not granted, additional off-site parking will have to be worked out. John O'Brien said that the hospital has made a commitment to the community that people who don't have to

park on site will not. Right now there are 75 spaces off site. Negotiations with employees will commence shortly to increase this number. He added that the hospital wants to offer incentives to employees to not park on site and to look at utilizing the shuttle system for patients.

Councillor Duehay said that he encouraged a separate meeting at a later time on these issues. He asked Robert W. Healy to comment on Councillor Toomey's question. Mr. Healy outlined the city's plans to work with City unions and employees on positive approaches to encourage the use of public transportation. Parking control resources will be devoted to enforcing current restrictions to ensure that traffic issues are not exacerbated by violations.

Councillor Duehay asked about the issue of competition from Mount Auburn Hospital. John O'Brien said that Mount Auburn's purchase of a building in Watertown signals their intention to seek more market share in Western suburbs. Cambridge Hospital's markets are in Cambridge and Somerville.

Councillor Wolf asked about the free-care pool. John O'Brien said that Cambridge Hospital has had great support around the disproportionate share payments. Bob Cooper, Associate Administrator of Fiscal Services, said that in the last 5-6 years, with strong support from the Cambridge delegation of state legislative representatives, these payments have increased. The rate setting commission has recently finalized regulations relating to medicaid payments for disproportionate share hospitals. Cambridge has been allocated 26% of the \$11 million dollars set aside for this purpose. Also physician free care payments will be funded from a pool set up to cover these costs for the first time ever. Cambridge has been allocated about \$660,000 from a \$2 million dollar pool. Barbara Ackermann noted that when health care goes further in the direction it is heading, there will not be any disproportionate share programs.

Councillor Wolf moved that the matter be referred back to the City Council with the recommendation that a public hearing be held in the near future. The motion passed on a unanimous voice vote. Councillor Duehay noted that the hospital staff will be arranging for City Council members to have a tour of the facilities in the near future.

Councillor Duehay congratulated the hospital staff and Board on all of the hard work that has gone into this process. He said that the City Council and the city is very proud of the improvements and achievements of the Cambridge Hospital.

Thereupon Councillor Duehay requested of Paul Hollings, Administrator of Neville Manor, an update on Neville Manor. John

O'Brien introduced Paul Hollings and noted the excellent job Mr. Hollings has done in dealing with some very serious issues at Neville Manor. Paul Hollings said that Neville Manor experienced a good budget surplus last year, primarily on account of old collections. This year Neville Manor will go overbudget about \$500,000 and will seek a transfer from its previous surplus. There has been an improvement of air quality through major renovations of heating, ventilation and air conditioning, with boiler house renovations and water heater improvements, for a total of 1.3 million. The roof and windows still need to be addressed. This project will include masonry repairs and electric door additions for a total of \$700,000. There is \$200,000 left from the board appropriation.

Paul Hollings described the reorganization of the nursing organizations. There is a conversion to a nurse manager organization so that each unit has a manager. This is a major change and an important way to improve the quality of service. There have been many other operational changes but this is the most exciting.

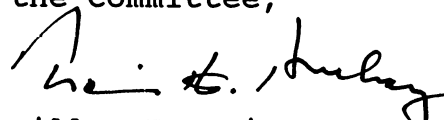
Robert W. Healy said that although this request will include some non-recurring funds to address operating expenses, it makes sense at this time in view of the changes to operations. Mr. Healy noted that there is still the danger of the loss of the public institution rate.

Councillor Sullivan noted that Neville Manor has greatly improved.

Councillor Toomey asked about nursing home closings. Paul Hollings said that Harvard Manor and Clarendon Hill in Somerville are both closing. Neville Manor is accepting residents from both. At present, there is no waiting list at Neville Manor but all beds are filled. In the future, nursing homes will be required to care for more sub-acute patients and Neville Manor is well-positioned to care for such patients.

Councillor Duehay thanked all those present for their attendance. The meeting was adjourned at 10:05 a.m.

For the Committee,



Councillor Francis H. Duehay
Chair

1.

COMMITTEE REPORTS

S-75

Report from the Health and Hospital
Committee for hearings held on Dec. 18,
1992 and Feb. 3, 1993 regarding the
Cambridge Hospital facilities master
plan.

In City Council,

February 8, 1993

*Report accepted
&
placed on file
Mayor to schedule
hearing in March, 1993*