UMC
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MEDICAL CENTER

Monthly Board Meeting Date: March 26, 2025

2025 Fiscal Management Board of Directors

Angell Jacobs, Chair
Girume Ashenafi
Dr. Malika Fair, MD
Donita Reid-Jackson
Robert Bobb
Wayne Turnage
Dr. Jacqueline Payne-Borden
Dr. Mina Yacoub, MD

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THE NOT-FOR-PROFIT HOSPITAL CORPORATION
FISCAL MANAGEMENT BOARD OF
DIRECTORS NOTICE OF PUBLIC MEETING

ANGELL JACOBS, BOARD CHAIR

The monthly Governing Board meeting of the Board of Directors of the Not-For-Profit Hospital Corporation, an independent instrumentality of the District of Columbia Government, will convene at 3:30PM on Wednesday, March 26, 2025. The meeting will be held via Zoom.

Notice of a location, time change, or intent to have a closed meeting will be published in the D.C. Register, posted in the Hospital, and/or posted on the Not- For-Profit Hospital Corporation's website (www.united-medicalcenter.com).

DRAFT AGENDA

I. CALL TO ORDER
II. DETERMINATION OF A QUORUM
III. APPROVAL OF AGENDA
IV. READING AND APPROVAL OF MINUTES – February 26, 2025
V. CLOSED SESSION
VI. CONSENT AGENDA
1. **Dr. Mina Yacoub, MD- Chief Medical Officer**
2. **Dr. Francis O'Connell, MD – Chief of Medical Staff**
3. **Teka Henderson - VP of Nursing**

VII. EXECUTIVE MANAGEMENT REPORT
Dr. Jacqueline Payne-Borden, CEO/CNO
VIII. FINANCIAL REPORT
Lillian Chukwuma, Chief Financial Officer
IX. PUBLIC COMMENT
X. OTHER BUSINESS
1. **Old Business**
2. **New Business**

XI. ANNOUNCEMENTS
XII. ADJOURNMENT

NOTICE OF INTENT TOCLOSE. The NFPHC Board hereby gives notice that it may close the meeting and move to executive session to discuss collective bargaining agreements, personnel, and discipline matters. D.C. Official Code§§2 -575(b)(1)(2)(4A)(5),(9), (10),(11),(14).

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Monthly Board Meeting

Date: March 26, 2025

Reading and Approval of Minutes

Minutes Date:

February 26, 2025

Not-For-Profit Hospital Corporation
FISCAL CONTROL BOARD MEETING
Wednesday, Febuary 26, 2025 3:30pm
Held via Zoom

Directors:
Chair Angell Jacobs, Donita Reid-Jackson, Girume Ashenafi, Dr. Malika Fair, Deputy Mayor Wayne Turnage

UMC Staff: CEO Dr. Jacqueline Payne–Borden, CFO Lilian Chukwuma, CMO Dr. Mina Yacoub, Gen Counsel Eric Goulet, Perry Sheeley, Roosevelt Dzime-Assion, Marlanna Dixon, Kendrick Dandridge, Attorney Yanira Van Den Broeck, Dr. Francis O'Connell, SM Williams, Cheron Rust, Tracy Follin, Maxine Lawson, Teka Henderson, Tonia Johnson, Derrick Lockhart, Vineela Yannamreddy, LaMonica Threet

Other: Kai Blissett

Agenda Item	**Discussion**
Call to Order/ Determination of Quorum	By Chair Jacobs at approximately 4:35pm. Quorum determined by Eric Goulet.
Approval of Agenda	***Mot to approve agenda by Dir. Reid Jackson, 2nd by Dr. Fair unanimous vote***
Approval of Minutes	***Mot to approve minutes by Dir. Reid Jackson, 2nd by Dr. Fair unanimous vote.***
	CMO Report – Dr. Yacoub • April 15, 2025 will be the last day of UMC hospital inpatient operations, and is the scheduled date for opening of Cedar Hill Regional Medial Center.

- UMC Hospital Administration is working collaboratively with our local healthcare partners, patient transport vendors, hospital and city logistical support services, DC Department of Health, and our patient community on plans to rapidly and safely phase out inpatient care services as we approach closing.
- The ability to maintain staff retention in clinical and support areas remain challenges that continue to be addressed. UMC is collaborating with Cedar Hill Regional Medical Center executive and clinical leaderships to facilitate patient transfers to Cedar Hill on its opening day.
- Communication to Medial Staff members to update on closure plans pertaining to responsibilities for medical records completion, appointment files, and procedure logs will follow shortly.

MCOS Report – Dr. Francis O'Connell

- The inpatient and emergency services at UMC remain vital in supporting the health and well-being of Southeast Washington, DC. Emergency Department volume remains steady with the number of admissions and patient acuity increasing over the past month.
- With the anticipated closure of UMC in 2 months, it is imperative that UMC continues delivering essential care aligned with patient needs. UMC's closure and Cedar Hill Regional's opening on April 15th present significant challenges.
- Reducing UMC's patient volume in the final month is essential to minimize last-day discharges and transfers. However, current ambulance and walk-in trends make this difficult. Redirecting UMC's patient load without enhancing other District hospitals' capacity risks overwhelming an already strained system with high occupancy, long ED wait times, and increased boarding.
- Maintaining essential care and addressing transportation constraints during the transition is imperative.
- The medical staff remains engaged with the hospital's efforts to meet the ongoing needs of the community during the transition to Cedar Hill.

CNO Report – Teka Henderson, VP of Nursing

- We continue with our milestones and are making great progress with the hospital's pending closure in two months. We continue to monitor staffing, patient volume, acuity, etc. on a daily basis as this combination is fluid and ongoing. As a result, currently, we are on track with staffing and anticipate continuing our efforts to reduce contract labor to a minimum.

- UMC nurses continue to support patient care by remaining steadfast and dedicated to providing patient care at UMC and continuing their education to provide the best evidence-based practices until hospital closure. This demonstrates our commitment to improving patient care, our bond in strengthening nursing excellence and advancing nursing care overall.
- Case management is working extremely hard at facilitating timely discharges and placement of hard to place patients. Discharges began with admission and ends after discharge. We continue to manage seven complex and challenging cases, that do not meet medical necessity, have social barriers, or other determinants of health making it difficult to provide a safe discharge. We are partnering with various local entities in the District of Columbia to facilitate safe and appropriate placements and transitions prior to hospital closure.

Executive Management Report - Dr. Jacqueline Payne Borden

- At the end of January UMC's leadership hosted two hybrid town hall sessions to discuss UMC's path forward as the hospital prepares for closure. There were over 120 employees in attendance at each session both in person and remotely. Employees asked frank questions and received responses accordingly; employees expressed appreciation for having this forum which enhanced communication. In mid-November, the request for Phase 3 - closure of the Emergency Services, Inpatient and all Ancillary and Support Services was submitted to State Health Planning and Development Agency (SHPDA) and the Health Regulation and Licensing Administration (HRLA). These agencies have been in close contact with UMC, seeking clarifications, additional data, and providing guidance. On the request of SHPDA and HRLA, clinical and staffing data are being provided on a weekly basis and will continue through closure.
- Preliminary meetings were held with both DC and PG County Fire Emergency Services (FEMS) Fire Chiefs, Medical Directors, key UMC staff and physician leaders. This is in preparation for timely communication and strategic planning on the day of closure, with the goal of safe and coordinated transport of patients to other healthcare facilities. The hospital currently has two transportation vendors with different capabilities and limitations. Primary vendor will provide an addendum to current contract to include enhanced capabilities such as providing nursing support and additional ambulances on the closure date to facilitate effective and timely transportation.

	• The hospital will have a closure drill on March 6. Invitees include external stakeholders such as DC/PG FEMS, Vesper, Protector, SHPDA, HRLA, Children's National Medical Center and Cedar Hill Regional Medical Center (CHRMC). The purpose of the drill is to rehearse the entire walk-through tasks that must be completed to safely, efficiently and timely transport all patients from UMC to other facilities on April 15, 2025. This drill/discussion will also cover key activities that must be completed prior to the actual transfer of patients, including but not limited to non-emergent patients, long stay patients and decompressing/limiting ED activity especially the patients arriving by Emergency Medical Service (EMS) which accounts for approximately 63% of our inpatient admissions. The plan is to officially request DC/PG EMS, and Comprehensive Psychiatric Emergency Program (CPEP) to bypass UMC starting at least 15 days prior to closure. • Case Management leaders, other hospital team members and various external agencies lead by the office of the Deputy Mayor of Health and Human Services (DMHHS) have increased work group meetings from bi-weekly to weekly meetings to strategize and bring solutions for complex to place/discharge patients. At present there are nine long stay patients ranging from 19 - 426 days awaiting appropriate disposition. The hospital closure date is rapidly approaching, decisions need to be made as to definitive measures beyond conventional, to expedite appropriate patient discharge well before the hospital is closed. • In preparation for closure and post closure activities, UMC remains in collaboration with external agencies such as Office of Risk Management (ORM), Department of General Services (DGS), Office of Contracting and Procurement (OCP) and Office of the Chief Technology Officer (OCTO). Two of the agencies have visited campus and toured the building on couple of occasions. • United Medical Center's Communications Liaison and this writer attended a Ward 8 Health Council meeting early in January, as well as anticipate attending upcoming Advisory Neighborhood Commission sessions to thank community and remind community of the upcoming hospital closure. • The Information Technology Department continues with monthly activities. Ongoing reporting for audits-completed attestations for promoting systems interoperability CY2024. Decommissioned wireless network for the Medical Outpatient Building (MOB). Working with OCTO regarding data archival and UMC data center transition. There were no cyber-attacks for the month of January. • The Voluntary Healthcare Professionals Training Program facilitated by George Washington University Hospital/UHS, in collaboration with Department of Health Care Finance and NFPHC/UMC officially launch on November 6, 2023 and ended January 31, 2025. Employees were

	encouraged to participate in this self-paced training program, not only to enhance their knowledge base but to increase the probability of being hired should they apply for employment at CHRMC. There were a total of 215 participants of which 67% completed at least one learning module. *Please see attached, DC Workforce Development Voluntary Healthcare Professional Training Program Report for details. • All departments within UMC continues to provide services at or above the standards required by the various regulatory and accrediting agencies. The hospital continues to serve patients in the Emergency Department, Inpatients Units, Dialysis, Emergency Surgery, Post Anesthesia Care, in conjunction with all Ancillary and Support Services. ***Mot to accept CEO, VP of Nursing, CMO and MCOS reports by Dr. Fair, 2nd by Deputy Mayor Turnage, unanimous vote.*** **Preliminary Financial Report Summary for January 31, 2025 – Lilian Chukwuma, CFO** • Hospital is operating at a net loss from operations of $25,144,000, but with the $26,000,000 District Subsidy, there is presently an $856,000 operating margin • Revenue - Total operating revenues are lower than budget by 11% ($1M) MTD and 11% ($4M) YTD despite District subsidy reflected in the period. • Net patient revenue is lower than budget by 18% ($1.1M) MTD and 18% ($4.7M) YTD • Expenses - Total operating expenses are lower than budget by 4% ($374K) MTD but higher than budget by 4% ($1.3M) YTD. ***Mot to accept CFO reports by Dr. Fair, 2nd by Deputy Mayor Turnage, unanimous vote.***
Public Comment	Eric Goulet asked if there was any public comment, and there was not.
Closed Session	Eric Goulet read the justification for entering Closed Session. ***Motion to enter Closed Session by Deputy Mayor Turnage, 2nd by Dr. Fair.*** ***Eric Goulet conducted roll call, 5-0***

	Open Session ended at approximately 4:54 pm. Closed session began at approximately 4:55 pm. • MEC Proposed Bylaws Changes. Mot to approve bylaws change, as presented, by Dir. Fair, 2nd by DM Turnage • MEC Medical Staff Credentialing Activity Mot to approve new appointments, reappointments as presented by Dir. Fair, 2nd by DM Turnage Mot to approve contracts & settlements by DM Turnage 2nd by Dir. Reid-Jackson, unanimous vote. Mot to end closed session by Dir. Reid Jackson, 2nd Dr. Fair ***Closed session ended at approximately 5:15pm.***
Announcements	During closed session the board approved medical credentials, and MEC policies and proposed contracts and settlements.
Adjourned.	Mot to adjourn DM Turnage, 2nd Ashenafi Meeting adjourned at approximately 5:21pm

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Monthly Board Meeting

Date: March 26, 2025

Consent Agenda

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Monthly Board Meeting

Date: March 26, 2025

CMO Report, February 2025

Dr. Mina Yacoub MD
Chief Medical Officer

CHIEF MEDICAL OFFICER REPORT

NFPHC BOARD OF DIRECTORS MEETING-MARCH 2025

HOSPITAL CLOSURE

Cedar Hill Regional Medical Center (CHRMC) is scheduled to open, and be ready to accept patients on April 15, 2025 at 12:01 a.m., whereas United Medical Center is scheduled to close on April 15, 2025 at 11:59 p.m. UMC patients will be provided a choice as to which hospital they would prefer to be transferred to. If, however, all UMC patients are to be transferred to the new hospital, UMC would have a 24-hour window to complete those transfers. UMC administration and clinical leadership is meeting regularly in collaboration with administration and clinical leadership from CHRMC to coordinate and facilitate the patient transfer process.

Given the current average daily census and admissions at UMC, coupled with occasions of unpredictable surges in ED visits and admissions, there is significant concern about the ability to safely and successfully transfer all ED and inpatients from UMC on April 15th. Additionally, the ability of our patient transport vendors to meet the transport needs for a patient census similar to our current daily averages, will be exceptionally challenging. UMC administration continues to work collaboratively with its transport vendor partners, with DC Department of Health, and with DC Healthcare Finance to secure guarantees for additional transportation services availability.

Administration is working to overcome the current barriers in order to safely, and efficiently close the hospital on April 15, 2025. We understand the increased strain on DC and PG Fire and EMS, and other local hospitals` emergency departments and inpatient medical units when ambulance traffic is diverted away from one hospital to the rest. These challenges include delayed Fire and EMS patient off-loading times, and increased patient boarding times in local hospitals emergency departments. UMC will work in the two weeks prior to closure on trying to transfer inpatients to local hospitals after medical stabilization. This process though depends on several external factors, including;

1) acceptance by a receiving hospital,
2) bed availability at the receiving hospital,
3) prioritization of patient transfer by the receiving hospital

These three criteria are sole prerogatives of the receiving hospitals and outside of UMC control. Given that ambulance traffic represents almost 30% of ED volume and 63% of admissions at UMC, it is strongly recommended that ambulance traffic be re-triaged or re-directed from UMC, in keeping with strict patient safety criteria and regulatory requirements. We had initially requested that to occur starting March 15th, 2025, but would strongly recommend it be no later than April 1st, 2025. This would allow United Medical Center to slowly "decompress" the inpatient census by allowing us to have more discharges than admissions daily, and hopefully reach April 15 with a smaller, manageable census of patients needing transfer. Understanding the strain this plan would place on DC/PG Fire & EMS, and local hospitals over a two-week period, we still believe this process would be more feasible than trying to manage a surge of transfers on April 15th.

CASE MANAGEMENT

Administration is working with DC Department of Health, DC Healthcare Finance, and DC Department of Behavioral Health, to secure placement for patients at UMC who no longer meet medical necessity criteria for hospital care, but now require safe post-discharge placement. The number of patients on the list had decreased initially, but has remained fairly stable for the past couple of weeks. It is imperative to secure placement for the patients remaining on this list prior to hospital closure.

PHARMACY

UMC Medical Executive Committee approved UMC inpatient pharmacy closure plan policy. UMC inpatient pharmacy has notified the United States Federal Drug Enforcement Agency (DEA) that pharmacy operations under the Not-For-Profit Hospital Corporation DEA number will cease on April 15, 2025 and pharmacy will have until April 22 to complete decommission and inventory management processes.

QUALITY IMPROVEMENT AND INFECTION CONTROL

As required, UMC submitted to National Healthcare Safety Network (NHSN) the 2024 UMC Hospital Facility report, 2024-2025 Influenza employee compliance report, and employee COVID vaccine compliance report with 2024-2025 vaccinations. UMC will withdraw from data submission to the NHSN effective April 14th 2025, to coincide with hospital closure, and in accordance with regulatory requirements.

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HEALTH INFORMATION MANAGEMENT

Health Information Management (HIM) continues to work to identify a custodian for patient medical records keeping for the legally required duration after hospital closure. Meanwhile, HIM is working to allow providers access to request medical records from a link on the hospital website starting 4/30/2025.

MEDICAL STAFF OFFICE

Medical Staff office is currently working with Applied Statistics and Management Inc, on finalizing data archival procedures for physician personnel files, MEC/MEC committee meetings minutes, and medical staff accounting files.

Respectfully,
Mina Yacoub, MD
Chief Medical Officer
United Medical Center

March 15, 2025

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Monthly Board Meeting

Date: March 26, 2025

Medical Chief of Staff Report for February 2025

Dr. Francis O'Connell,
Medical Chief of Staff

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Francis O'Connell, **M.D.,** Chief of Staff

Re: Chief of Staff Monthly Report

This monthly report is being submitted on behalf of the Medical Staff at United Medical Center (UMC):

As UMC approaches its scheduled closure, there remain logistical questions regarding patient transfers and discharges on April 15, 2025. The transition will occur simultaneously with the opening of Cedar Hill Regional Medical Center (CHRMC) at midnight on this date. At that time, UMC will stop accepting new Emergency Department (ED) patients, while CHRMC begins patient intake. UMC will continue operations for an additional 24 hours to facilitate the orderly transfer and discharge of remaining patients.

Currently, the hospital's average midnight census—comprising patients in the ED, ICU, BHU, and Med/Surg—ranges between 75 and 90 patients, with approximately 20-25 of these patients located in the ED. As most ED and some inpatients require laboratory testing, imaging, and medication administration, we recommend that these services remain operational during the transition period to complete patient evaluations efficiently and minimize unnecessary transfers.

While patient visit trends have remained relatively consistent month-to-month, admissions have gradually declined year-over-year. Nonetheless, patient admission numbers remain significant, with occasional increases tied primarily to seasonal surges in influenza, upper respiratory, and gastrointestinal illnesses.

To further mitigate logistical challenges associated with the closure, we suggest a gradual reduction in ambulance traffic directed to UMC in the weeks preceding the closure. Without such measures, patient census levels in both inpatient units and the ED are likely to remain elevated, potentially requiring the transfer of 60-70 patients within a single 24-hour period. Considering an average ambulance crew capacity of 10-15 patient transfers per 24-hour period, this scenario presents significant logistical challenges.

The Medical Staff continues to collaborate closely with hospital leadership, committed to ensuring community healthcare needs are met throughout the transition to Cedar Hill.

Francis O'Connell M.D.
Chief of Staff
United Medical Center

EMERGENCY MEDICINE
The GW Medical Faculty Associates

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Mar 15, 2025

Re: Emergency Department Monthly Report

Enclosed is a summary of United Medical Center's (UMC) Emergency Department (ED) volume and key measures for Feb 2025 and the first half of Mar 2025.

Data used for this, and past ED reports was derived from Meditech (hospital EMR) raw data provided by hospital's IT department.

Definitions of the terms used in this report are as follows:

- **Total Patients**: number of patients who register for treatment in the ED
- **Daily Average Census:** total patients divided by days of the month
- **Ambulance Arrivals**: number of patients who arrive by ambulance
- **Admit**: number of admissions to UMC
    - **Med/Surg:** number of medical/surgical patients admitted (includes ICU admissions)
    - **Psych:** number of patients admitted to the behavioral health unit
- **ED Transfers:** number of patients requiring transfer to a higher level of care
- **LWBS:** Left without being seen rate is the number of patients who leave prior to seeing a provider and is made up of two categories: LAT and LPTT
- **Ambulance Admission Rate:** percentage of ambulance arrivals that are admitted
- **Walk-In Admission Rate:** percentage of walk-in patients that are admitted

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Data tables:

ED Volume and Events						
	Feb 2023	**%**	**Feb 2024**	**%**	**Feb 2025**	**%**
Total patients	2555		2654		2395	
Daily Avg Census	82		86		89	
Ambulance Arrivals	775	30.3%	692	26.1%	666	27.8%
Admit	396	15.5%	345	13.0%	279	11.6%
• Med Surg	306	12.0%	288	10.9%	232	9.7%
• Psych	90	3.5%	57	2.1%	47	2.0%
Transfers	66	2.6%	68	2.6%	65	2.7%
LWBS	242	9.5%	202	7.6%	271	11.3%
Ambulance Admission Rate	33.4%		30.6%		26.1%	
Walk-In Admission Rate	7.7%		6.8%		6.1%	

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ED Volume and Events						
	Mar 2023	**%**	**Mar 2024**	**%**	**Mar 1-16 2025**	**%**
Total patients	2908		2956		1331	
Daily Avg Census	94		95		43	
Ambulance Arrivals	842	29.0%	776	26.3%	394	29.6%
Admit	407	14.0%	353	11.9%	134	10.1%
• Med Surg	317	10.9%	285	9.6%	113	8.5%
• Psych	90	3.1%	68	2.3%	21	1.6%
Transfers	79	2.7%	85	2.9%	49	3.7%
LWBS	319	11.0%	287	9.7%	135	10.1%
Ambulance Admission Rate	31.1%		29.5%		20.6%	
Walk-In Admission Rate	7.0%		5.7%		5.7%	

Key Points:

1. The tabular data reported this month includes data from the past three years.
2. Trends for total ED visits (ambulances and walk-in visits) remains steady with minor month-to-month fluctuations
3. The LWBS trend is generally flat.
4. The number of transfers continues to trend upwards.

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Commentary:

• **ED Visit trends:** Visit trends remain fairly constant month to month. There has been a slight drop in admissions year to year, however, the number of patients being admitted remains substantial month to month.

• **Anticipated Closure and Patient Care:** The closure of UMC will coincide with the opening of Cedar Hill Regional Medical Center (CHRMC) at midnight on April 15, 2025. UMC will cease accepting new ED patients at this time, while CHRMC simultaneously begins patient intake. UMC will remain operational for an additional 24 hours to facilitate transfers and discharges of remaining patients.

The current average ED census at midnight, including patients in beds and waiting areas, is approximately 25. Typically, two-thirds of these patients are discharged, with the remaining third requiring transfer or admission. Given that most ED visits involve lab tests, imaging, and medication administration, it is recommended these services remain available during the transition period to complete patient evaluations and reduce transfers.

To further minimize logistical challenges, it is recommended to gradually decrease ambulance traffic to UMC in the weeks preceding closure. Without this reduction, both inpatient and ED census levels are anticipated to remain high, potentially necessitating the transfer of 60-70 patients within a 24-hour timeframe, an extraordinary logistical challenge.

Sincerely,

Francis O'Connell M.D.
Chair, Emergency Medicine
United Medical Center
Associate Professor of Emergency Medicine
George Washington University

Musa Momoh, M.D., Chairman

FEBRUARY 2025

The Department of Medicine remains the major source of admissions to and discharges from the hospital.

ACTIVITY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	TOTAL
ADMISSIONS													
OBSERVATION													
MEDICINE	104	82											**186**
HOSPITAL	104	82											**186**
PERCENTAGE	**100%**	**100%**											**100%**
REGULAR													
MEDICINE	182	152											**334**
HOSPITAL	236	202											**438**
PERCENTAGE	**77%**	**75%**											**76%**
DISCHARGES													
OBSERVATION													
MEDICINE	104	80											**184**
HOSPITAL	104	80											**184**
PERCENTAGE	**100%**	**100%**											**100%**
REGULAR													
MEDICINE	134	122											**256**
HOSPITAL	186	169											**355**
PERCENTAGE	**72%**	**72%**											**72%**
PROCEDURES													
HEMODIALYSIS	137	100											**237**
EGD'S	9	8											**17**
PEG'S	1	1											**2**
COLONOSCOPY	3	6											**9**
ERCP	0	0											**0**
BRONCHOSCOPY	0												**0**
QUALITY													
Cases Referred to Peer Review	0	0											**0**
Cases Reviewed	0	0											**0**
Cases Closed	0	0											**0**

Musa Momoh, M.D.
Chairman, Department of Medicine

Sreedevi Kurella, M.D., Chairwoman

FEBRUARY 2025

United Medical Center Laboratory Services- Indicators 2025

Performance Indicators		Goal	Baseline 2024	JAN	FEB	MAR	YTD AVG/TOTAL	Improvement vs baseline	
STAT ED TEST SPECIFIC TATs 45 minutes and Volumes STAT 60 minutes and Volumes	Chem7	95%	97.0	96.0	97.7		96.9	(0.15)	
		# test	2171	205	166		371		
	Chem12	95%	96.8	95.7	97.9		96.8	-	
		# test	14716	1170	1017		2187		
	Troponin	95%	88.4	87.0	89.7		88.4	(0.05)	
		# test	8375	712	606		1318		
	URINALYSIS	95%	97.5	98.0	97.8		97.9	0.40	
		# test	11041	921	708		1629		
	Urine Drug	90%	94.3	93.6	94.9		94.3	(0.05)	
		#test	2202	141	118		259		
	Covid PCR	90%	91.6	84.7	93.6		89.2	(2.45)	
		#test	10942	1161	920		2081		
		Average	45.6	50	45		47.5	(1.90)	
		Goal		JAN	FEB	MAR			
Blood Culture Contamination	% Blood culture Contamination	<3%	7.3	6.4	7.6		6.8	(0.55)	
	Volumes	# test	4365	390	407		797		
	Number Contaminated	#	326	25	31		56		
	Collected by Ed	#	298	21	29		50	89.3%	% of total Contaminated
Performance Indicators		Goal		JAN	FEB	MAR			
Utilization of Red Blood Cell Transfusion C/T Ratio = 1.0 - 2.0	Utilization of Red Blood Cell Transfusion C/T Ratio = 1.0 - 2.0	1.0 - 2.0	1.2	1.2	1.3		1.3		
Wasted/Expired Blood and Blood Products; Target = 0	Wasted/Expired Blood and Blood Products; Target = 0	0	0	2	1		3		
STAT ED		Goal		JAN	FEB	MAR			
30 minutes	CBC	95%	96.4	93.0	97.3		96.4	0.0	
		# test	16321	1304	1128		2432		
45 minutes and Volumes	PT	95%	93.5	93.9	85.4		89.7	-3.8	
		# test	2439	231	158		389		
	PTT	95%	92.8	92.1	83.0		87.6	-5.3	
		# test	2437	230	159				

FEBRUARY Notes: Chem 7 & 12 met the 95% goal in 45 minutes with 97.7 and 97.9%, Urinalysis met the 95% goal in 45 minutes with 97.8%. Troponin still has not met the 95% in 45 minutes but has shown improvement over the baseline at 89.7%. Urine Drug met the 90% goal in 60 minutes at 94.9%. Covid met target 90% in 60 minutes at 93.6.%. CBC met the 95% in 30 minutes at 97.3%. PT did not meet the 95% goal in 45 minutes at 85.4% and PTT meet the 95% goal in 45 minutes, at 83.0%. Blood Culture contamination 7.6% with a target of 3%. 1 FFP expired – expired In storage.Phlebotomist 0 needlesticks. No safety concerns.

Sreedevi Kurella, M.D.

Dida Ganjoo, M.D., Chairwoman

FEBRUARY 2025

		UMC Behavioral Health Unit February 2025 Board Report											
Description		**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Admissions													
	ALOS (Target <7 Days)	3.84	4.33										
	Voluntary Admissions	22	22										
	Involuntary Admissions = FD12	29	26										
	Total Admissions	51	48										
	Average Daily Census	8	9										
Other Measures	**Average Throughput (Target: <2 hrs)**	1.47	2.78										
	# TeleCourt Meetings (Pt Hearings)	0	0										
	# Psych Consultations	165	34										
	Psychosocial Assessments (Target: 80%)	67%	58%										
Discharge													
	Discharges	49	47										

Dida Ganjoo, M.D.
Chairwoman, Department of Psychiatry

Kusha Mehta, M.D., Chairman

FEBRUARY 2025

Exam Type	Exams (INP)	Units (INP)	Exams (ER)	Units (ER)	Exams (OUT)	Units (OUT)	Exams (TOTAL)	Units (TOTAL)
CT Scan	40		477		71		588	
Fluoro	2		0		0		2	
Ultrasound	35		134		30		199	
X-ray	135		787		258		1180	
CNMC CT Scan	0		41		0		41	
CNMC X-ray	0		265		0		265	
Grand Total	21		1704		359		2275	

Quality Initiatives, Outcomes:

1. **Core Measures Performance**
   100% extracranial carotid reporting using NASCET criteria
   100% fluoroscopic time reporting
   100% presence or absence hemorrhage, infarct, mass.
   100% REPORTING <10% BI RADS
2. **Morbidity and Mortality Reviews:** There were no departmental deaths.
3. **Code Blue/Rapid Response Teams ("RRTs") Outcomes:** No code.
4. **Evidence-Based Practice (Protocols/Guidelines):**
   - Staff attention and PPE procedures for COVID -19 is regular, in line with DC Government recommendations.

Services:

Fluoroscopy: Philips bariatric table room is tailored to general diagnostic Barium exams mainly GI (gastrointestinal) applications, and fluoroscopic guided radiological procedures.

Active Steps to Improve Performance: The active review of staff performance and history to be provided for radiologic interpretation continues.

Kusha Mehta, M.D.
Chairman, Department of Radiology

Gregory Morrow, M.D., Chairman

FEBRUARY 2025

For the month of February 2025, the Surgery Department performed a total of 52 procedures.
The chart and graft below show the annual and monthly trends over the last 6 years:

	2019	2020	2021	2022	2023	2024	2025
OCT	211	175	146	135	150	100	59
NOV	196	138	156	137	127	110	51
DEC	192	156	146	132	110	102	50
FIRST QUARTER TOTALS	***599***	***469***	***448***	***404***	***387***	***312***	***160***
JAN	210	195	147	121	111	84	53
FEB	180	167	153	126	106	96	52
MAR	158	82	133	146	145	101	
SECOND QUARTER TOTALS	***548***	***444***	***433***	***393***	***362***	***281***	***105***
APR	211	57	156	148	125	111	
MAY	186	74	159	123	128	111	
JUN	177	126	172	113	108	117	
THIRD QUARTER TOTALS	***574***	***257***	***487***	***384***	***361***	***339***	
JUL	186	140	177	103	92	120	
AUG	193	161	155	114	119	98	
SEP	182	162	126	124	96	55	
FOURTH QUARTER TOTALS	***561***	***463***	***458***	***341***	***307***	***273***	
ANNUAL TOTAL	***2282***	***1633***	***1826***	***1522***	***1417***	***1205***	***265***

This month ended with a 1.9% decrease compared to last month and 45.8% decrease compared to the same month last year.
Factors contributing to this trend include:

- Stable ED admissions but fewer inpatient surgeries
- Closure of Specialty Clinics and Elective Outpatient Surgery
- Impending permanent Hospital Closure

We will continue to monitor trends related to the Covid-19 pandemic and resurgence and institute additional safety measures, as necessary.

We continue to meet or exceed the monthly quality and performance improvement outlined for the Surgery Department.

MEASURE	UMC	NAT'L AVG
1) Selection of Prophylactic Antibiotics	100%	92%
2) VTE Prophylaxis	100%	95%
3) Anastomotic Leak Interventions	1.9%	2.2%
4) Unplanned Reoperations	1.9%	3.5%
5) Surgical Site Infection	3.8%	4.8%

We remain below national benchmarks for our annual numbers.

We will continue to assess the data and make improvements where possible.

Starting September 1, 2024, the OR reduced to a 1 room daily schedule to accommodate inpatient surgical procedures only. In response, changes in the OR staffing shifts were made to optimize OR utilization.

We continue to optimize staffing to maximize efficiency and reduce overtime in the OR for Perioperative Nursing and OR Techs.

We are preparing for the permanent hospital closure on April 15, 2025.

Respectfully,

Gregory D. Morrow, M.D., F.A.C.S.
Chairman, Department of Surgery

UMC
UNITED
MEDICAL CENTER

Monthly Board Meeting

Date: March 26, 2025

Nursing Department Report for February 2025

Teka Henderson, VP of Nursing

United Medical Center
Nursing Board Report
March Meeting 2024

Overall State of Nursing Department(s)

Staffing:

We are experiencing challenges in nursing and case management. We anticipate more challenges with voluntary resignations with the hospital closure insight. Despite the challenges we have been able to overcome them with strategic oversight.

Nursing Excellence
We are truly thankful for our dedicated nurses, case management, and overall nursing staff who remain committed to the hospital and the community.

Case Management
Case management continues to work extremely hard at facilitating timely discharges and placement of hard to place patients with the help of various entities in the District of Columbia. This is complicated due to patient volume, geographic location, social barriers and social determinants of health that contribute to safe discharges. This is truly an all hands-on-deck task.

ICU

Month	Admission	ADC	Sepsis	Code Blue	Rapid Response	Transfers
February	76	13	0	0	0	1

There were 76 ICU admissions for the month of February compared to 74 in January.

Education
Heparin Infusion Protocol
Certifications (ACLS/BLS)
Hypoglycemia Protocol
Hyperglycemia DKA or Tight Glucose Control protocol
Insulin Administration for Accuracy
Patient Consent Forms
Suicide Risk and Prevention Training
Foley Catheter Physician Orders
Wound Care Protocol
Braden Scores for skin assessment
Turning and Repositioning
Restraint Monitoring
Medication management (administration/waste)

PI Initiatives
Continuation of wound Consults and initiation of treatment plans
Wound treatment orders will be automatically generated from wound consults and skin assessment documentation in meditech.
Pictures of all wounds for documentation
Measure to prevent respiratory infections in ventilated patients
Hand Hygiene

PERIOPERATIVE

OR/PACU	CASES	In Pt	Out Pt	# of CX	CODE BLUE	Infinite Legacy	Death
February	46	46	0	8	1	0	0

There were 50 cases last month.

Education
Relias 2025 Hospital Based Mandatories

PI Initiatives
Pain medication care plan chart audits (PACU)
Handwashing - PACU
OR – inpatient readiness consents for surgery and intra-operative documentation
Service Recovery
In real time

DIABETES
There were 14 insulin drips this month all for DKA.

UMC QAPI Master Dashboard					At or Exceeds Target				Within 10% of Target				Target not met				Amended				
2025	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Q1	Q2	Q3	Q4	YTD
DIABETES CENTER→ QAPI MEETING																			
CORRECTION INSULIN ADMINISTRATION COMPLIANCE									BENCHMARK = 100%										
Total # of Novolog ORDER		78	85																
Total # of Novolog orders administered correctly		77	85																
% Compliance		98.7%	100.0%	-	-	-	-	-	-	-	-	-	-		-	-	-	-	-

February compliance rate was 100%. The overall accuracy for 2024 is 96.4%. Insulin accuracy improvement has been achieved by the collaboration of administration, Nursing, Physicians, Quality, and Pharmacy. The implementation of scheduled orders for all insulin medication orders contributed to a significant improvement in insulin accuracy.

We will continue to use evidence-base practice and compliance according to the American Diabetes Association Standards of 2024-2025 until closure.

Education
Daily insulin audits. Continuous unit huddles, Relias required training and detailed instructions to all new hires during onboarding. We have maintained a 99% benchmark for the past 5 months.

Emergency Department

ED Metrics Empower Data	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Visits	2958	3014	3013	2693	2890	2840	2395
Change from Prior Year (Visits)	3084	2867	2866	2927	3011	2972	2552
% Growth	-4.26	4.88	4.88	-8.69	-4.19	-4.65	-6.56
Ambulance Admitted	201	227	198	203	178	208	176
Ambulance Arrivals	747	837	870	812	857	819	666
Ambulance Patients Admission Conversion	0.27	0.28	0.23	0.25	0.21	0.25	0.26
% of ED patients arrived by Ambulance	0.25	0.27	0.29	0.30	0.30	0.29	0.28
% of Ambulance Patients Admitted	0.27	0.28	0.23	0.25	0.21	0.25	0.26

ED Metrics Empower Data	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Door to triage	19	20	18	21	21	21	22
Door to room	88	97	77	75	94	111	95
Door to provider	96	108	91	87	105	122	107
Door to departure	253	263	242	250	272	278	249
Door to decision to admit	346	371	308	326	364	359	389

Education
EMTALA
Infinite Legacy- call with 1 hour of death
Vital signs and rounding notes Q2hrs/LWBS/ CSSR nursing documentation
Restraints: Mechanical: assessment every 15 minutes
Chemical: every 15 minutes x 2 hours

PI Initiatives
Sitter FD12 hourly documentation/sitter handoff
Property list documentation for FD12 (contraband search)

Service Recovery
In real time

Respiratory Therapy

Education
Shift huddle education on patient advocacy, respiratory therapist responsibility and accountability.

PI Initiative
Critical value reporting compliance was 98%. Documentation compliance increased to 88%.

Occupational Health:

Month	PRE-EMP	ANNUAL	COVID TEST	Work CLEARANCE	COVID +	Fit Test	Flu Vacc	Covid Booster	Others	Totals
February	0	13	8	10	1	14	2	0	19	67

Behavioral Health:

Month	ADM	ADC	AMA	LOS	DISC	FALLS	ELOP	SECLUSION	MECHANICAL Restraints	PHYSICAL HOLD
Feb 48 FD-12 26 Vol 22	48	9	1	4.27	47	0	0	0	0	0

There were no transfers to St. Elizabeth, one transfer to ICU, no transfers from the medical floor to behavioral health for the month of February. There were no court appearance/commitment hearings.

Education
Education focused on securing patient property, safety and security rounds, environmental rounds and reporting of issues, and crisis intervention.

PI Initiatives
A. Q 15-minute tech & Q 2-hour RN clinical observation
B. Pain and restraint/seclusion audits
C. Documentation

Respectfully submitted,
Dr. Teka Henderson, DNP, MSN, BSN, ADN, RN
Vice President of Nursing

UMC
UNITED
MEDICAL CENTER

Monthly Board Meeting

Date: March 26, 2025

Executive Management Report for February 2025

Dr. Jacqueline Payne-Borden
Chief Executive Officer

Executive Leadership Board Report
Meeting: March 2025

The standards set by the District of Columbia Health, Joint Commission, and Centers for Medicare & Medicaid Services, and the Mission, Vision and Values of NFPHC posits for a safe and functional environment for all patients, visitors, and hospital employees. The Executive Leadership team continues to strive to function by these standards and to hold each employee accountable to these standards.

The following are some highlights:

Closure Plan Updates: On February 6, Mayor Bowser announced April 15 as the opening of Cedar Hill Regional Medical Center (CHRMC)/GW Health. United Medical Center will cease all patient operations NLT 1159pm April 15. All employees received the required Worker Adjustment and Retraining Notification (WARN) letters. The three unions - District Nurses Association, Service Employees International Union and United Federation of Special Police and Security received timely notifications.

During the month, key internal stakeholders prepared for a mock closure drill for the upcoming interfacility patient transfers on April 15. The actual drill was conducted on March 6, and successfully led by Teka Henderson, VP Nursing, Derrick Lockhart, VP Operations and Christopher Mosely, Project Manager, Hospital Closure, and members of various UMC departments. Invited external attendees included representatives from DC FEMS, PG FEMS, DC Health, State Health Planning and Development Agency (SHPDA) District Columbia Hospital Association (DCHA), Children's National Hospital, CHRMC, transportation companies Vesper and Protector.

During the mock drill debrief, it was evident that UMC's current only transportation vendor with Advance Life Support (ALS) and Basic Life Support (BLS) capabilities would be challenged if UMC needed to transfer up to 30 patients within a 24-hour period. There was productive discourse about strategies to decrease patient throughput and increase transportation capabilities. The general message is: to close efficiently and timely, UMC must significantly decompress both the Emergency Department and Inpatient units. UMC and the office of the Deputy Mayor of Health and Human Services (DMHHS) spearheaded a work group with several District agencies within a very impressive compressed time to create and propose a time line of activities to accomplish efficient timely strategies leading up to and including the day of closure.

Case Management leaders and other hospital team members, now engage in weekly vs bi-weekly work group with various external agencies lead by the office of the DMHHS to strategize and bring solutions for complex to place/discharge patients. At present there are 11 patients with length of stays between 20-454 days. The District's Ombudsman was recently added to the work group; this has significantly facilitated expedient access to resources and follow through of key contributors. The work group's goal is to have all these patients discharged from UMC by April 7.

In preparation for closure and post closure activities, UMC remains in collaboration with external agencies such as Office of Risk Management (ORM), Department of General Services (DGS), Office of Contracting and Procurement (OCP) and Office of the Chief Technology Officer (OCTO).

The Information Technology Department continues with monthly activities. The team is working closely with OCTO to migrate UMC Data Center, trained DGS staff on UMC's video surveillance systems and granted access. Ongoing reporting for audits, completed attestations for promoting systems interoperability CY2024. Continue to maintain all IT and communication infrastructure There were no cyber-attacks for the month of February.

On March 21, 2025, authorization to permanently close the hospital was received from SHPDA. The hospital continues to serve patients in the Emergency Department, Inpatients Units, Dialysis, Emergency Surgery, Post Anesthesia Care, in conjunction with all Ancillary and Support Services until end of day April 15, 2025. All departments within UMC will continue to provide services at or above the standards required by the various regulatory and accrediting agencies.

As this is the last Fiscal Management Board meeting while the hospital remains operational; I would like to sincerely acknowledge and thank the employees, physicians and vendors for their unwavering commitment and support to this community and hospital for the many years whether during challenges or triumphs. Many thanks to the well credentialed and experienced Fiscal Management Board for the oversight, guidance, and the trust in our team that "UMC could run UMC."

Respectfully submitted,

//Jacqueline A. Payne-Borden//
Chief Executive Officer/Chief Nursing Officer

UMC
UNITED
MEDICAL CENTER

Monthly Board Meeting

Date: March 26, 2025

Financial Report Summary February 2025

Lilian Chukwuma
Chief Financial Officer

Not For Profit Hospital Corporation
United Medical Center

Board of Directors Meeting
Preliminary Financial Report Summary
For the month ending February 28, 2025

DRAFT

Table of Contents

Gap Measures Tracking

Not-For-Profit Hospital Corporation
FY 2025 Actual Gap Measures
As of March 31, 2025

	FY 2025 Original Initiatives	Initiatives Not Realized	Realized/ Recognized	
Net Loss from Operations Before District Subsidy				($25,818,000)
District Subsidy				$26,000,000
				$182,000

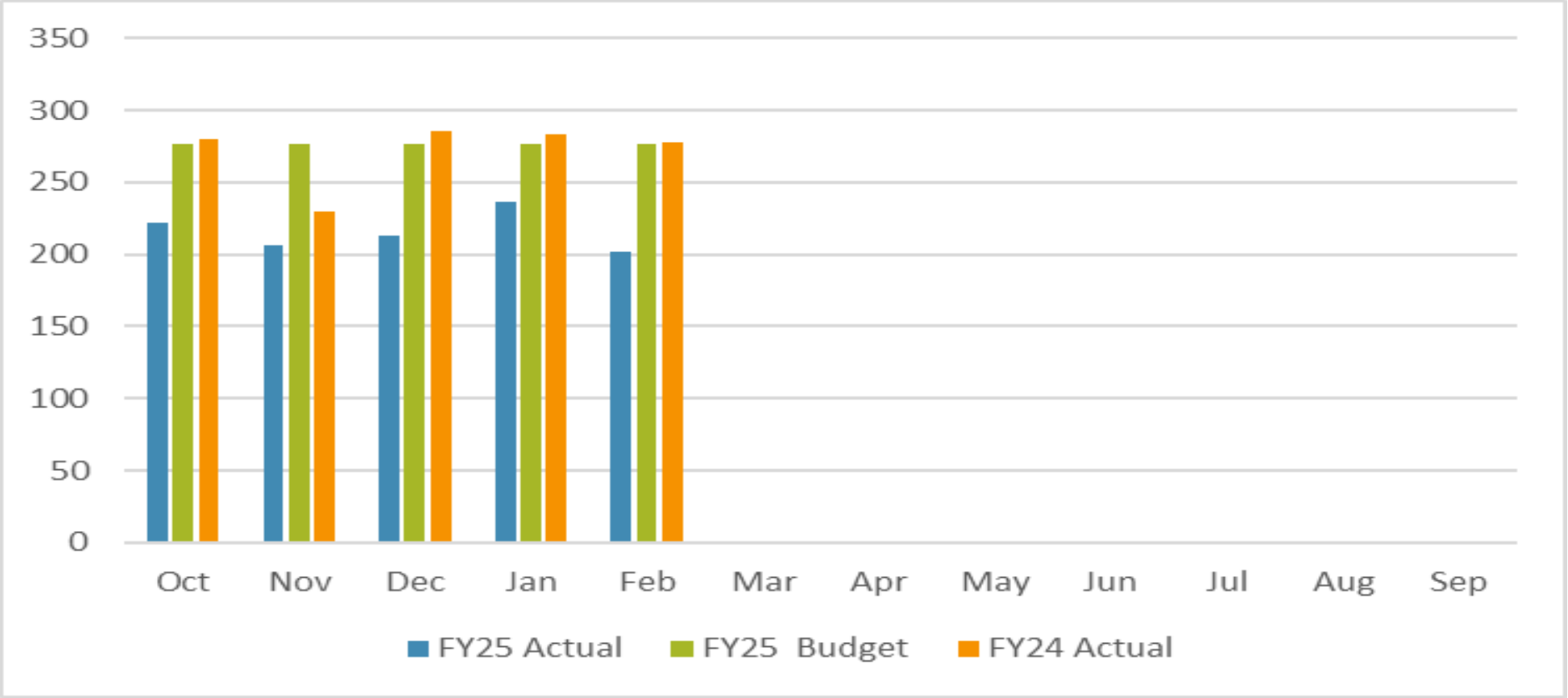
Report Summary

- **Revenue**
  - ❖ **Total operating revenues are higher than budget by 32% ($3M) MTD due to the District subsidy, but lower than budget by 2% ($1M) YTD despite the district subsidy.**
  - ❖ **Net patient revenue is lower than budget by 46% ($2.9M) MTD and 24% ($7.7M) YTD due to the following:**
    - ❖ **Admissions are lower than budget by 27% MTD and 22% or 301 admissions YTD which translates to approximately $7M.**
    - ❖ **Patient days are lower than budget by 16% MTD and YTD.**
    - ❖ **Emergency room visits are lower than budget by 18% MTD and 5% YTD.**
- **Expenses**
  - ❖ **Total operating expenses are trending lower than budget by 26% ($2.4M) MTD and 2% ($1M) YTD due to the following:**
    - ❖ **Salaries are lower than budget by 44% ($1.7M) MTD and 15% ($2.8M) YTD due to reduction in FTE because of the closing process, however overtime is still trending at over $1M for the period.**
    - ❖ **Employee Benefits are lower than budget by 32% ($331K) MTD and 3% (176K) YTD.**
    - ❖ **Contract labor is lower than budget by 26% ($278K) MTD but higher by 28% ($1.5M) YTD as a result of agency use even though patient days are trending very low.**
    - ❖ **Professional fees are lower than budget by 18% ($210K) MTD and 18% ($1M) YTD due to reductions as a result of the closing process.**
    - ❖ **Purchased services are lower than budget by 3% ($29K) MTD but higher than budget by 7% ($303K) YTD.**

Key Indicators

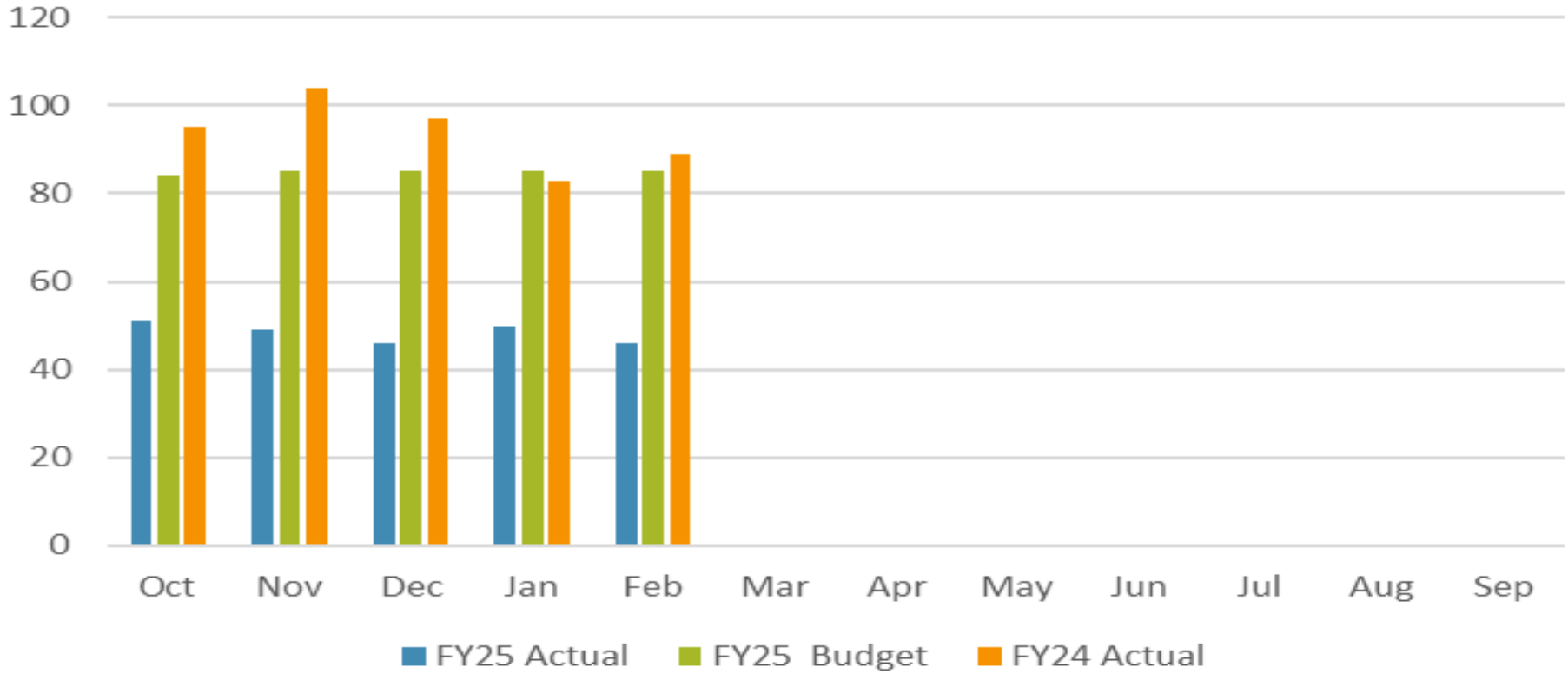
Fiscal Year 2025 thru 02/28/25 Key Performance Indicators	Calculation	MTD Actual	MTD Budget	MTD FY24	Actual Trend	Desired Trend
VOLUME INDICATORS:						
Admissions (Consolidated)	Actual Admissions	202	276	278	▼	▲
Inpatient/Outpatient Surgeries	Actual Surgeries	46	84	89	▼	▲
Emergency Room Visits	Actual Visits	2,385	2,893	2,650	▼	▲
PRODUCTIVITY & EFFICIENCY INDICATORS:						
Number of FTEs	Total Hours Paid/Total Hours	432	601	541	▼	▼
Case Mix Index	Total DRG Weights/Discharges	1.28	1.00	1.25	▲	▲
Salaries/Wages and Benefits as a % of Total Expenses	Total Salaries, Wages, and Benefits /Total Operating Expenses	47%	47%	47%	=	▼
PROFITABILITY & LIQUIDITY INDICATORS:						
Net Account Receivable (AR) Days (Hospital)	Net Patient Receivables/Average Daily Net Patient Revenues	83	52	43	▲	▼
Cash Collection as a % of Net Revenue	Total Cash Collected/ Net Revenue	97%	92%	100%	▲	▲
Days Cash on hand	Total Cash /(Operating Expenses less Depreciation/Days)	65	45	102	▲	▲
Operating Margin % (Gain/Loss YTD)	Net Operating Income/Total Operating Revenue	0.4%	1.0%	-15.5%	▼	▲

Total Admissions (Consolidated)



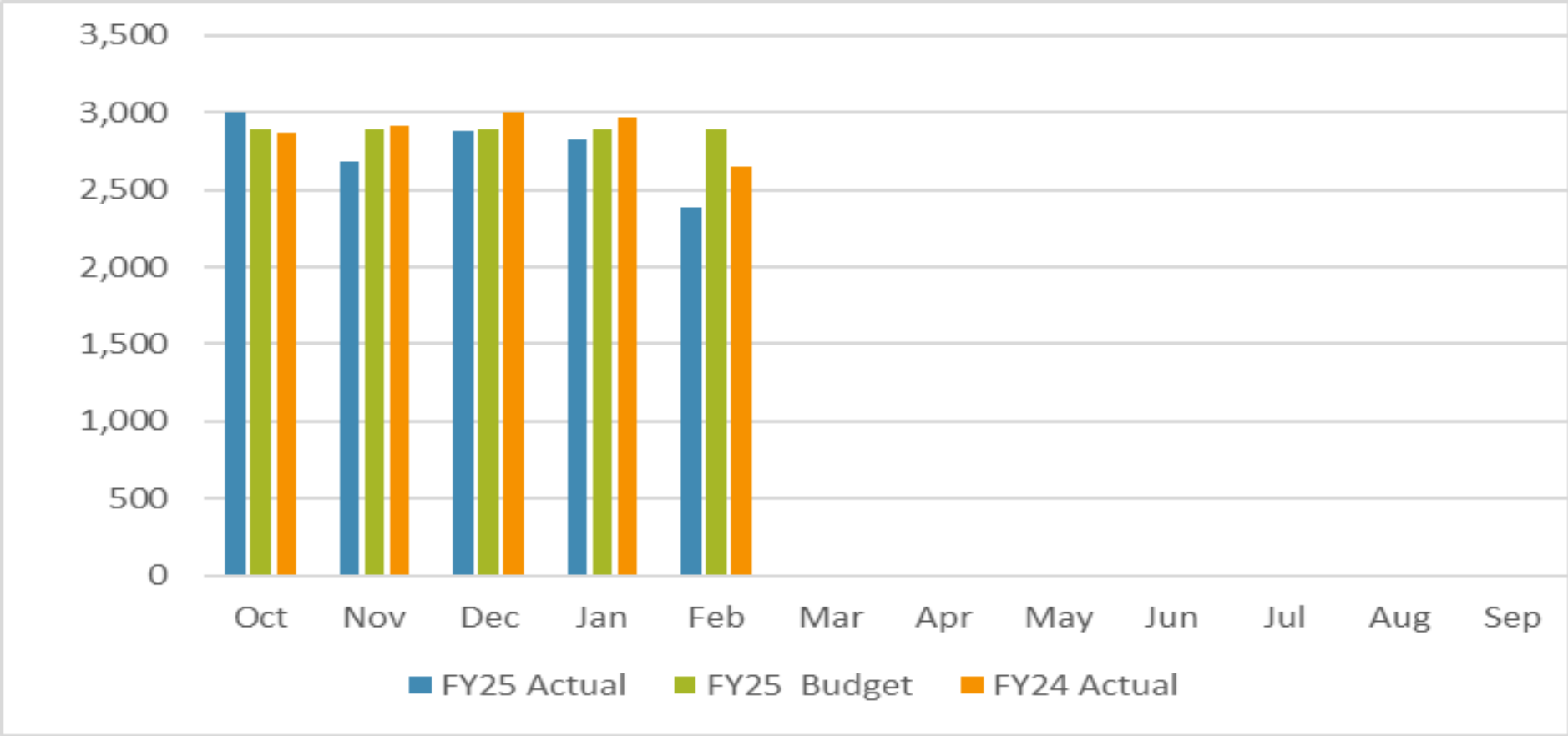
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY25 Actual	222	206	213	236	202							
FY25 Budget	276	276	276	276	276							
FY24 Actual	280	230	286	283	278							

Inpatient/Outpatient Surgeries



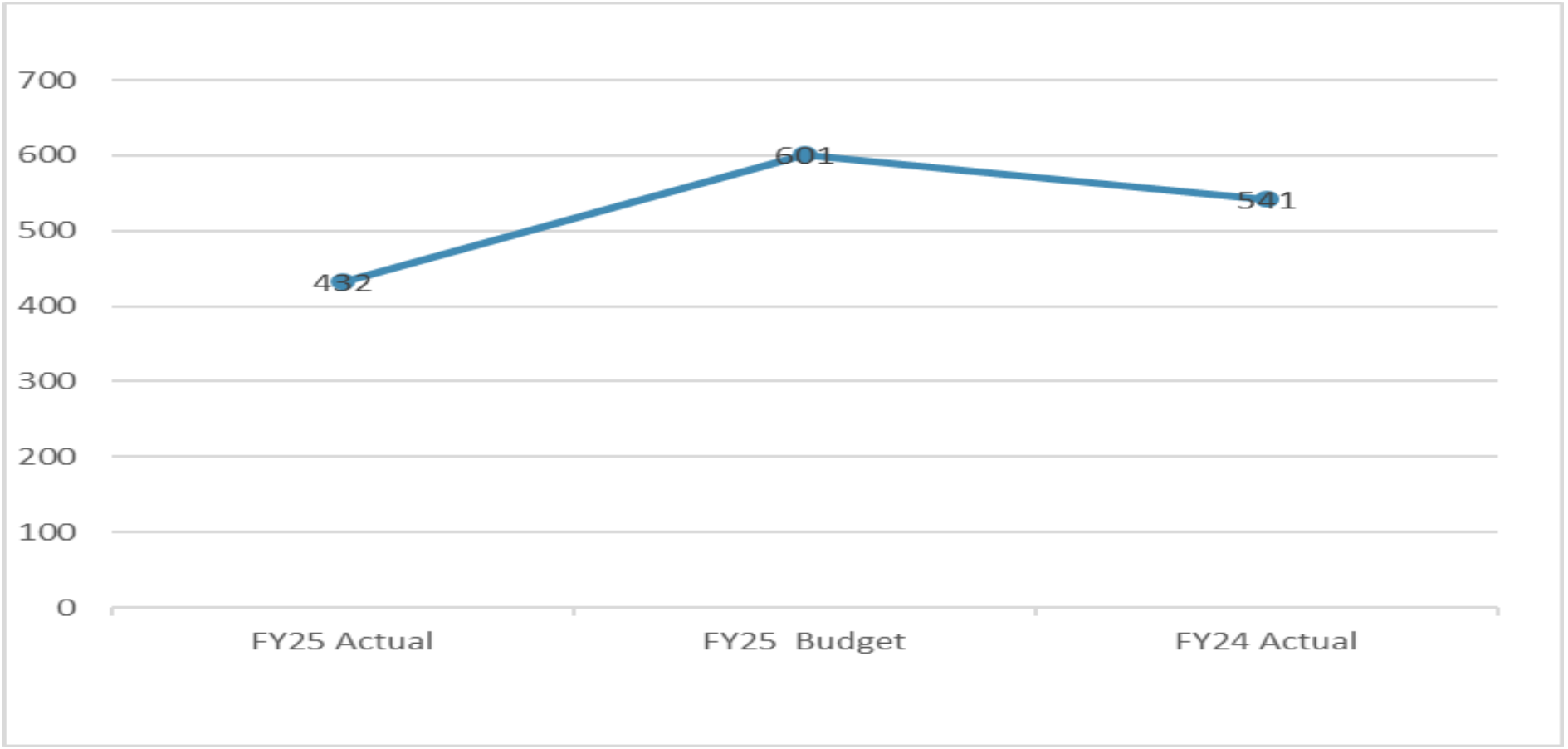
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY25 Actual	51	49	46	50	46							
FY25 Budget	84	84	84	84	84							
FY24 Actual	95	104	97	83	89							

Total Emergency Room Visits



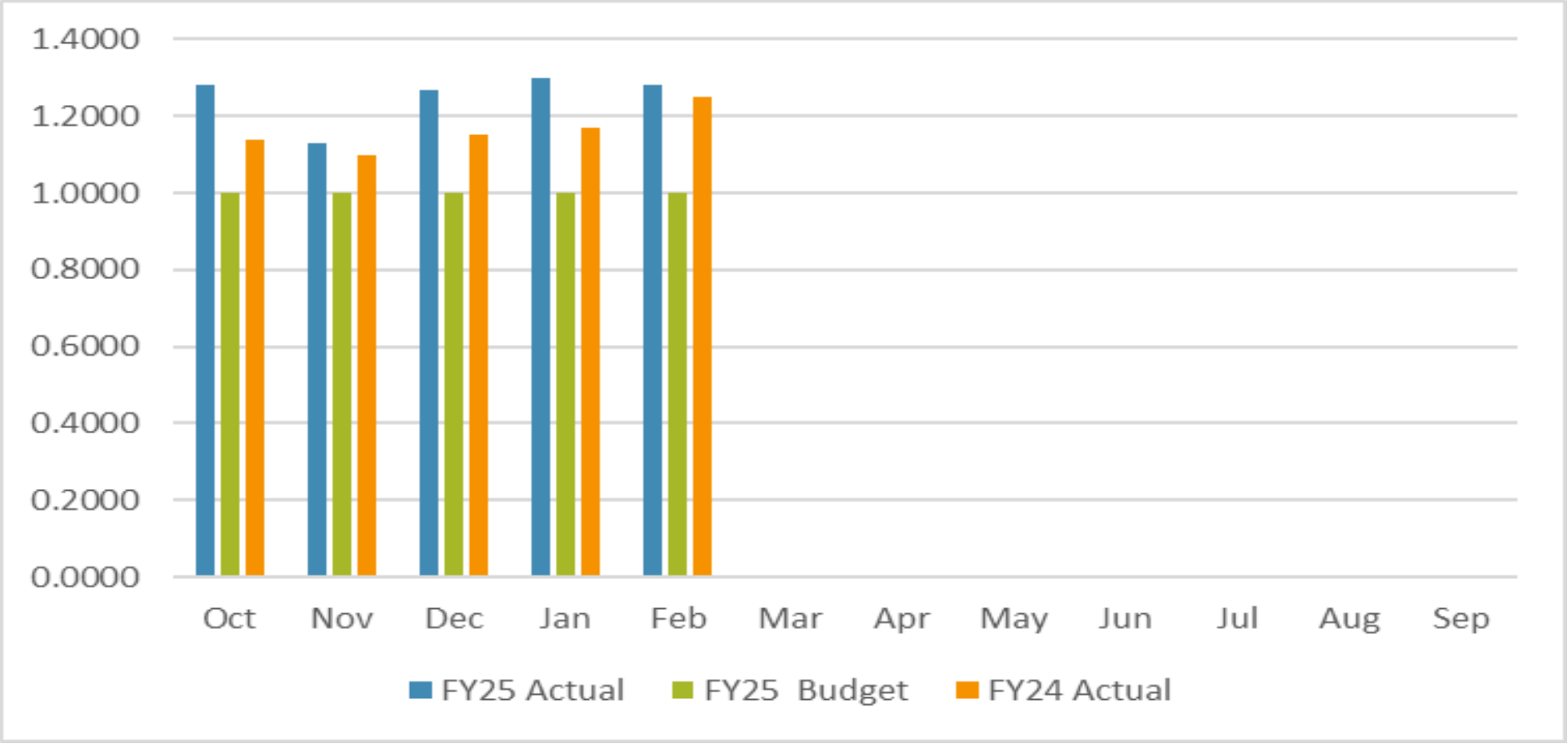
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY25 Actual	3,002	2,684	2,876	2,826	2,385							
FY25 Budget	2,893	2,893	2,893	2,893	2,893							
FY24 Actual	2,865	2,916	3,002	2,970	2,650							

Number of FTEs



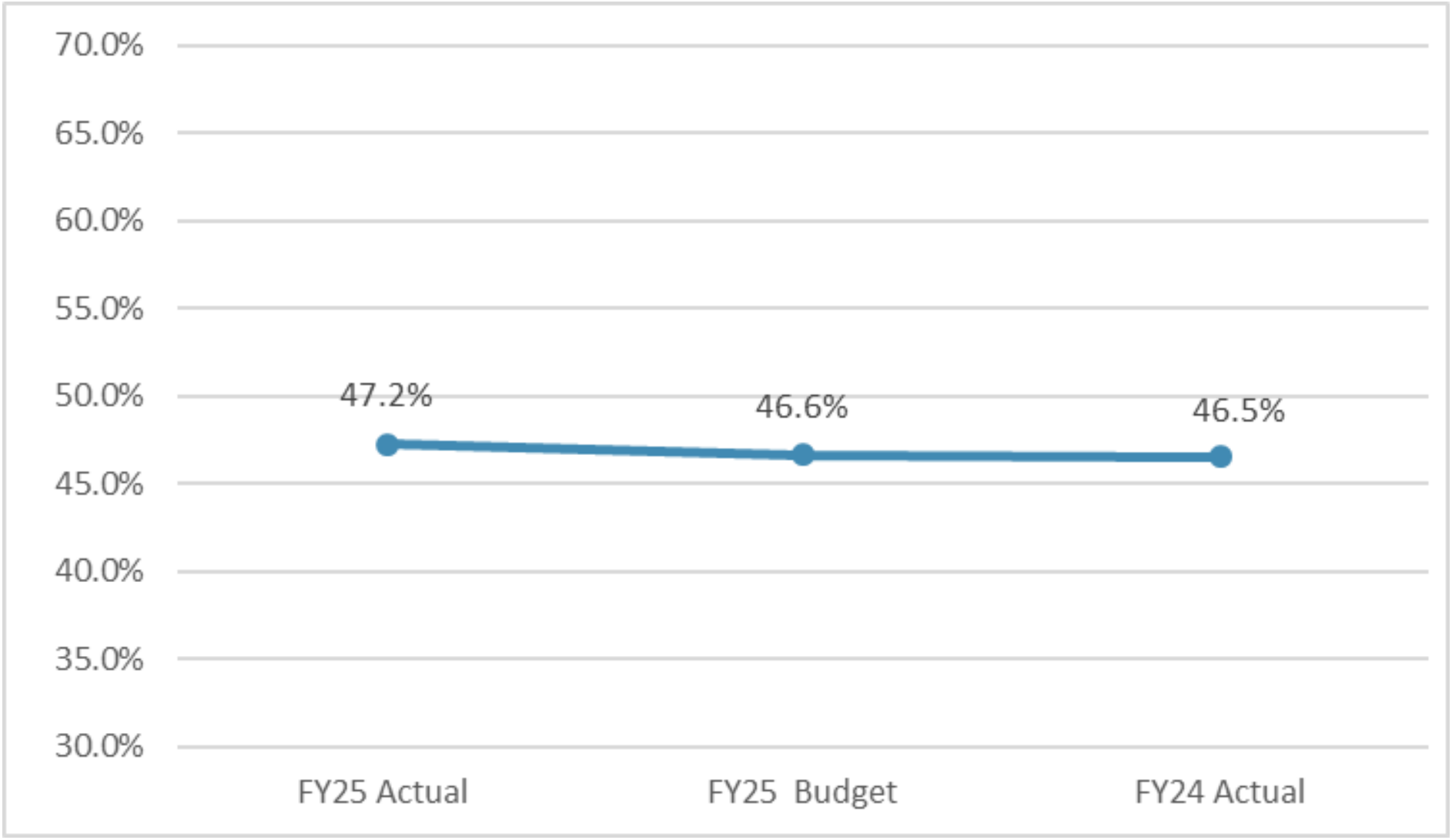
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY25 Actual	455	448	444	440	432							
FY25 Budget	601	601	601	601	601							
FY24 Actual	555	547	562	553	541							

Case Mix Index

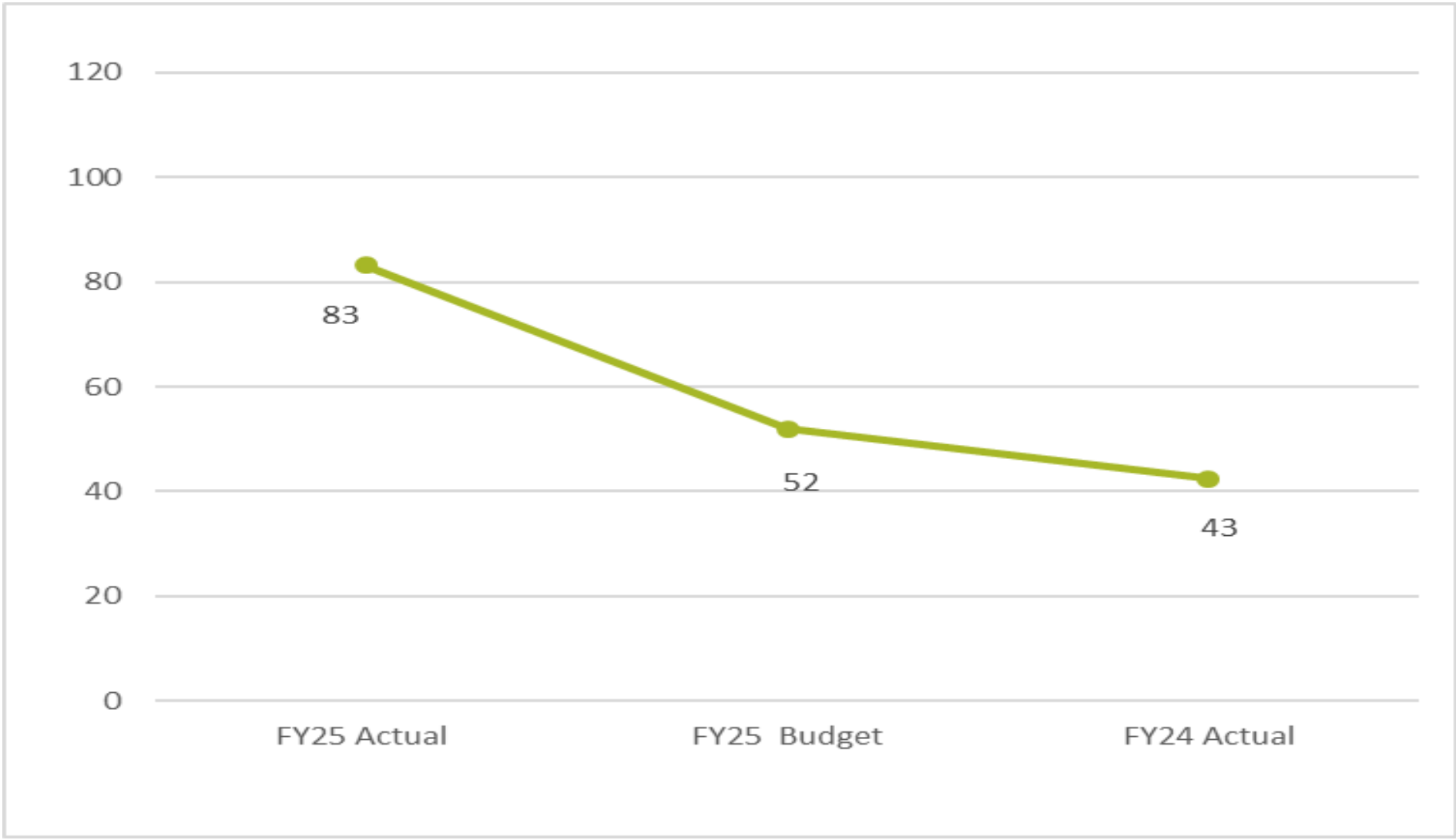


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY25 Actual	1.2800	1.2700	1.1300	1.3000	1.2800							
FY25 Budget	1.0000	1.0000	1.0000	1.0000	1.0000							
FY24 Actual	1.1400	1.1000	1.1500	1.1700	1.2500							

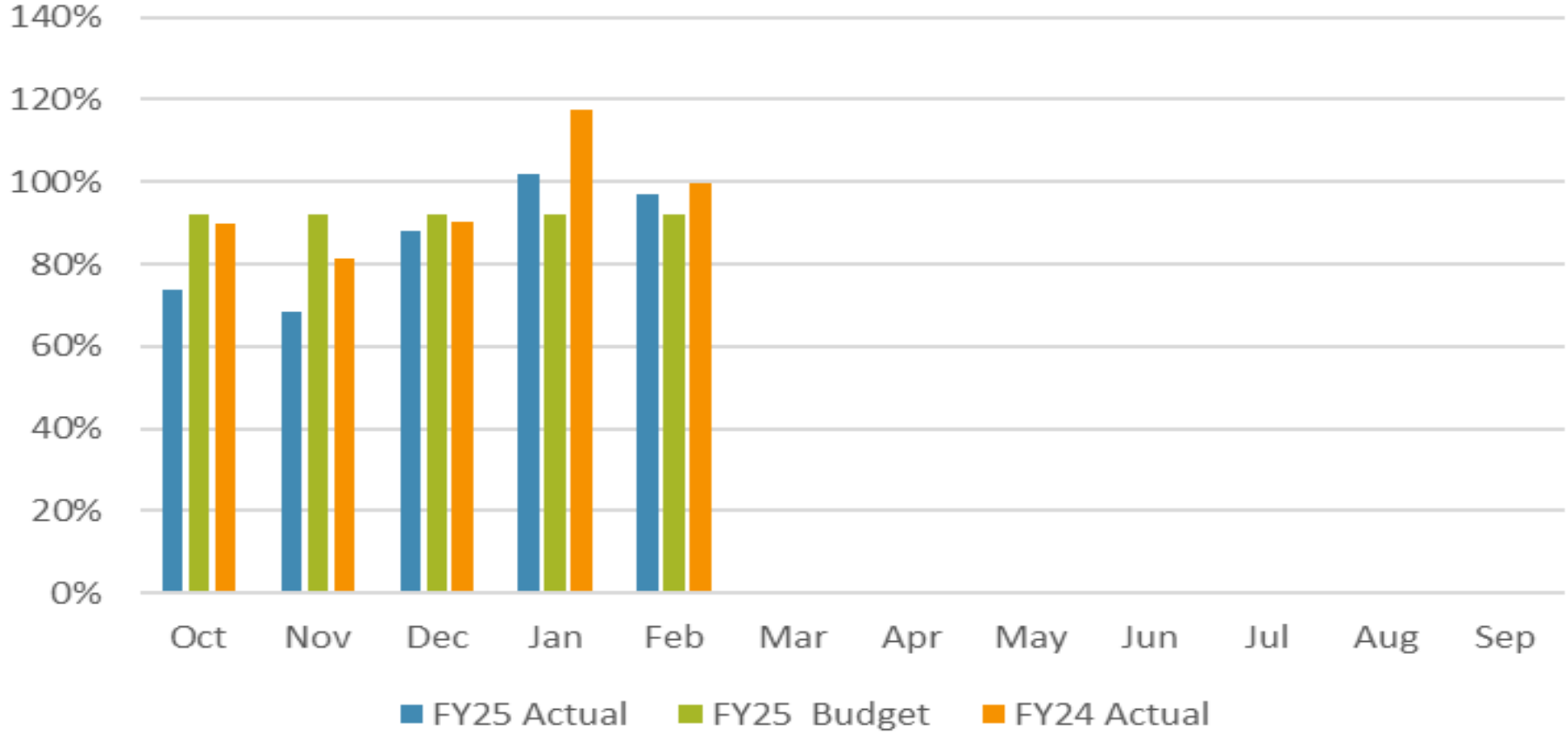
Salaries/Wages & Benefits as a % of Operating Expenses



Net Accounts Receivable (AR) Days With Unbilled

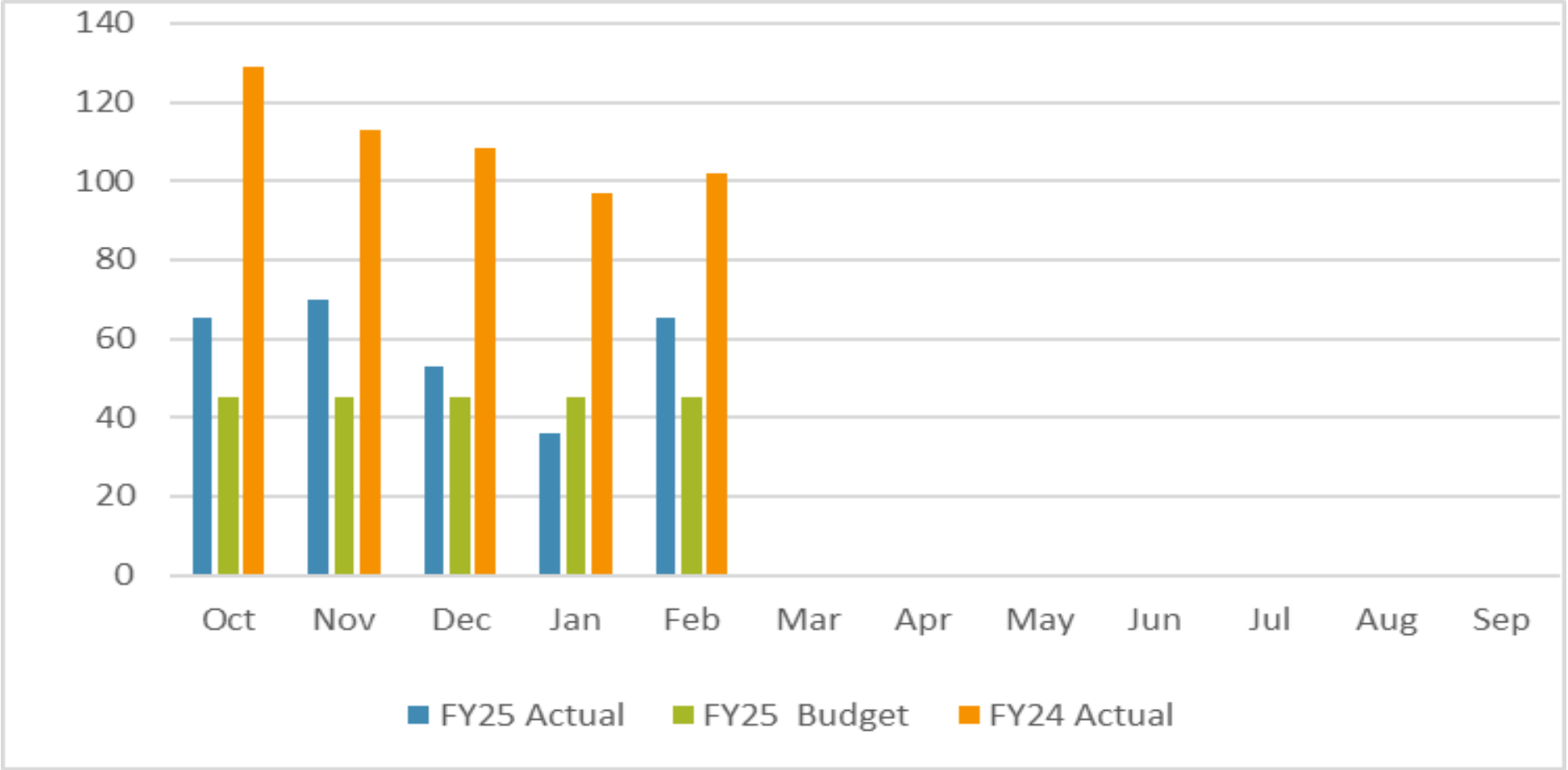


Cash Collection as a % of Net Revenues



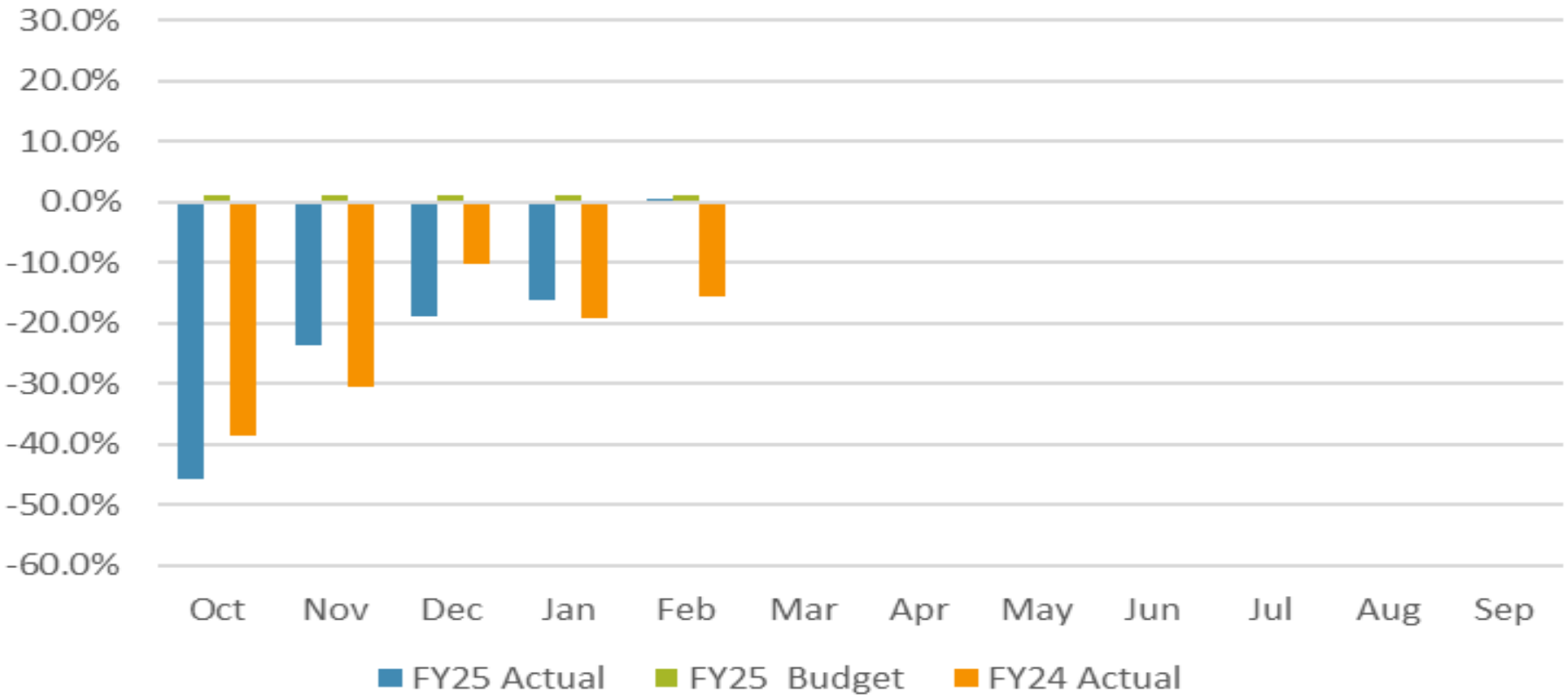
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY25 Actual	74%	69%	88%	102%	97%							
FY25 Budget	92%	92%	92%	92%	92%							
FY24 Actual	90%	81%	90%	118%	100%							

Days Cash On Hand



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY25 Actual	65	70	53	36	65							
FY25 Budget	45	45	45	45	45							
FY24 Actual	129	113	108	97	102							

Operating Margin % (Gain or Loss)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY25 Actual	-45.8%	-23.5%	-18.9%	-16.0%	0.4%							
FY25 Budget	1.0%	1.0%	1.0%	1.0%	1.0%							
FY24 Actual	-38.6%	-30.4%	-10.3%	-19.2%	-15.5%							

Income Statement

FY25 Operating Period Ending February 28, 2025

	Month of February			Variance				2025 Year to Date			Variance			
	Actual	Budget	Prior	Actual/Budget		Actual/Prior		Actual	Budget	Prior	Actual/Budget		Actual/Prior	
Statistics														
Admission	202	276	264	(74)	-27%	(62)	-23%	1,079	1,380	1,373	(301)	-22%	(294)	-21%
Patient Days	1,703	2,018	2,066	(315)	-16%	(363)	-18%	8,446	10,090	10,235	(1,644)	-16%	(1,789)	-17%
Emergency Room Visits	2,385	2,893	2,650	(508)	-18%	(265)	-10%	13,773	14,465	14,403	(692)	-5%	(630)	-4%
Clinic Visits	9	859	847	(850)	-99%	(838)	-99%	327	4,295	4,036	(3,968)	-92%	(3,709)	-92%
IP Surgeries	46	39	36	7	18%	10	0%	163	195	172	(32)	-16%	(9)	-5%
OP Surgeries	-	45	53	(45)	-100%	(53)	0%	-	225	296	(225)	-100%	(296)	-100%
Radiology Visits	-	601	744	(601)	-100%	(744)	-100%	2,832	3,005	3,976	(173)	-6%	(1,144)	-29%
Revenues														
Net Patient Service	3,453	6,423	7,369	(2,971)	-46%	(3,916)	-53%	24,453	32,117	32,486	(7,664)	-24%	(8,033)	-25%
DSH	-	-	735	-	0%	(735)	0%	-	-	3,674	-	0%	(3,674)	-100%
CNMC Revenue	110	-	150	110	0%	(40)	-27%	551	-	752	551	0%	(200)	-27%
Other Revenue	8,736	2,867	1,306	5,869	205%	7,429	569%	20,321	14,333	6,712	5,988	42%	13,609	203%
Total Operating Revenue	**12,299**	**9,290**	**9,560**	**3,009**	**32%**	**2,739**	**29%**	**45,325**	**46,450**	**43,623**	**(1,125)**	**-2%**	**1,702**	**4%**
Expenses														
Salaries and Wages	2,152	3,828	3,394	(1,676)	-44%	(1,243)	-37%	16,332	19,142	19,072	(2,810)	-15%	(2,740)	-14%
Employee Benefits	703	1,034	1,022	(331)	-32%	(319)	-31%	4,992	5,168	6,717	(176)	-3%	(1,725)	-26%
Contract Labor	772	1,050	1,071	(278)	-26%	(299)	-28%	6,734	5,249	5,375	1,485	28%	1,359	25%
Supplies	547	390	768	156	40%	(221)	-29%	2,491	1,951	3,035	540	28%	(544)	-18%
Pharmaceuticals	132	158	267	(26)	-17%	(135)	0%	669	791	1,007	(122)	-15%	(338)	0%
Professional Fees	927	1,137	1,275	(210)	-18%	(348)	-27%	4,677	5,685	6,059	(1,008)	-18%	(1,382)	-23%
Purchased Services	796	825	1,163	(29)	-3%	(367)	-32%	4,426	4,123	4,269	303	7%	157	4%
Other	792	824	1,115	(32)	-4%	(323)	-29%	4,822	4,121	5,066	701	17%	(243)	-5%
Total Operating Expenses	**6,821**	**9,246**	**10,076**	**(2,425)**	**-26%**	**(3,255)**	**-32%**	**45,143**	**46,230**	**50,600**	**(1,087)**	**-2%**	**-5,456**	**-11%**
Operating Gain/ (Loss)	**5,478**	**44**	**(516)**	**5,434**	**12327%**	**5,994**	**-1161%**	**182**	**220**	**(6,976)**	**(38)**	**-17%**	**7,158**	**-103%**

Balance Sheet

As of the month ending February 28, 2025

Feb - 25	Jan - 25	MTD Change		Sep-24	YTD Change
			Current Assets:		
$ 22,452	$ 16,848	$ 5,604	Cash and equivalents	$ 19,010	$ 3,442
13,463	14,326	(863)	Net accounts receivable	13,099	364
988	982	6	Inventories	2,701	(1,713)
2,855	3,255	(400)	Prepaid and other assets	1,669	1,186
39,758	35,410	4,347	Total current assets	$ 36,479	$ 3,279
			Long- Term Assets:		
27,201	28,385	(1,184)	Capital Assets	34,878	(7,677)
27,201	28,385	(1,184)	Total long term assets	34,878	(7,677)
$ 66,958	$ 63,795	$ 3,163	Total assets	$ 71,357	$ (4,399)
			Current Liabilities:		
4,086	4,786	(700)	Trade payables	10,285	(6,199)
3,404	3,958	(554)	Accrued salaries and benefits	3,401	3
2,413	2,461	(48)	Other liabilities	1,078	1,335
9,903	11,204	(1,302)	Total current liabilities	14,764	(4,861)
			Long-Term Liabilities:		
6,042	5,875	167	Unearned grant revenue	-	6,042
813	813	-	Estimated third-party payor settlements	813	(0)
3,711	3,711	-	Contingent & other liabilities	3,711	0
10,566	10,399	167	Total long term liabilities	4,524	6,042
			Net Position:		
46,489	42,191	4,298	Unrestricted	52,069	(5,580)
46,489	42,191	4,298	Total net position	52,069	(5,580)
$ 66,958	$ 63,795	$ 3,163	Total liabilities and net position	$ 71,357	$ (4,399)

Statement of Cash Flow
As of the month ending February 2025

Dollars in Thousands

Month of February			Year-to-Date	
Actual	Prior Year		Actual	Prior Year
		Cash flows from operating activities:		
$ 3,083	$ 11,265	Receipts from and on behalf of patients	$ 22,714	$ 7,068
(4,271)	(6,616)	Payments to suppliers and contractors	(28,144)	(4,470)
(3,409)	(4,653)	Payments to employees and fringe benefits	(21,321)	(4,445)
10,196	3,588	Other receipts and payments, net	30,439	(443)
5,599	3,584	Net cash provided by (used in) operating activities	3,689	(2,290)
		Cash flows from investing activities:		
-	-	Proceeds from sales of investments	-	-
-	-	Purchases of investments	-	-
-	-	Receipts of interest	-	-
-	-	Net cash provided by (used in) investing activities	-	-
		Cash flows from noncapital financing activities:		
-	-	Repayment of notes payable	-	-
-	-	Receipts (payments) from/(to) District of Columbia	-	15,000
-	-	Net cash provided by noncapital financing activities	-	15,000
		Cash flows from capital and related financing activities:		
5	-	Net cash provided by capital financing activities	161	-
-	(38)	Receipts (payments) from/(to) District of Columbia	-	23
0	(37)	Change in capital assets	1,755	(56)
5	(75)	Net cash (used in) capital and related financing activities	1,916	(33)
5,604	3,509	Net increase (decrease) in cash and cash equivalents	5,605	12,677
16,848	**45,345**	**Cash and equivalents, beginning of period**	**16,848**	**35,939**
$ 22,452	**$ 48,854**	**Cash and equivalents, end of period**	**$ 22,452**	**$ 48,616**
		Supplemental disclosures of cash flow information		
		Cash paid during the year for interest expense		
		Equipment acquired through capital lease		
		Net book value of asset retirement costs		