TABLE OF CONTENTS

University of Minnesota Hospitals and Clinics
Board of Governors

March 26, 1986
1:30 P.M.
555 Diehl Hall

AGENDA

I.	Approval of February 26, 1986 Minutes	Approval
II.	Chairman's Report - Ms. Barbara O'Grady	Information
III.	Hospital Director's Report - Mr. C. Edward Schwartz	Information
IV.	Committee Reports	
	A. Planning and Development Committee Report Mr. Robert Latz	
	1. Metropolitan Health Planning Board - Draft Health Plan	Information
	2. Set Aside Contracts Program	Information
	3. Move Update Presentation	Information
	B. Joint Conference Committee Mr. George Heenan	
	1. Revisions to the Bylaws and the Rules and Regulations of the Medical Staff	Approval
	2. Medical Staff Credentials Process	Information
	C. Finance Committee Report Mr. Robert Nickoloff	
	1. Report of Operations for the Period July 1, 1985 through February 28, 1986	Information

2. Comparable Worth — Approval

3. Refinancing Update — Information

4. Peat, Marwick, Mitchell & Company
1984-85 Management Letter of Recommendations — Information

V. Helicopter Update — Information
Mr. C. Edward Schwartz
Mr. Ronald Werft

VI. Adjournment

MINUTES

Board of Governors

University of Minnesota Hospitals and Clinics

February 26, 1986

CALL TO ORDER:

Chairman Barbara O'Grady called the February 26, 1986 meeting of the Board of Governors to order at 1:35 P.M. in Room 555 Diehl Hall.

ATTENDANCE:

Present:	Leonard Bienias
	Shelley Chou, M.D.
	Phyllis Ellis
	Al Hanser
	George Heenan
	Kris Johnson
	Robert Latz
	James Moller, M.D.
	Robert Nickoloff
	Barbara O'Grady
	Nancy Raymond
	C. Edward Schwartz
	Neal A. Vanselow, M.D.
Absent:	David Lilly
	Jerry Meilahn

APPROVAL OF THE MINUTES:

There were two corrections to the minutes of the January 22, 1986 meeting. Ms. Phyllis Ellis asked that the minutes reflect the fact that the Joint Conference Committee did not meet in January of 1986. Secondly, Mr. Latz suggested that the January 22, 1986 Board action on the Nominating Committee Report reflect that the Chair and Vice Chair for 1986 were "reelected" rather than "reappointed." With those two corrections, a motion was seconded and passed to approve the minutes of the January 22, 1986 meeting of the Board of Governors.

CHAIRMAN'S REPORT:

Chairman O'Grady noted that the Committee appointments for 1986 had been finalized.

Ms. O'Grady also noted several upcoming events. They included:

- On March 4, 1986 the Metro Trustee Council is sponsoring a Legislative Reception at the Holiday Inn in Town Square.
- On March 21, 1986 the Board of Governors Executive Committee will meet to develop a Board work plan for the calendar year.
- On May 6, 1986 the Metro Trustee Council is holding a conference entitled "Entrusting Tomorrow's Hospital to Today's Trustee." The conference will be held at the Amfac Hotel in Minneapolis and will feature Mr. Kenneth Kaufmann as keynote speaker.
- On August 25, 26, and 27, 1986 the Board of Governors Annual Retreat will be held at Riverwood Conference Center in Monticello, Minnesota.

HOSPITAL DIRECTOR'S REPORT:

Mr. Schwartz reported that the Regents had approved the appointments of Dr. Bruce Work as the Chairman of the Department of Obstetrics and Gynecology and Dr. Peter Lynch as the Chairman of the Department of Dermatology. Pending Regental approval, the Chairmanship of the Department of Radiology will also be filled. Searches continue for the Chairman in Neurology and for a Director of the Heart Catherization Laboratory. Dr. Stuart Jamieson, the new Division Head for Cardiovascular Surgery, will begin working at the University Hospitals in mid-March.

Secondly, Mr. Schwartz asked that the planned assessment of the Clinical Program Development Fund be postponed for approximately 6 months. Many of the new initiatives funded through the Clinical Program Development Fund have been started too recently to evaluate progress. The medical staff committee overseeing the fund has recommended that new funds not be allocated until the evaluation of existing programs can be completed.

Thirdly, Mr. Schwartz reported that the University Hospital Consortium (UHC) has been incorporated as a not-for-profit association with a for-profit component under which purchasing contracts can be executed. CEO candidates for the UHC are currently being interviewed. In mid-February the Consortium members met to exchange ideas about positioning university hospitals within their respective states and universities to participate in purchasing programs. That meeting included the Vice Presidents for Health Sciences from members organizations. The Governors discussed the anticipated level of participation in purchasing programs among UHC members, noting that similar national associations had experienced diminished economics of scale where limited participation in purchasing programs had been experienced.

The Board discussed the proposal currently being considered to reimburse hospitals for major capital and equipment expenditures under the Medicare DRG payment system. The administration has proposed regulatory changes that would have a profoundly negative effect on our hospital. Senator David Durenberger has suggested an alternative payment plan in the form of a Senate bill that would correct many of the inequities of the administration's proposal. Mr. C. Edward Schwartz and Mr. Clifford Fearing will be going to Washington on March 14, 1986 to testify on these proposed payment alternatives.

Lastly, Mr. Schwartz reported that the public events scheduled to introduce the new University Hospital to the community are proceeding well. Participation and enthusiasm by a broad variety of groups has been high. Approximately 550 guests are expected at the March 7, 1986 opening celebration dinner.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Committee Chair Robert Latz made note of two items that the Planning and Development Committee will begin hearing monthly status reports on: Primary Care Network (PCN) and University of Minnesota Clinical Associates (UMCA).

Secondly, Mr. Latz presented a proposal creating a committee that will be charged with advising the Planning and Development Committee on Variety Club Children's Hospital fund raising, programs, public relations, and goals. The Variety Club Children's Hospital Advisory Committee will initially be comprised of Variety Club members, University staff and Hospital staff. A typographical error in misspelling the word advise in two places was noted. With that minor correction, the Board of Governors seconded and passed a motion approving the proposal as written.

Thirdly, Mr. Latz presented a purchasing report summarizing activities for the months of November and December, 1985 and January of 1986. For several quarters now, purchasing volumes have been elevated over what would have been normally anticipated. In response to a question as to what "average volumes" would be without major Unit J expenditures, Mr. R. Edward Howell reported that 8,000 transactions and $10-11 million dollars in expenditures would represent a more typical purchasing period. At the request of the Planning and Development Committee, the Quarterly Purchasing Report also included vendor appeals.

The Board of Governors seconded and passed a motion approving the Purchasing Report as submitted.

JOINT CONFERENCE COMMITTEE REPORT:

Committee Chair Ms. Phyllis Ellis provided an informational report on the history and current status of the Community University Health Care Center (CUHCC). CUHCC was formed in the 1960's and received most of its funding in its early years from the Minneapolis Health Department as part of the Federal Children and Youth Project. Since the 1970's CUHCC has seen a large number of Native American patients, and more recently has provided services to a number

of Southeast Asians. Today the Southeast Asian population comprises approximately 35% of those seen at CUHCC. The clinic currently serves 2300 pediatric patients, 2000 adult patients, and 600 mental health care patients. A large majority of the population utilizing CUHCC have incomes below poverty level. As a result, CUHCC has developed a graduated payment scale for its services involving a prepayment methodology. CUHCC has an annual operating budget of $1.78 million dollars.

Secondly, the Board of Governors discussed the process for credentialling medical staff in some detail. Following that discussion the Board of Governors seconded and passed a motion approving the February 6, 1986 report of the Credentials Committee.

Thirdly, Mr. Greg Hart presented an overview of the Patient Evaluation Survey project and the newly initiated guest relations program.

Results of the first two months of the Patient Evaluation Survey were presented. The response rate has been quite high (30%). Feedback from the survey is being distributed to the appropriate medical staff and hospital staff members.

A new guest relations program entitled "Patient First" is just now being introduced and is designed, in sum, to promote a positive cultural change and attitude. The program will include, for example, communications training for those employees who must frequently interface with patients and visitors. During the summer months more specific goals, based on patient, employee, and medical staff feedback, will be established. Training sessions will be conducted for all staff in the fall of 1986.

CHANGE IN BUSINESS MEETING CHAIRMAN:

Ms. Barbara O'Grady requested that Vice Chairman Robert Latz assume the role of business chairman for the meeting to enable she and Hospital Director C. Edward Schwartz to greet members of the Dome Club in Unit J.

FINANCE COMMITTEE REPORT:

Mr. Cliff Fearing overviewed the financial and activity levels for the month of January and for the period of July 1, 1985 through January 31, 1986. During January, inpatient admissions were just above the projected level of 1,555. Patient days for January totalled 11,809, 437 days below projected levels. Outpatient visits for January were 6.2% above the projected number of visits, 17,500.

Year to date admissions are running 2.3% below the budgeted level of 10,486. The average length of stay is running 2.5% above the projected 8.1 days. The total number of patient days from July through January are 1.7% below the projected 85,786. Outpatient clinic visits through January totalled 128,038, 5.1% above budget and 4.9% above the January total of a year ago.

The Hospital Statement of Operations shows a total of revenues over expenses year to date of $10,921,636, a favorable variance of $5,497,323. This overall variance reflects both the favorable variance in revenues from operations, and a favorable variance in non-operating revenue.

Mr. Fearing also reviewed the fiscal year 1985-86 year-end projections, which were based on the first six months of activity. The projections, which were reviewed in more detail in the Finance Committee, indicate that the financial objectives for the fiscal year will be met.

Board discussion of the Peat Marwick, Mitchell & Company Management Letter and Minnesota Medicaid were deferred until the Finance Committee can review both in more detail.

ADJOURNMENT:

There being no further business, the meeting of the February 26, 1986 Board of Governors was adjourned at 3:50 P.M.

Respectfully submitted,

Nancy Janda

Nancy C. Janda
Assistant Director and
Secretary to the Board of Governors

MINUTES
Planning and Development Committee
March 12 1986

CALL TO ORDER
Committee Chairman, Mr. Robert Latz, called the March 12, 1986 meeting of the Planning and Development Committee to order at 10:07 a.m. in Hospital Dining Room III.

Attendance:	Present	Robert Latz, Chair Leonard Bienias Frank Cerra, M.D. B. Kristine Johnson Geoff Kaufmann John LaBree, M.D. C. Edward Schwartz I. Dodd Wilson, M.D.
	Absent	Clint Hewitt
	Staff	Greg Hart Ed Howell Nancy Janda Mark Koenig Lisa McDonald Merle McGrath
	Guest	Lou Vietti

APPROVAL OF MINUTES
The minutes of the February 12, 1986 meeting were approved as mailed.

SET ASIDE CONTRACTS
Mr. Edward Howell and Mr. Lou Vietti, Director of Purchasing, and gave an overview of the set aside program. UMHC uses the University vendor list for set asides but does an addendum to incorporate medical suppliers. Compliance monitoring is done through self-policing in that competitors will voice a concern if they believe someone is abusing the program. Mr. Schwartz commented that construction set asides are handled differently because compliance can be checked on site.

UMCA UPDATE
Dr. Wilson stated that UMCA is in the process of organizing its internal structure and negotiating jointly with the hospital for HMO contracts (Share, PHP, and Group Health). He commented that UMCA has three very active committees. The Planning and Marketing committee is serving in an advisory capacity to prioritize marketing goals. Initial goals of the committee under the direction of Dr. Simmons are to concentrate on the referring physician and hospital marketing goals in conjunction with the Strategic Planning Steering Committee. They are also looking at the impact of increased volume based on

the marketing and referral physician program. The Executive Committee is working well. Also, there is another committee that is looking at the division of income among departments.

PCN UPDATE

Mr. Schwartz stated that Drs. Vanselow, Thompson and he are attending the PCN board meetings. They have moved to a new office in Eden Prairie and are in the process of setting up their operations and recruitment.

METROPOLITAN HEALTH PLANNING BOARD HEALTH PLAN

Mr. Kaufmann reported on the Metropolitan Health Planning Board testimony on its 1986 Draft Health Plan. He summarized the Council of Community Hospital's response, which UMHC is in agreement with, that the metropolitan area's health care system should be shaped by market forces. It was concluded that the Board has no authority to designate centers of obstetrics, heart surgery, neonatal care, spinal injury care, etc. and that they may not receive federal funds to continue after September of 1986.

UNIT J MOVE UPDATE

Ms. Janda reported that ICU patients will be moving April 18 and the rest of the patients will move on April 19. The census will be purposely lowered during the move through postponement of elective procedures. Departments will be moving in phases beginning April 7.

FACILITY AND PARKING TUNNEL UPDATE

Mr. Koenig updated the committee on the parking ramp tunnel which is being done in two phases. The first phase is the connecting link to Unit J and the second is the linkage to BC. Code problems are being worked out on phase two and a final design and bid will be available for Board approval in April. He is looking at ways to enhance the tunnel by increasing the tunnel height and incorporating various light sources. Mr. Schwartz suggested that we work with the University student group to incorporate student access points which would minimize traffic through the hospital.

LEGISLATIVE UPDATE

Mr. Latz and Mr. Kaufmann informed the committee on legislative activity that would impact UMHC. Medical assistance is a major area being worked on. Rule 54 would rework the method for determining inpatient rates for assistance recipients. Outpatient reimbursement roll backs for medical assistance patients from November 1985 to May 1987 is under consideration in order to save about $26MM. Mental illness would be exempted and negotiated at a per diem rate. Competitive bidding is also being proposed with a roll back to 90 percent of 1984 rates as well as enrolling the Medical Assistance patients in prepaid plans.

General Assistance Medical Care is the other area under great debate. Outpatient reimbursement cuts, reductions in Aid to Families with Dependent Children, Catastrophic Health, Home Health Care, Medical Malpractice Reform, Juvenile Justice, Employee Right to Know, HMO regulation, and swing beds are issues being discussed.

Mr. Fearing and Mr. Rode have been informing the legislature on UMHC's position on these and other issues.

DEVELOPMENT OFFICE UPDATE

Mr. McGrath stated that he is in the process of recruiting a director for the development office and following up on Ken Merwin's existing projects. He felt that there was a need to publicize the availability of room remembrances. He has also been working closely with the Variety Club and their finance committee.

OTHER

The hospital insert was shown that will go into the Minneapolis and St. Paul newspapers on April 20 as well as being mailed to former patients in the non-metro area. Copies will be mailed to the Board of Governors and Regents this week.

Mr. Latz would like the Board to commend the individuals who scheduled the events and the opening ceremony festivities.

ADJOURNMENT

The Planning and Development Committee adjourned at 11:55 a.m.

Respectfully submitted,

Lisa Gaines McDonald

Lisa Gaines McDonald
Assistant Director
Planning and Marketing

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
Department of Planning and Marketing
Box 200 Mayo
420 Delaware Street S.E.
Minneapolis, Minnesota 55455
(612) 376-7317

Date: March 12, 1986

To: Board of Governors

From: Geoff Kaufmann GK

Subject: **METROPOLITAN HEALTH PLANNING BOARD - DRAFT HEALTH PLAN**

On February 20, 1986, the Metropolitan Health Planning Board heard testimony on its 1986 Draft Health Plan. Only a handful of individuals presented verbal testimony.

Attached are the Council of Community Hospital's response and the UMHC response to this draft plan. It appears that there will be no formal designation of centers as called for in the plan because the Metro Health Planning Board has no authority to designate centers of obstetrics, heart surgery, neonatal care, spinal injury care, etc. This Board's major function is in public education and in the provision of data. The planning agency may not receive federal funds to continue after September of 1986. If this happens, the purpose and use of this plan are questionable.

GLK:asf

Attachments

Council of Community Hospitals'
Response to the Health Systems Plan
Delivered by Mary Samoszuk, Vice President of Public Affairs
February 20, 1986

On behalf of the Council of Community Hospitals (or COCH), I appreciate this opportunity to comment on the Health Planning Board's Health Systems Plan. COCH has identified several general areas at which its comments will be directed. It is not our intention to delve into the specifics of the HSP, but rather to highlight those areas which are of particular concern to metro hospitals.

HEALTH PROMOTION - COCH applauds the Health Planning Board's new emphasis on health promotion and wellness which includes attention to prenatal care, alcohol abuse and family violence. The promotion of healthy lifestyles appropriately falls into the domain of a public agency such as the Health Planning Board.

LONG-TERM CARE - COCH is also pleased that the Health Planning Board plans to place greater emphasis on restructuring the financing of long-term care. Long-term care will increasingly consume a larger portion of the health care dollar and it is important to continue planning for the future in this important area.

EQUITABLE ACCESS - COCH agrees that society has a responsibility to ensure access to health care despite a person's ability to pay. Health care providers, insurers, government and consumers should work cooperatively to formulate solutions to the "uncompensated care" or "indigent care" problem. Solutions should address catastrophic health expense coverage and geographic distribution of health care services. In addition, the public and private sectors should recognize the competitive disadvantage which a hospital may have if, relative to other hospitals, its prices must make up for the costs of a disproportionate share of uncompensated care.

MARKET FORCES - COCH agrees with the Health Planning Board's philosophy that the metropolitan area's health care system should be shaped by market forces. At this point, it is appropriate to note that recently the U.S. House of Representatives voted to fund the Health Services Act until October of 1986. The Senate has not taken final action but efforts are being made to turn the program away from past federal guidelines and toward a block grant approach. This approach would provide some federal funds but the state and community would determine the activities to be undertaken.

2550 University Avenue West • Suite 221 North • St. Paul, Minnesota 55114 • (612) 641-1121

COCH perceives a strong message from this action. We believe that Congress recognizes that market forces have begun to show some promising cost-containing results. Furthermore, in an effort to contain the federal government's own health care budget, legislators view health planning activities in a market-driven system as costly and in most cases unnecessary.

ACUTE INPATIENT SERVICES - COCH would like to note several objections to the goals and guidelines presented in the HSP section on inpatient services. First, the numbers used to support the guidelines are seriously outdated. They are based on old studies which did not take into consideration current and future technologies. Second, the guidelines cannot be considered standards for quality. The health care community has not yet reached consensus on how to define or measure quality. Finally, COCH views the HSP recommendation to eliminate 4,800 inpatient beds and close one-half of the area's hospitals as unnecessarily regulatory and prescriptive and, therefore, incongruous with the philosophy that market forces will shape the health care system. The total capacity of the inpatient acute-care system should continue to be determined by competitive market forces. The implementation of this goal should not be carried out by government agencies. Clearly, reliance upon government intervention to reduce overcapacity and the number of specialty services offered by area hospitals is inconsistent with COCH's philosophy, the prevailing philosophies on the state and federal levels, and presumably the Health Planning Board's own guiding principles.

Hospitals are already responding to the marketplace. Increasingly, hospitals are initiating mergers and acquisitions, liquidating sites, and converting unused, acute-care facilities for use as one-day surgery centers, outpatient clinics, and psychiatric or chemical dependency facilities.

COCH believes that an appropriate and useful role for the Health Planning Board should be to facilitate hospitals' efforts to find uses for surplus facilities and, more importantly, displaced human resources.

HIGH COST SPECIALTY SERVICES - COCH would like to go on record in opposition to the goals and guidelines on high cost specialty services for the same reasons noted in our testimony on acute inpatient services. The data is outdated, the guidelines do not ensure quality, and the guidelines are inappropriately regulatory. Finally, the Health Planning Board does not have the financial data to support the goals and guidelines which it has set forth.

DATA - The Twin Cities hospitals have consistently demonstrated their willingness and ability to provide accurate and meaningful data to the public. This helps to ensure informed purchases and stimulates price competition.

The Health Planning Board may wish to augment the information being made available by the hospitals and through other organizations and initiatives. Many of the data collection and analysis activities proposed by the HSP are either occurring elsewhere already or will be undertaken elsewhere soon. Therefore, whenever possible the Health Planning Board should avoid duplicating the data collection and analysis efforts which are being undertaken by COCH and other organizations.

COCH hopes that these comments will serve to direct the Health Planning Board's focus and activities in the future.

UNIVERSITY OF MINNESOTA
TWIN CITIES

Office of the Hospital Director and
Assistant Vice President for Health Sciences

University Hospitals and Clinics
B-313 Mayo Memorial Building. Box 604
420 Delaware Street S.E.
Minneapolis. Minnesota 55455

March 5, 1986

Mr. Malcolm Mitchell
Executive Director
Metropolitan Health Planning Board
300 Metro Square Building
St. Paul, MN 55101

Dear Mr. Mitchell:

Please accept our written comments for the record on the Draft Health Systems Plan for the Twin Cities Metropolitan Area 1986-88. The University of Minnesota Hospital and Clinic finds the overall report to be positive especially in the areas regarding substance abuse, individual prevention and detection services and the general educational role of the Health Planning Board in providing information to consumers.

We would like to specifically address the acute inpatient services section of the draft. While there is no doubt that there is excess capacity in terms of acute care beds in the metro area, there is considerable debate on what to do about the excess capacity. We believe this excess capacity issue will be resolved through the competitive market place through a combination of efforts including merger, consolidation, closure, and alternative use. The cost issues are only a part of this very complex problem.

We also agree that regional specialty services should exist at a limited number of centers. However, the competitive market place will probably determine which hospitals will be successful in providing these services. University Hospital believes the quality issue should be stressed in your plan. You refer primarily to JCAH accreditation as the bench mark for quality. We think that patient satisfaction and outcome measures of clinical care are, and should be, more appropriate measures of quality.

With regard to specific specialty services we would suggest the following changes:

- Pediatrics - Three teaching and referral centers should be maintained. The University has the largest volume and is the source of the pediatric teaching program in the metropolitan area. Both Minneapolis and St. Paul Children's hospitals should qualify under your guidelines as well.

- Perinatal - At least three perinatal centers should be maintained. Perinatal centers include, by your definition, the obstetrical and neonatal components of service. University Hospital does not deliver 1,500 babies annually, but most of its deliveries are high-risk, complicated deliveries that require the resources of a perinatal center. Our NICU is the busiest in the metro area because of its region-wide reputation of excellence. We have no intention of eliminating these high-risk, high demand services, and should remain a perinatal center because of the complex nature of our patients in these areas.

- Spinal Injury Care - We concur with the recommendation of the Health Board in one spinal injury center. The University has served as the designated spinal injury center for the past five years and meets all of your guidelines to continue in this capacity. In addition, the University is engaged in research designed to improve the lives of spinal injured patients. The linkage with the Spinal Cord Society provides the University with a national advocacy group of some 4,000 members with spinal cord injuries. If one center is designated, we believe we should be that center.

- Trauma - We continue to meet all criteria to qualify as a trauma center and specifically to serve as the state trauma referral center. This status has been reaffirmed through our participation in a multi-state helicopter and fixed wing patient transport service.

We thank you for the chance to respond to your Draft Plan and look forward to the final plan once approved by the Metropolitan Council. If we can be of any further assistance to you in the drafting process, please let us know.

Sincerely,

C. Edward Schwartz
Hospital Director

CES:GLK:asf

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

March 20, 1986

TO: Board of Governors

FROM: Ed Howell
Associate Director

SUBJECT: **Set Aside Program**

Attached are copies of the University Set Aside Program application form and a description of the University Hospital and Clinic participation in that program. This is being presented for your information at your March 26, 1986 meeting.

I will be available to answer any questions that you may have at that time.

REH/kf

UNIVERSITY OF MINNESOTA
TWIN CITIES

Purchasing Department
Administrative Services Center
1919 University Avenue
St. Paul, Minnesota 55104
(612) 373-2073

To Whom It May Concern:

The Set Aside Program was mandated by State Law (Chapters 086 and 361) and Regents' Resolution. This is a program for small businesses, and for small businesses owned and operated by socially or economically disadvantaged persons.

A one page form is enclosed for you to fill out and return to us so that we may validate your information.

All firms wishing to participate in the University of Minnesota's Set Aside Program must have this current form on file with the University Purchasing Department. Read the form over carefully; check the definitions on the reverse side; and, if you qualify, fill out the form and return it to the Set Aside Coordinator. All details and information will be handled through the University Purchasing Department and the Hospital Purchasing Department.

We thank you in advance for your continuing concern and cooperation with this program.

Any questions, call the Set Aside Coordinator at (612) 373-2073.

Sincerely,

Michael Johns Hopkins,
Set Aside Coordinator

MJH/bf
MJH000

Enclosure

UNIVERSITY OF MINNESOTA
TWIN CITIES

Purchasing Department
Administrative Services Center
1919 University Avenue
St. Paul, Minnesota 55104
(612) 373-2073

SET ASIDE PROGRAM

The Set Aside Program is directed by
Regents' Resolution and Policy, Purchasing Policy and Procedures, October, 1979

"Specifically seek out through a Set Aside program, within the needs framework of the University of Minnesota, small business firms, as well as firms owned by socially and economically disadvantaged persons; and involve them directly or indirectly in the University of Minnesota's procurement program."

This means that, wherever possible, we seek to identify and buy from minority or small business vendors, and that these vendors must be certified with the University.

The University has made a full commitment to this program. We hope that through our deep concern and support, this on-going program will meet its goals.

Self Certification Form

All firms wishing to participate in the University of Minnesota's Set Aside Program must have the current form on file with the Purchasing Department. Read the form over carefully; check the definitions on the reverse side; and, if you qualify, fill out the form and return it to the Set Aside Coordinator. All details and information will be handled through our Purchasing Department.

GENERAL

The Purchasing Department for the University of Minnesota purchases for all activities of the University of Minnesota throughout the state. Each member of the staff is responsible for purchasing in specific product areas.

If you are interested in selling to the University, we would like to get acquainted with you and your product and, if possible, obtain a copy of your catalog. The name of your firm, at the buyer's request, may then be placed one of our source lists. The Purchasing Department hours are from 8:00 a.m. - 4:30 p.m. for the Set Aside vendor. The receptionist will tell you which buyer to see about selling your product.

THE BID SYSTEM

When the Purchasing Department receives a requisition from a University Department, it is assigned to a buyer for processing. The buyer may send a request for bid to vendors, solicit telephone quotes, or order directly depending on the money amount involved. Bids must be returned to the University before the date and time which is shown on the form. The bid request number is in the upper right-hand corner.

Sealed bids are publicly opened at the time and place shown on the forms and with a sealed bid you will receive a pink envelope in which we ask that you return your bid. These bids are opened in the Bid Room by our Purchasing Department staff. Vendors, as well as all interested parties, are invited to attend these bid openings. All non-sealed bids are clocked in and distributed to the individual buyers at the time the bid is due. Current requests for bids, both Set Aside and non-Set Aside are publicly posted in the Purchasing Department. If you wish to submit bids on any of the requests which are posted, you may obtain forms from the receptionist and office staff.

All bids are available for examination after an order has been placed. If you wish to check any bids (in person, by letter, or by phone) mention the file number given on the form and communicate directly with the buyer who made the purchase. The Set Aside Program bid requests for Small, Socially and Economically Disadvantaged Firms will be designated by a stamp indicating Set Aside, and only Set Aside vendors may participate.

BID REQUEST FORM SUGGESTIONS

The date the bid is due is stamped just below the request number. The bid request must be clocked in before the time that is indicated on the bid.

Be sure you state both unit price and the extension total for that particular item. Please indicate overall total of the bid.

State whatever terms are necessary for your quote, such as net 30, discount, etc..

Indicate delivery time and FOB point if other than the University of Minnesota, or destination.

The University prefers freight to be pre-paid and added, or directly included in the total bid price.

QUESTIONS

If there are any questions, please call the buyer involved or the Set Aside Coordinator. If you need the User Department's phone number, we will provide this for you.

CONSTRUCTION

Construction requests are handled either at 2:00 p.m. openings or at our basic bid time of 3:00 p.m. Remodeling or new construction projects marked Set Aside will be so posted, and responses solicited from SED Construction Companies. Construction requests over $100,000.00 have a 5% sub-contract (flowdown) to SED contractors.

PURCHASE ORDER AND DELIVERIES

Purchase Orders are awarded on the basis of price, quality, time of delivery, availability of parts and service, and any other relevant factors. If all requirements are met, the lowest responsible bidder receives the purchase order.

Please deliver only to the "Ship To" address as shown on the purchase order. All purchase orders show a contact person and phone number for any questions.

Please instruct all people within your company not to make deliveries to the University of Minnesota without a purchase order number. If you receive an order by phone, ask for the purchase order number; a confirming order will be sent later. Always refer to the purchase order number when contacting us about an order.

If you have any questions about how an order was awarded, the buyer who handled the order will be glad to discuss it with you. If you need further explanation, you may take the matter up with the Set Aside Coordinator.

PAYMENTS

In order to receive payments, send invoices in duplicate to the Accounting Records and Services, University of Minnesota, 1919 University Avenue, St. Paul, Minnesota 55104. Our Purchase Order number must appear on your invoice or we cannot make payment to you. Be sure that your invoice references no more than one purchase order. Any breakage, shortage, or error in a shipment must be adjusted before payment can be made. The University of Minnesota is tax exempt and so states this on the purchase order.

GENERAL

Salespersons are not permitted to solicit orders or to demonstrate equipment on the University premises without the permission of the buyer who handles the particular product.

Please call us for help if there is any question concerning a bid or purchase order. You'll get faster service if you ask to speak to the buyer whose name appears on the request for bid or on the purchase order.

ADDRESS AND TELEPHONE

Purchasing Department
University of Minnesota
420 Administrative Services Center
1919 University Avenue
St. Paul, Minnesota 55104

Telephone: (612) 373-2073

MJH001-4

UNIVERSITY OF MINNESOTA
BA FORM 482 (P279B)

SMALL BUSINESS/SET ASIDE SELF CERTIFICATION

(attach additional pages if necessary)

Please type or print all information

GOVERNMENTAL BODY OR AGENCY APPLYING TO: University of Minnesota

PLEASE INDICATE BELOW WHICH DESIGNATION YOU ARE APPLYING FOR:

SMALL BUSINESSES ONLY

☐ **SMALL BUSINESS OWNED AND OPERATED BY SOCIALLY OR ECONOMICALLY DISADVANTAGED PERSON(S)** which may include racial minorities, women, and persons who have suffered a substantial physical disability. Percentage of ownership must be 51%. Please provide information indicating the basis of claim for this designation below. (If this information is not provided, your application will not be considered. The responsibility of determining the classification type for your business is yours.) If substantial physical disability, this form must be accompanied by a letter from your doctor, stating the disability and that it is a substantial physical disability.*

☐ Female ☐ Ethnic Minority (please specify) _____ ☐ American Indian (Indicate Tribal Number) _____

☐ Substantial Physical Disability* ☐ Labor Surplus County _____ ☐ Other (please specify) _____

BUSINESS IDENTIFICATION	LEGAL STRUCTURE
Firm Name _____	☐ Corporation
Street _____ P.O. Box _____	☐ Partnership
City, State, Zip _____ County _____ Area Code ( ) Phone _____	☐ Proprietorship
	☐ Other _____

PRINCIPAL PRODUCT(S) OR SERVICES(S) ☐ Construction. ☐ Products. ☐ Services. ☐ Other _____

Describe _____

DATES: Established under current ownership _____ Registered with Secretary of State _____

MINNESOTA TAX IDENTIFICATION # _____ **FEDERAL EMPLOYER #** _____ **LICENSE** (if applicable) _____

METHOD OF ACQUISITION: ☐ Bought Existing ☐ Franchise ☐ Concession ☐ New ☐ Other _____

NUMBER OF FULL-TIME EMPLOYEES _____ **GROSS VOLUME OF BUSINESS LAST YEAR $** _____

DEPARTMENT of HUMAN RIGHTS CERTIFICATE OF COMPLIANCE: ☐ Yes ☐ No ☐ Applied for Date Certified _____

PRINCIPAL OWNER(S) OR MAJORITY STOCK HOLDER(S):

Name _____	Name _____
Address _____	Address _____
Percent of ownership _____ Social Security Number _____	Percent of ownership _____ Social Security Number _____

OWNERSHIP IN OTHER FIRMS: If any of the owners have ownership or partial ownership in any other firms, stores, etc., please check ☐ Yes ☐ No

If response is yes, list names and addresses as well as other owners, individual or company.

NAME	ADDRESS	% of Ownership	Gross Revenue Last Fiscal Year
			$
			$
			$
			$

CERTIFIED BY:

I certify that my company is eligible for the program as defined in this form and law applicable to the Program I am applying for, and that my firm is not an affiliate or a subsidiary of a firm dominant in it's field of operation, and that I will notify you of any change in status, address, telephone, capability, etc.

SIGNATURE _____ Title (Must be owner or officer of company) _____ DATE _____

The Governmental Body or Agency involved reserves the right to request any additional information deemed necessary.

Return all copies to the appropriate agency. WHEN CERTIFIED, A COPY WILL BE RETURNED TO YOU.

SEE OTHER SIDE FOR APPLICABLE LAW

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
SET ASIDE PROGRAM

The Hospital has adopted the Set Aside Program as mandated by the Board of Regents on October 12, 1979.

In complying with the above mandate the Hospital:

1 - Has assigned a Hospital Set Aside Coordinator who works closely with the University Set Aside Coordinator.

2 - Reports on a Quarterly basis it's Set Aside efforts to the Board of Governors and the University Set Aside Coordinator.

3 - Maintains a SED Directory for those items that are specifically Set Aside.

4 - Has incorporated all Set Aside Vendors into the overall Vendor Directory to insure that SED Vendors receive copies of all bids relating to their products even if the item has not been specifically Set Aside.

5 - Monitors it's Set-Aside efforts in order to insure compliance.

MINUTES
JOINT CONFERENCE COMMITTEE
MARCH 12, 1986

ATTENDANCE: PRESENT:

Phyllis Ellis, Chair
Jack Duvall, M.D.
George Heenan
Seymour Levitt, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Nancy Raymond
C. Edward Schwartz

STAFF: Greg Hart
Nancy Janda
Barbara Tebbitt

GUEST: Lois Kelly

I. Call to Order

The meeting was called to order at approximately 5:45 p.m.

II. Approval of Minutes

The minutes of the February 12, 1986 meeting of the Joint Conference Committee were approved as submitted.

III. Discussion of Committee Meeting Time

The Committee members agreed that future Committee meetings will begin at 4:30 p.m., followed by dinner at 6:00 p.m.. The April meeting of the Committee will be in the Campus Club; beginning with the May meeting, the Board Room in Unit J will be utilized by the Joint Conference Committee.

IV. Medical Staff Hospital Council Report

Dr. James Moller recommended a change in Article 4, Part A, Section 2 of the Medical Staff Bylaws, and several changes in Section 5, Part E of the Medical Staff Rules and Regulations. Dr. Moller reported that these changes had been reviewed and recommended for approval by the Medical Staff Hospital Council and the Council of Chiefs of Clinical Services. The Joint Conference Committee acted to endorse these recommended changes.

A discussion then ensued regarding the impact of the new payment methodologies and systems such as, Same Day Surgical Admissions on the educational programs of the Hospital and Medical School, particularly for undergraduate medical students. It was suggested that this subject receive further discussions at future Joint Conference Committee meetings.

V. Medical Staff Credentials Process

Dr. Moller and Ms. Lois Kelly, Director of Medical Staff Services, described for the Committee the process used in reviewing the credentials of physicians considered for appointment to the Medical Staff. Ms. Kelly reviewed the items in the application, including educational background, past hospital affiliations, professional memberships, certification and licenses, letters of reference and malpractice status. Ms. Kelly stressed the fact that each of these items are verified through follow-up with other hospitals, educational institutions, licensing and specialty certification boards, and referrals. The Credentials Committee review process was then discussed.

A discussion followed on the systems which are in place to identify and support potentially impaired physicians. Dr. Moller described the alternatives available to such physicians, both internal and external to the University. The consensus of opinion of Committee members was that an environment which provides support for treatment of potentially impaired physicians is the most appropriate approach to such problems. It was also noted that similar support systems are available for employees of the Hospital.

Dr. Moller indicated that a follow-up report will be provided to the Committee relative to the reappointment and reappraisal process for the Medical Staff.

VI. Committee Work Plan

The Committee discussed a proposed 1986 Work Plan. Mr. Hart suggested that the Committee divide its efforts into three areas, those of major projects, current issues, and "routine" business. He suggested that the Committee establish as major areas of focus the topics of Guest Relations and Quality Assurance.

In discussion, it was suggested that a third major project area be added, that of assessing the impact of health care system changes on the educational mission of the institution, with an eye toward improving the educational environment. It was also suggested that an item be added under "routine" business, that of an evaluation of the Committees activities, at least annually.

There being no further business, the meeting was adjourned at approximately 7:30 p.m.

Respectfully,

Gregory Hart
Senior Associate Director
Director of Operations

Office of the Chief of Staff

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
Box 707 Mayo Memorial Building
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

TO: Members of the Board of Governors

FROM: James H. Moller, M.D., Chief of Staff

SUBJECT: Revisions to the Bylaws, Rules and Regulations of the Medical Staff

Attached are proposed revisions to the Bylaws, Rules and Regulations of the Medical Staff for your consideration. The revisions have been reviewed and approved by the Medical Staff-Hospital Council, Council of Chiefs of Clinical Services, and the Joint Conference Committee.

The revisions to the Bylaws, Article IV, Part A:, Section 2., relate to the reappraisal and reappointment process. The new language will insure that the reappraisal and reappointment of the staff will occur within two years from the time of initial application to comply with the Joint Commission on Accreditation of Hospitals Standard 10.5, Characteristic 10.5.2.

Revisions to the Rules and Regulations of the Medical Staff, Section V, E., 2., reflect the revisions made to UMHC Policy 14.1, Medical Records Completion, portions of which are contained in the Rules and Regulations of the Medical Staff. The purpose of the revisions clarify when a physical and history must be performed and what documentation must be made in the patient medical record.

Approval of these revisions by the Board of Governors is requested. I will be happy to respond to any questions that you may have.

JHM/lk

Article IV Actions Concerning Medical Staff Members

Part A: Procedure for Reappraisal and Reappointment

Section 2. When Application is Required:

Members of the medical staff ~~except those who received their regular medical staff appointment within the previous 12 months,~~ who wish to continue their appointment to the staff must submit to the Chief of Staff, through their Chief of Service, an application for reappraisal and reappointment and any requested supporting documentation by the required date indicated each year of reappointment. Persons holding a provisional staff appointment shall not be subject to reappraisal and reappointment but shall continue in their provisional appointment until being considered for a regular appointment.

Paragraph 2, no change

Revisions to the Rules and Regulations of the Medical Staff

Section V. Conduct of Patient Care.

E. Medical Record Completion Requirements.

2. Data Base/History and Physical.

a. ~~A complete data base shall be recorded within 24 hours of admission.~~
A history and physical report must be provided for each admission. It is the responsibility of the attending physican to see that the report is recorded in the record within 24 hours after admission.

b. ~~A history and physical must be repeated with each admission. If a complete history and physical has been performed by a University Hospitals physician within one week prior to admission, a copy of this report may be used in the record, provided there has been no change subsequent to the original examination or the changes have been recorded at the time of admission. It is the responsibility of the attending physican to see that this copy is one the record within 24 hours of admission.~~

If a patient is scheduled for a surgical or other invasive procedure on the day of admission and if a complete history and physical examination has been performed within thirty days prior to admission, a copy of the report may be used as part of the history and physical report for the admission in accord with the following:

(1) COMPLETED WITHIN SEVEN DAYS PRIOR TO ADMISSION WITH NO CHANGE IN PHYSICAL CONDITION

The history and physical report for the admission may consist of a copy of the report from the pre-admission examination and a note in the record indicating that there has been no change in the patient's physical condition.

(2) COMPLETED WITHIN SEVEN DAYS PRIOR TO ADMISSION WITH CHANGE IN PHYSICAL CONDITION

The history and physical report for the admission may consist of a copy of the report from the pre-admission examination and a note in the hospital record updating the documentation of the patient's physical condition with specific reference to the history and physical findings.

(3) COMPLETED BETWEEN EIGHT AND THIRTY DAYS PRIOR TO ADMISSION

The history and physical report for the admission may consist of a copy of the pre-admission report and a note in the hospital record detailing the findings of the examination of the patient's physical condition completed at the time of admission.

c. If a patient is readmitted within 30 days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is less than one year old and it is readily available in the unit record.

d. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending physician states in writing that such delay would be detrimental to the patient.

EXCERPT FROM

BYLAWS OF THE
MEDICAL AND DENTAL STAFF
UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

PART C: CREDENTIALS COMMITTEE

Section 1. Composition:

The Credentials Committee shall consist of five (5) members of the Attending Staff who are not serving as clinical chiefs or as an officer of the staff.

Section 2. Duties:

The duties of the Credentials Committee shall be:

(a) to review the credentials of all applicants and to make recommendations for appointment and delineation of clinical privileges in compliance with these bylaws, and to review the credentials and the performance of persons holding provisional staff appointments and to make recommendations as to whether such persons should be given regular attending or clinical staff appointments or be dropped from the medical staff at the end of their provisional appointment; *Amended September 19, 1979.*

(b) to make a report through the Medical Staff-Hospital Council to the Board on each applicant for medical staff membership or clinical privileges, including specific consideration of the recommendations from the departments in which such applicant requests privileges;

(c) to review periodically all information available regarding the competence of staff members and as a result of such review to make recommendations for the granting of promotions, privileges, reappointments, and the assignment of staff members to the various departments and make recommendations through the Chief of Staff to the Board;

(d) to investigate any breach of ethics reported to it;

(e) to review reports that are referred by the Medical Staff-Hospital Council, other medical staff committees, and by the Chief of Staff; *Amended October 21, 1981.*

(f) to report policy-related problems through the Chief of Staff to the Council of Chiefs of Clinical Services;

(g) to consult with any standards committee relating to specified professional personnel and, upon consultation with such groups, make recommendations to the Medical Staff-Hospital Council and Board for permitted activities and responsibilities of specified professional personnel. *Amended October 21, 1981.*

Section 3. Meetings:

The Credentials Committee shall meet as often as necessary or at least quarterly and shall maintain a permanent record of its proceedings and actions and shall submit a report of its recommendations through the Medical Staff-Hospital Council to the Board.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Application for Appointment to the Medical and Dental Staff

INSTRUCTIONS: The information submitted on this application must be typewritten.

If more space is needed to adequately respond to questions, attach additional sheets of paper and reference the questions answered.

1. IDENTIFYING INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	
BIRTHDATE	BIRTHPLACE	CITIZENSHIP	
OFFICE STREET ADDRESS	CITY	STATE	ZIP CODE
OFFICE PHONE NO.	UMHC MAIL BOX NO.	UNIVERSITY OF MINNESOTA FACULTY RANK	
MINN. MEDICAL ASSISTANCE PROVIDER NO. INDIVIDUAL	DEPARTMENTAL GROUP NO. - WHEN APPLICABLE		
HOME STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE NO.	PRACTICE LIMITED TO - SPECIALTY		
OTHER MEDICAL INTERESTS IN PRACTICE, RESEARCH, ETC.			
PRESENTLY PRACTICING WITH WHOM			
STREET ADDRESS	CITY	STATE	ZIP CODE

2. PREMEDICAL EDUCATION

COLLEGE OR UNIVERSITY	DEGREE		GRADUATION DATE
STREET ADDRESS	CITY	STATE	ZIP CODE

3. MEDICAL EDUCATION

MEDICAL OR DENTAL SCHOOL			GRADUATION DATE
STREET ADDRESS	CITY	STATE	ZIP CODE

18986, JAN 86

4. **POST GRADUATE EDUCATION**—*Internship, residency, fellowships, preceptorships, teaching appointments or equivalent positions - please provide information in chronological order.*

POSITION	DEPARTMENT AND SPECIALTY		BEGINNING AND ENDING DATES
SCHOOL OR HOSPITAL		NAME OF SUPERVISOR	
STREET ADDRESS	CITY	STATE	ZIP CODE
POSITION	DEPARTMENT AND SPECIALTY		BEGINNING AND ENDING DATES
SCHOOL OR HOSPITAL		NAME OF SUPERVISOR	
STREET ADDRESS	CITY	STATE	ZIP CODE
POSITION	DEPARTMENT AND SPECIALTY		BEGINNING AND ENDING DATES
SCHOOL OR HOSPITAL		NAME OF SUPERVISOR	
STREET ADDRESS	CITY	STATE	ZIP CODE
POSITION	DEPARTMENT AND SPECIALTY		BEGINNING AND ENDING DATES
SCHOOL OR HOSPITAL		NAME OF SUPERVISOR	
STREET ADDRESS	CITY	STATE	ZIP CODE
POSITION	DEPARTMENT AND SPECIALTY		BEGINNING AND ENDING DATES
SCHOOL OR HOSPITAL		NAME OF SUPERVISOR	
STREET ADDRESS	CITY	STATE	ZIP CODE

5. **AFFILIATIONS**

PREVIOUS AFFILIATION WITH THIS HOSPITAL?	☐ YES → ☐ NO	IF "YES", IN WHAT CAPACITY?	BEGINNING AND ENDING DATES

List all current and previous HOSPITAL affiliations in chronological order.

NAME OF HOSPITAL	CATEGORY OF APPOINTMENT		BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF HOSPITAL	CATEGORY OF APPOINTMENT		BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF HOSPITAL	CATEGORY OF APPOINTMENT		BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF HOSPITAL	CATEGORY OF APPOINTMENT		BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE

HAS YOUR MEMBERSHIP EVER BEEN TERMINATED, REVOKED OR NOT RENEWED BY ACTION OF ANY HOSPITAL?	☐ YES → ☐ NO	IF "YES", PROVIDE FULL DETAILS OF EACH INSTANCE ON A SEPERATE SHEET OF PAPER.
HAVE YOUR PRIVILEGES EVER BEEN SUSPENDED OR REDUCED?	☐ YES → ☐ NO	

6. MEMBERSHIP IN PROFESSIONAL SOCIETIES—*If member past or present or applicant to any county, state or national medical society, provide the following information.*

NAME OF ORGANIZATION			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF ORGANIZATION			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF ORGANIZATION			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF ORGANIZATION			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE

7. MEMBERSHIP AND FELLOWSHIP IN SPECIALTY ORGANIZATIONS

NAME OF ORGANIZATION			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF ORGANIZATION			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF ORGANIZATION			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF ORGANIZATION			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE

8. CERTIFICATION (CERTIFIED BY BOARD, COLLEGE OR EQUIVALENT)

NAME		DATE
NAME		DATE
ADDITIONAL SPECIALTY/ CERTIFICATION ☐ YES → ☐ NO	NAME	DATE
	NAME	DATE
IF NOT CERTIFIED, GIVE CURRENT STATUS		

9. RECERTIFICATION (CERTIFIED BY BOARD, COLLEGE OR EQUIVALENT)

NAME		DATE
NAME		DATE
HAVE YOU EVER BEEN DENIED MEMBERSHIP OR RENEWAL THEREOF, OR BEEN SUBJECT TO DISCIPLINARY ACTION BY ANY MEDICAL ORGANIZATION?	☐ YES → ☐ NO	IF "YES", GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER.

10. LICENSURE

STATE OF MINNESOTA MEDICAL OR DENTAL LICENSE NUMBER ➤	DATE ISSUED OR RENEWED

OTHER STATE MEDICAL LICENSES (CERTIFICATES—ALL PAST OR PRESENT)

STATE	DATE ISSUED OR RENEWED	LICENSE NO.
STATE	DATE ISSUED OR RENEWED	LICENSE NO.
STATE	DATE ISSUED OR RENEWED	LICENSE NO.

HAS YOUR LICENSE TO PRACTICE MEDICINE IN ANY STATE EVER BEEN LIMITED, SUSPENDED OR REVOKED?		☐ YES ☐ NO	IF "YES", GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER.
DEA (DRUG ENFORCEMENT AGENCY) REGULATION NUMBER:	HAS YOUR DEA NUMBER EVER BEEN SUSPENDED OR REVOKED?	☐ YES ☐ NO	

11. MEDICAL REFERENCES—*Provide the names of three members of your most recent hospital medical staff affiliation (Note: References will be evaluated primarily by the extent of direct clinical observation and other work with applicant).*

NAME	HOSPITAL	TITLE	
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME	HOSPITAL	TITLE	
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME	HOSPITAL	TITLE	
STREET ADDRESS	CITY	STATE	ZIP CODE

SUBMIT THREE LETTERS OF REFERENCE WITH THIS APPLICATION

12. PREVIOUS PRACTICE—*Include military experience. List in chronological order.*

NAME			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME			BEGINNING AND ENDING DATES
STREET ADDRESS	CITY	STATE	ZIP CODE

13. SPECIALTY IN WHICH PRIVILEGES ARE DESIRED

- ☐ ANESTHESIOLOGY
- ☐ DENTISTRY
- ☐ DERMATOLOGY
- ☐ FAMILY PRACTICE & COMMUNITY HEALTH
- ☐ LABORATORY MEDICINE AND PATHOLOGY
- ☐ MEDICINE
- ☐ NEUROLOGY
- ☐ NEUROSURGERY
- ☐ OBSTETRICS & GYNECOLOGY
- ☐ OPHTHALMOLOGY
- ☐ ORTHOPEDICS
- ☐ OTOLARYNGOLOGY
- ☐ PEDIATRICS
- ☐ PHYSICAL MEDICINE & REHABILITATION
- ☐ PSYCHIATRY
- ☐ RADIOLOGY
- ☐ SURGERY
- ☐ THERAPEUTIC RADIOLOGY
- ☐ UROLOGY

NOTE: Submit the appropriate departmental clinical privilege form signed by the Chief of Service with this application.

If you are applying to the Attending Staff Category and wish clinical privileges in a department other than the one in which you may hold your primary appointment, a joint medical staff appointment will be necessary (see Number 15 for category definitions).

Department in which you are requesting a joint medical staff appointment: _____

Submit a clinical privileges form signed by the Chief of Service of the Department in which you are requesting a joint appointment with this application.

14. PROFESSIONAL LIABILITY—*Malpractice insurance carrier providing liability for your practice at the University of Minnesota Hospital and Clinic.*

CARRIER NAME		INSURANCE AGENCY NAME		
AGENCY STREET ADDRESS		CITY	STATE	ZIP CODE
POLICY NUMBER	AMOUNT OF COVERAGE		EFFECTIVE DATE	EXPIRATION DATE
ARE THE REGENTS OF THE UNIVERSITY OF MINNESOTA NAMED AS AN INSURED ON YOUR POLICY?	☐ YES ☐ NO			

A CERTIFICATE OF INSURANCE MUST BE SUBMITTED WITH THIS APPLICATION.

HAVE JUDGEMENTS BEEN MADE AGAINST YOU OR HAVE YOU ENTERED INTO ANY FORMAL SETTLEMENTS OF PROFESSIONAL LIABILITY CASES?	☐ YES → ☐ NO	IF ANY OF THESE QUESTIONS HAVE BEEN ANSWERED "YES", PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER.
HAS YOUR MALPRACTICE INSURANCE COVERAGE EVER BEEN TERMINATED BY ACTION OF AN INSURANCE CO.?	☐ YES → ☐ NO	
IF "YES", WHAT COMPANY? / DATE TERMINATED		
HAVE ANY MALPRACTICE SUITS BEEN FILED AGAINST YOU WHICH ARE PRESENTLY PENDING?	☐ YES → ☐ NO	

15. I HEREBY APPLY TO THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC FOR APPOINTMENT IN THE FOLLOWING CATEGORY:

☐ ATTENDING STAFF → *The Attending Medical and Dental Staff shall consist of strict and geographic full-time physicians and dentists. Physicians and dentists in these categories shall assume all functions and responsibilities of membership of the Attending Staff.*

Members of the Attending Staff are eligible for privileges in services other than that service in which they hold their primary appointment. Members of the Attending Staff shall be entitled to vote, to hold office and to serve on medical staff committees, and as chairmen of such committees, and shall be required to attend medical staff meetings.

☐ CLINICAL STAFF → *The Clinical Medical and Dental Staff shall consist of physicians and dentists qualified for staff membership but who do not utilize University Hospital as their primary hospital. These are physicians and dentists who have primary affiliations in other hospitals in the community, but do occasionally utilize the facilities at University Hospital. Clinical staff members shall be appointed to a specific service. They are not eligible to vote or hold office, however they may be eligible for committee membership, participate in medical staff conferences, seminars and teaching programs and admit patients.*

In making this application for appointment to the medical staff of University of Minnesota Hospitals (hereafter called "Hospital"), I acknowledge that I have received and read the Bylaws, Rules and Regulations of the medical staff of the Hospital and I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the medical staff.

I agree to accept committee assignments and such other reasonable duties and responsibilities as may be assigned to me by the hospital and the medical staff.

I agree to abide by the principles of medical and dental ethics including providing for continuous care of my patients.

I acknowledge that the Hospital Policies and Procedures have been made available to me for my review and I agree to comply therewith.

By applying for appointment to the medical staff I hereby signify my willingness to appear for an interview in regard to my application, if requested authorize the Hospital, its medical staff and their representatives to consult with members of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the Hospital, its medical staff and its representatives of all records and documents, including medical records at other hospitals, that may be material to an evaluation of my professional quaiifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership; I hereby release from liability all representatives of the Hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the Hospitals or to members of its medical staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby authorize and consent to the release of information by University Hospital, to other hospitals, medical associations, licensing boards, and organizations concerned with quality of patient care concerning me as long as such release of information is done in good faith and without malice. I hereby release from liability this hospital from releasing information under such circumstances.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I expressly agree to the terms and conditions of Article VIII of the Medical Staff Bylaws. I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to the best of my knowledge and belief.

_____ _____

SIGNATURE OF APPLICANT DATE

RECOMMENDED

, Chief of Service	DATE

NOTE: Please forward completed documents to the Medical Staff Office, Box 707.

CREDENTIALS COMMITTEE	MEDICAL STAFF – HOSPITAL COUNCIL
, Chairman	, Chairman
DATE	DATE

APPROVED

BOARD OF GOVERNORS	APPLICANT NOTIFIED	LETTER OF ACCEPTANCE RECEIVED
DATE	DATE	DATE

Minutes
Meeting of the
Board of Governors Finance Committee
University of Minnesota Hospitals & Clinics
February 16, 1986

MEMBERS PRESENT:	C. Edward Schwartz Edward Ciriacy, M.D. Clifford Fearing William Krivit, M.D., Ph.D. Anton Potami Vic Vikmanis
MEMBERS ABSENT:	Al Hanser Jerry Meilahn Robert Nickoloff
STAFF:	Greg Hart Nancy Janda Nels Larson Jane Morris Helen Pitt
GUESTS:	Jerry Collingham Dan Rode

CALL TO ORDER: The meeting of the Finance Committee was chaired by Mr. C. Edward Schwartz and was called to order at 10:00 a.m. in Room 624 of the Campus Club.

JANUARY YTD FINANCIAL STATEMENTS (INFORMATION): Mr. Fearing reviewed the Report of Operations for the period July 1, 1985 through January 31, 1986. He reported that admissions through January of 10,247 were 2.3% below projections and patient days for the period totaling 84,289 were 1,497 below budget. Overall length of stay of 8.3 days was slightly above the projected level of 8.1 days. Outpatient clinic visits for the period were 128,038 or 6,254 (5.1%) above projected visits.

Total revenues over expense through January 31, 1986 are $10,921,636, a favorable variance of $5,497,323 reflecting both a favorable variance in net operating and non-operating revenues. Patient care charges through January totaled $113,396,939 (4.4% above budget). Ancillary revenue is approximately $4,419,000 (5.9%) above budget. Operating expenditures for the period were $102,144,316, or approximately $1,466,000 above budgeted levels.

The balance in patient accounts receivable as of January 31, 1986 totaled $50,658,855 representing 94.0 days of revenue outstanding. Total receivables increased during the month of January primarily within the Minnesota Medical Assistance category.

Mr. Fearing gave an itemized review of the January financial statements. In regard to the cash flow, he stated that total operating cash available of $3,932,305 plus transfers to plant of $4,222,866 plus transfer to sinking fund of $4,289,167 equals cash generated from operations of $12,444,338. Mr. Fearing concluded that the Hospital is in a very good position financially.

6/30/86 FINANCIAL PROJECTIONS (INFORMATION):

Mr. Fearing provided the Committee with a Summary Statement of Operations and Operating Cash flow for 1985-86 FYE. Census is projected at 17,190 for inpatient admissions (4.2% under budget), 142,670 patient days (1.5% below budget), and 218,000 clinic visits (3.3% over budgeted figure). In summary, the projections show a steady decline in total population, an increase in intensity of care and a loss of less acute patients.

Data from the the first six months of this fiscal year was used to project the figures shown on the Summary. Mr. Fearing explained that Gross Patient Charges are expected to be about $4.5 million over budget and Deductions from Charges will be slightly under budget. At fiscal year-end, the Hospital is expected to be 45 FTE positions over budget, putting Salaries over budget by about $1.5 million. Allowance has been made in these projections for comparable worth adjustments. Other major areas of expenditure variance are due to booking depreciation and interest expense for Unit J.

Revenue over Expenses is expected to be $9,317,180 and Total Cash Available from Operations after capital purchases and other deductions is projected to be $3,391,350. Mr. Fearing stated that no significant changes are foreseen and our positive position will hold for the remainder of the year.

MINNESOTA MEDICAID UPDATE (INFORMATION):

Mr. Fearing introduced Mr. Dan Rode who presented background information on Minnesota Medical Assistance (MA) and the recent changes in the MA program. Mr. Rode explained that a cost/charge system for MA payments was in place up until 1983. In October of 1983, a prospective payment system was initiated using a flat payment per discharge. In August of 1985, the state proposed a payment system based on 36 diagnostic categories. Problems with initiating the new system led to the establishment of an interim payment system reimbursing hospitals 80% of charges. When the system based on diagnostic categories went into effect on

January 18, 1986, it was found that there were considerable problems with formulas for the new program. Currently there is negotiation occurring between the state and the Minnesota Hospital Association to correct the payment rates but it is unclear what the effective date of the changes will be. Mr. Rode added that until the final payment rates are determined, the exact impact on UMHC cannot be determined.

ADJOURNMENT: There being no further business, the meeting of the Finance Committee was adjourned at 11:30 am.

Respectfully submitted,

Jane E. Morris
Recording Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

March 26, 1986

TO: Members, Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Report of Operations for the Period
July 1, 1985 through February 28, 1986.

The Hospital's operations for February reflects inpatient census levels that are below budget and an outpatient census that continues to be above budgeted levels. Ancillary service utilization continues at levels higher than anticipated with regard to both inpatient and outpatient populations. To highlight our position:

Inpatient Census: For the month of February, inpatient admissions totaled 1,308 or 52 below projected admissions of 1,360. Our overall average length of stay for the month was 8.5 days. Patient days for January totaled 10,933 and were 332 days below projections.

Nearly all service areas experienced admission levels below budget this month. Only Psychiatry, Surgery and Urology experienced admission levels above budget during February. The year-to-date decrease in admission levels is primarily in the areas of Medicine, Newborn/Obstectrics, and Otolaryngology.

To recap our year-to-date inpatient census:

	1984-85 Actual	1985-86 Budget	1985-86 Actual	Variance	% Variance
Admissions	12,293	11,846	11,555	<291>	<2.5>
Avg. Lgth. of Stay	8.6	8.1	8.3	0.2	2.5
Patient Days	105,774	97,051	95,222	<1,829>	<1.9>
Percent Occupancy	64.9	66.8	66.3	<0.5>	<0.7>
Avg. Daily Census	435.3	399.4	391.9	<7.5>	<1.9>

Outpatient Census: Clinic visits for the month of February totaled 16,996 or 867 (5.4%) above projected visits of 16,129. The February year-to-date clinic census totaled 145,034 visits and is 5.2% (7,121 visits) above budget and 5.1% (7,016 visits) above our February total of a year ago.

Financial Operations: The Hospitals Statement of Operations shows total revenues over expenses of $112,344,884 a favorable variance of $6,488,781. This overall variance reflects both a favorable variance in net revenues from operations of $4,651,000 and a favorable variance in non-operating revenue of $1,838,000 due primarily to our investment income being higher than anticipated.

Patient care charges through February totaled $128,518,101 and is 4.6% above budget. Routine revenue is 0.8% above budget and differs somewhat from our patient day variance which is 1.9% below budget. This difference continues to be due to a change in the mix of our bed utilization whereby we have experienced a slightly higher proportion of patient days in our higher priced beds (Intensive Care Units and Psychiatry). Ancillary revenue is approximately $5,375,000 (6.3%) above budget and relates to the fact that (1) outpatient clinic visits are above projections, and (2) the utilization of ancillary services per patient are higher than anticipated. Inpatient ancillary revenue has averaged $5,941 per admission compared to the budgeted average of $5,570 per admission. Outpatient revenue per clinic visit is averaging $148 compared to the budgeted average of $136.

Operating expenditures through February totaled $115,758,077 and are approximately $1,700,000 (1.5%) above budgeted levels. The overall unfavorable variance is primarily related to personnel costs (salaries and fringe benefits), drugs, and medical supplies. The increased expenditure levels in these categories continues to reflect an increase in the average acuity of the inpatient population and the increase in our outpatient census levels. The increase in the overall acuity level of our inpatient population is evidenced by both the increase in the utilization of intensive care beds and the increased level of ancillary service utilization.

Accounts Receivable: The balance in patient accounts receivable as of February 28, 1986 totaled $52,096,901 and represents 94.3 days of revenue outstanding. The increase in receivables this month occurred primarily within the commercial insurance and Minnesota Medical Assistance categories.

Conclusion: The Hospital's overall operating position through February remains positive and above budgeted levels. While our inpatient census levels continue to be lower than anticipated, the impact is being offset by increased intensity of care and by outpatient demand in excess of budgeted levels.

/jem

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1985 TO FEBRUARY 28,1986

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$122,833,154	$128,518,101	$5,684,947	4.6%
Deductions from Charges	-19,499,840	-19,195,280	304,560	1.6%
Other Operating Revenue	2,800,931	3,162,561	361,630	12.9%
Total Operating Revenue	106,134,245	112,485,382	6,351,137	6.0%
Total Expenditures	-114,058,184	-115,758,077	-1,699,893	-1.5%
Net Operating Revenue	-7,923,939	-3,272,695	4,651,244	0.0%
Non-Operating Revenue	13,780,042	15,617,579	1,837,537	13.3%
Revenue Over Expense	$5,856,103	$12,344,884	$6,488,781	(1)

(1) Variance equals 5.4 % of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	11,846	11,555	-291	-2.5%
Patient Days	97,051	95,222	-1,829	-1.9%
Average Daily Census	399.4	391.9	-7.5	-1.9%
Average Length of Stay	8.2	8.2	0.0	
Percentage Occupancy	66.8%	66.3%	-0.5%	-0.7%
Outpatient Clinic Visits	138,018	145,034	7,016	5.1%

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1985 TO FEBRUARY 28, 1986

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$122,833,154	$128,518,101	$5,684,947	4.6%
Deductions from Charges	19,499,840	19,195,280	-304,560	-1.6%
Other Operating Revenue	2,800,931	3,162,561	361,630	12.9%
Total Revenue from Operations	$106,134,245	$112,485,382	$6,351,137	6.0%
Expenditures				
Salaries	$53,729,835	$54,855,134	$1,125,299	2.1%
Fringe Benefits	9,554,539	10,228,065	673,526	7.0
Contract Compensation	5,851,994	5,880,235	28,241	0.5
Medical Supplies, Drugs, Blood	17,202,763	18,224,023	1,021,260	5.9
Campus Administration Expense	3,945,348	3,945,348	0	
Depreciation	4,941,484	5,110,695	169,211	3.4
General Supplies & Expense	18,832,221	17,514,577	-1,317,644	-7.0
Total Expenditures	$114,058,184	$115,758,077	$1,699,893	1.5%
Net Revenue from Operations	$-7,923,939	$-3,272,695	$4,651,244	
Non-Operating Revenue				
Appropriations	$9,455,138	$9,455,138	0	
Interest Income on Reserves	2,857,246	4,627,614	$1,770,368	
Shared Services	266,056	303,648	37,592	14.1%
Investment Income on Trustee Held Assets	1,201,602	1,231,179	29,577	2.5
Total Non-Operating Revenue	$13,780,042	$15,617,579	$1,837,537	13.3%
Revenue Over / -Under Expenses	$5,856,103	$12,344,884	$6,488,781	(1)

(1) Variance equals 5.4% of total budgeted revenue.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

March 21, 1986

TO: Board of Governors

FROM: C. Edward Schwartz C. Edward Schwartz

SUBJECT: **Comparable Worth**

I am writing to request your approval to proceed with payment of comparable worth increases for 1985-86, per the Board of Governors resolution of April, 1985. A copy of that resolution is attached.

The Board approved a comparable worth implementation plan in April, 1985. Funding for the plan was included in the 1985-86 budget. Authorization for payment of the actual increases was not requested at that time, however, primarily due to the fact that the Board of Regents had not yet approved a University (non-hospital) pay equity plan. The Board of Governors, as you may recall, has expressed an interest in acting in concert with the Board of Regents on this matter.

The Board of Regents did approve a pay equity plan at their March 7th meeting. The University plan which was approved by the Regents was the same as that developed by the Universtiy Personnel Department earlier in the year, i.e., the Regents approved the plan which we had anticipated when the Hospital plan was developed.

Given the Regent's action, we now request Finance Committee and Board of Governors authorization to actually pay the comparable worth increases per the principles endorsed earlier. The cost of implementation is $450,000 (a portion of this amount has already been provided to AFSCME employees, per our contract settlement last August). Fifty one employee classes and approximately 1900 employees receive comparable worth increases under the proposed plan.

We are in the process of developing compensation plan recommendations for fiscal year 1986-87, including a second year of implementation for comparable worth. These recommendations will come to you at the April and May Board meetings.

We will be happy to answer any questions you may have on this subject.

University Hospitals and Clinics

Comparable Worth Plan Summary

1. The male market line, established as part of University Hospitals' job evaluation and comparable worth study, shall be the pay line which shall be targeted for purposes of the Hospitals' compensation practices.

2. The use of the targeted pay line shall be applied to female dominated, male dominated and balanced job classifications.

3. The initial phase of implementation shall be structured such that the affected job classifications which are more than 5% away from the targeted pay line shall be brought to within 5% of the targeted pay line.

4. The initial phase of implementation shall be four years in length.

5. During the four year initial implementation period, and at the end of the four year implementation period, continued comparable worth analyses will be conducted. Additional adjustments may be necessary after the initial four year period if there continues to be a differential between the target payline and the female internal payline.

Board of Governors

Resolution on Comparable Worth

April 24, 1985

Whereas, the State of Minnesota and University of Minnesota have made a commitment to pay equity in compensation practices, and

Whereas, consistent with that commitment, University Hospitals has completed a job evaluation study and comparable worth analysis, and

Whereas, the findings of the job evaluation study and comparable worth analysis suggest that certain adjustments may be appropriate, and

Whereas, the objective of the Board of Governors is to take action consistent with those adjustments,

Therefore be it resolved, that the Board of Governors endorse the direction outlined in the five point plan recommended by hospital administration (attached), and

That the Board of Governors instruct hospital administration to incorporate the comparable worth plan into the Hospitals' financial planning process for fiscal year 1985-86, and

That the Board of Governors instructs hospital administration to continue to provide the Board with information, and recommendations where appropriate, on any modifications to this plan which may be considered based upon Federal action, State action, Board of Regents action, the results of the comparative Hospital/University job evaluation study, or other factors which may arise in the future.

PEAT MARWICK

Peat, Marwick, Mitchell & Co.
Certified Public Accountants
1700 IDS Center
Minneapolis, Minnesota 55402

January 15, 1986

CONFIDENTIAL

Ms. Barbara O'Grady, Chairperson
Hospital Board of Governors
Mr. C. Edward Schwartz, Hospital Director
University of Minnesota Hospitals and Clinics:

Dear Ms. O'Grady and Mr. Schwartz:

We have examined the financial statements of University of Minnesota Hospitals and Clinics (the Hospitals) for the year ended June 30, 1985, and have issued our report thereon dated October 18, 1985. As a part of our examination, we made a study and evaluation of the Hospitals' system of internal accounting control to the extent we considered necessary to evaluate the system as required by generally accepted auditing standards. Under these standards, the purposes of such evaluation are to establish a basis for reliance on the system of internal accounting control in determining the nature, timing, and extent of other auditing procedures that are necessary for expressing an opinion on the financial statements and to assist the auditor in planning and performing his examination of the financial statements.

The objective of internal accounting control is to provide reasonable, but not absolute, assurance as to the safeguarding of assets against loss from unauthorized use or disposition and the reliability of financial records for preparing financial statements and maintaining accountability for assets. The concept of reasonable assurance recognizes that the cost of a system of internal accounting control should not exceed the benefits derived and also recognizes that the evaluation of these factors necessarily requires estimates and judgments by management.

There are inherent limitations that should be recognized in considering the potential effectiveness of any system of internal accounting control. In the performance of most control procedures, errors can result from misunderstanding of instructions, mistakes of judgment, carelessness and other personal factors. Control procedures whose effectiveness depends upon segregation of duties can be circumvented by collusion. Similarly, control procedures can be circumvented intentionally by management either with respect to the execution and recording of transactions or with respect to the estimates and judgments required in the preparation of financial statements. Further, projection of any evaluation of internal accounting control to future periods is subject to a risk that the procedures may become inadequate because of changes in conditions and that the degree of compliance with procedures may deteriorate.

Our study and evaluation of the Hospitals' system of internal control, which did not extend beyond October 18, 1985, was made for the purpose set forth in the first paragraph above and would not necessarily disclose all material weaknesses in the system. However, our study and evaluation disclosed no conditions that we believe result in more than a relatively low risk that errors or irregularities in amounts that would be material in relation to the financial statements of the Hospitals may occur and not be detected within a timely period.

We have presented our comments and recommendations regarding internal accounting control and other operating matters to Mr. Clifford P. Fearing, for his consideration, in our letter dated December 31, 1985. In the attached Exhibit, we are presenting an observation and recommendation contained in that letter which we believe warrants your consideration. The remaining observations and recommendations discussed in the letter to Mr. Fearing are related to internal accounting control and other operating matters that fall entirely within the scope of administrative responsibility, and implementation should not require Board of Governors action.

We would like to acknowledge the cooperation and courtesy extended to us by the officers and employees of the Hospitals during our examination.

Very truly yours,

Peat, Marwick, Mitchell & Co.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
RESPONSE TO PEAT, MARWICK, MITCHELL & CO. MANAGEMENT LETTER
FISCAL YEAR ENDING JUNE 30, 1985

ACCOUNTING AND MANAGEMENT REPORTING SYSTEM

Comment and Recommendation:

The Hospital is an accounting entity within the University of Minnesota (the University). As such, the accounting transactions of the Hospital are processed by the University general ledger system. The Hospital operates its own general ledger system to meet its own reporting requirements. The source of information processed by that system is data extracted from the University general ledger system through an interface with the University. A result of this processing method is that accounting for the Hospital's transactions are complex. The monthly general ledger closing procedures involve significant amounts of staff and management time.

The Hospital's current general ledger system was designed during the 1970s. Significant changes in the health care delivery system have occurred since that time. As a result, the financial information requirements of Hospital management have been greatly expanded, especially in the areas of cost accounting and operations management. The current general ledger system was not designed to provide management with the flexibility to obtain the data necessary for effective analysis and management in today's rapidly changing health care environment.

The Hospital and the University should work together to investigate alternatives to the current Hospital's general ledger system. We recommend that the Hospital obtain an accounting and management reporting system through which the Hospital's transactions are processed directly. The required interface with the University should be made from the Hospital's general ledger system to the University system, utilizing month-end summary accounting data processed by the Hospital. The Hospital's accounting system should provide the flexibility for management to obtain relevant cost accounting information for future strategic planning and analysis.

Response:

UMHC agrees with this comment and recommendation. We are currently reviewing and evaluating several software packages that will provide more flexibility as well as operational efficiencies. A July, 1987 implementation date is anticipated.

Discussions have commenced with the University relative to changing the way the Hospital reports financial transactions.

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

BOARD OF GOVERNORS

QUARTERLY REPORT TO THE REGENTS

MARCH 14, 1986

Chairman McGuiggan, members of the Board of Regents, I am pleased to be here with you this morning. Because this spring marks an especially exciting time for the University Hospitals, I would like to take a different approach to my presentation this morning. I have not included our regularly scheduled financial review or purchasing reports, for example, but have instead taken a step back to more comprehensively review the position of the Hospitals through the eyes of the Board of Governors.

You will recall that about sixteen months ago, the Hospitals embarked on a centrally coordinated marketing program. The Board of Governors felt, at that time, that if a marketing program was to meaningfully contribute to the long term viability of the organization, it had to go well beyond advertising our services. We viewed marketing as a mechanism to systematically evaluate our strengths and weaknesses and as a mechanism to help focus our priorities as an institution.

These months have indeed been a period of discovery and progress for the Hospitals.

First, recognizing that the type of insurance carried by a patient is an increasingly influential factor in choosing a hospital, we are aggressively pursuing contractual relationships with metro insurers and HMOs. In August of 1985 we agreed, with your support and the direct involvement of the medical staff, to acquire ownership interest in a new HMO, the Primary Care Network. P.C.N. now has a solid management staff on board and began enrolling members on March 1st. Several specific communities have been targeted for penetration. Early responses to enrollment offerings have been quite good.

The incorporation of the Medical Practice Plans was also a significant step in making these contractual relationships possible. We now have one organization, the University of Minnesota Clinical Associates, that can represent the Medical Staff in negotiating the professional service component of these contracts. Their presence and leadership in negotiations have been clearly been an asset.

Secondly, the Board of Governors felt strongly that once we worked to secure financial accessibility for patients to our institution we must be ready to treat each in a way that sends them home well cared for physically, but also with a positive impression of our Hospitals. Unit J is, of course, the most obvious improvement in making our patients more comfortable during their stay. Beyond the vast technological improvements available in the new building, we can provide patients and families with a more easily recognizable front door entrance, more instructive building signage, a tranquil view of the Mississippi River, convenient waiting areas and an attractive place to dine.

As an aside, the Hospitals' Chief Financial Officer, Cliff Fearing, and his staff continue to assist Vice President Lilly in monitoring bond interest rates to determine whether or not a second refinancing of the Series 1982 bonds would be prudent.

We are now surveying each patient discharged from the University Hospitals to solicit their impressions of the care and service received. Information obtained from discharged patients is being shared with the appropriate hospital employees and physicians.

One of the major concerns expressed by patients is difficulty in parking. I am delighted to report that the excavation of the new ramp site has begun. We are expecting to complete construction of the ramp in May or June of this year.

The Hospitals also recently initiated a program called "Patients First". The objective of the program is, basically, to formulate a positive cultural change and attitude. The concept is just now being introduced and will include, for example, communications training to those employees who most frequently interface with patients and visitors. As new medical residents are oriented each year, that introduction will include, for lack of a better term, emphasis on a customer oriented approach.

As has been a tradition at the Hospitals, the strength of our clinical, educational and research capabilities represent our foundation. For the sake of brevity, I will simply acknowledge the uncompromising commitment to excellence in these areas.

The Board of Governors and the Hospital staff also continue to carefully monitor proposed changes to the Medicine DRG payment system. Options for reimbursing Hospitals for major building and equipment expenditures are now under discussion. The administration has proposed regulatory changes that would have a profoundly negative effective on our Hospital. Senator Durenberger has suggested an alternative payment plan in the form of a Senate bill that would correct many of the inequities of the administration proposal.

Today, Mr. Schwartz and Mr. Fearing are in Washington testifying before the Health Subcommittee on these important payment alternatives. We will keep you apprised of the outcome of these hearings.

Lastly, I would note that activity and financial projections for the Hospitals 1986-87 budget year are currently being formulated. We will be sharing those projections with you approximately sixty days.

These examples represent a brief sampling of priorities shared by the Board of Governors and the Hospital staff.

During the past several weeks, thousands of interested citizens, state wide, have toured our new hospital. It is with great enthusiasm that we look forward to fulfilling the expectations that we have created for the public.

Thank you for the opportunity to share these thoughts with you. I would, at this point, be pleased to respond to any questions that you may have.

STATEMENT
OF THE
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE
OF THE UNITED STATES SENATE
ON
MEDICARE REIMBURSEMENT FOR CAPITAL COSTS
MARCH 14, 1986

SUMMARY

The University of Minnesota Hospital and Clinic (UMHC) is a major tertiary care teaching hospital located in Minneapolis, Minnesota. UMHC is in the process of operationalizing a major new building which replaces facilities, many of which are 70 years old. The current proposals by the Administration and Senate File 2121 in their present form will make it impossible for UMHC to provide adequate cash flows to pay its debt service and provide reasonable funds for future capital replacement needs. UMHC's situation is similar to that of several preeminent teaching hospitals, represented by the Coalition for Fair Capital Reimbursement, which includes twelve major institutions that have recently undertaken extensive mandatory renovation projects.

Congress must not leave this critical issue to the regulating agencies. The impact of incorporating capital into the prospective payment system must result in a fair and equitable system that takes into consideration existing capital commitments by hospitals and allows for fair and equitable access to capital for future years.

Congress must recognize that there are unique circumstances for certain hospitals which have made commitments to capital programs prior to the prospective payment system. Provision must be made for reimbursement of these capital costs just as the prospective payment system presently tailors payments in light of the special needs of various types of hospitals, such as sole community providers.

Flat rate national average per discharge payments must be eliminated and replaced with a system that does not create winners and losers because of a hospital's size, mission or place in its capital cycle.

The transition from cost pass-through payments to prospective payments must be of sufficient length to allow hospitals with major debt commitments to adjust to the new system without major disruptions in the provision of needed medical services.

Provisions for the advancement of medical technology must be made to assure that there will be funds available for future medical enhancements.

Congress must not make decisions regarding the capital payment structure in isolation. H.R.3838 and its companion bills in the Senate will also impact hospital capital costs and must be considered in conjunction with Medicare capital payments.

STATEMENT
OF THE
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE
OF THE UNITED STATES SENATE
ON
MEDICARE REIMBURSEMENT FOR CAPITAL COSTS
MARCH 14, 1986

The University of Minnesota Hospital and Clinic (UMHC) appreciates the opportunity to testify before the Subcommittee on the subject of capital financing under the Medicare Program and to discuss the incorporation of capital-related costs into the Medicare Prospective Payment System (PPS). UMHC commends Senator Durenberger's initiative in commencing an early dialogue on this subject among Members of Congress, Administration officials, the health care industry and other interested parties. The time devoted by the Subcommittee to this issue is extremely important. At stake here literally may be the future of many of the Nation's finest teaching hospitals, which for decades have been an essential part of the foundation of the American medical care system. Although we recognize that health policy must change in accord with other national priorities, we believe that any change must be fair and equitable.

The University of Minnesota Hospital and Clinic is a major teaching hospital located in Minneapolis, Minnesota. UMHC today is almost seventy-five years old. From its inception, its mission has been to provide state-of-the-art health care to patients from all parts of the country, to provide clinical education to graduate and undergraduate students in medicine and the other health sciences, and to serve as a center for

medical research. Over the years, UMHC has developed a broad range of health services that include a full range of inpatient and outpatient services in all medical specialty areas. This breadth of services includes complex, highly sophisticated tertiary care that is unavailable in community hospitals. At the present time, over half of the physicians who practice in the State of Minnesota are graduates of the University Medical School and significantly more than half received their residency training at the University. UMHC is clearly a cornerstone of the research and development component of the Minnesota health care system.

Although its complementary roles in education and research are equally critical to the fulfillment of its overall mission, UMHC is perhaps best known to the public for its outstanding patient care programs. Each year, tens of thousands of patients from the Minneapolis area, Minnesota, and throughout the Midwest and the country rely upon UMHC for medical care. Last year, UMHC provided 155,000 days of inpatient care to over 18,000 patients from across the country. As the nation's largest transplant center, UMHC is truly one of country's major providers of health care.

UMHC has one of the ten largest health sciences education programs in the country. Likewise, the health sciences research programs at the University of Minnesota have grown to the extent that UMHC is one of the largest health research centers in the Nation today. UMHC has played a prominent role in the development and testing of many new diagnostic and therapeutic protocols. Continued success in this area requires that UMHC

provide contemporary and progressive facilities to support the closely intertwined functions of patient care, teaching and research with a team of academicians, clinicians, practitioners and students.

UMHC is also a member of the Coalition for Fair Capital Reimbursement and is also appearing on their behalf. Although just recently organized, the Coalition already includes some of the Nation's preeminent teaching hospitals -- specifically, Brigham and Women's Hospital, the University of Michigan Hospitals, Montefiore Medical Center (New York), Mount Sinai Medical Center (New York), the New York Hospital, the Presbyterian Hospital in the City of New York at Columbia-Presbyterian Medical Center, the Stanford University Hospital, St. Luke's-Roosevelt Hospital Center, the University of West Virginia Hospital, the University of Washington Hospital and the University of Virginia Hospitals, as well as UMHC.

The Coalition for Fair Capital Reimbursement represents hospitals which have a number of unique capital characteristics and public service attributes which we sincerely believe necessitate special attention as Congress formulates legislation to incorporate capital-related costs into PPS.

The following is a summary of some of the common features of the Coalition's membership:

All of the members of the Coalition are major teaching hospitals, with an average size of over 1,000 beds. Each member plays a highly important role in the health care delivery system of its community and the Nation.

Each is a recognized center of excellence for both secondary and tertiary care. In addition, each performs major education and research functions.

All of the members of the Coalition are in the process of undertaking major renewal projects that require substantial capital expenditures. Their renewal projects are necessary at this time because their facilities with an average age of 55 years are functionally obsolete, inadequate to their mission, and generally substandard. Typical of Coalition members is the substantial age of hospital structures that these projects are intended to renovate or replace. For example, the 50-year old physical plant at UMHC has suffered from numerous accreditation and safety code deficiencies so as not to be able to adequately support UMHC's patient care.

Due to the obsolescence of their structures, these major teaching hospitals are also at a critical point in the "capital cycle." Without major renovation/replacement projects, they simply cannot survive as major teaching hospitals. Because these institutions have delayed inevitable major capital projects for long periods, their need for these projects has now become acute.

For many of these projects, such as that at UMHC, construction was initiated prior to the enactment of PPS in good faith reliance upon the cost-reimbursement methodology existing at the time. In every case, the project has been necessitated by compelling need. For each of these projects, there were substantial expenditures such as architects', engineers' and consultants' fees, prior to the enactment of PPS.

Many of the members of the Coalition must honor commitments to make outlays for essential capital projects that, as a percentage of operating costs, are well in excess of the national average. Thus, after its project is completed, UMHC projects a ratio of capital costs to operating costs that is almost twice the national average for many years.

Each of the hospitals in the coalition will suffer significant losses in Medicare reimbursements under the Administration's proposal and Senate File 2121.

The unique situations of the hospitals in the coalition demonstrate that Congress must carefully consider the impact of their actions on certain major teaching hospitals of this country. A payment system that does not consider the unique roles and circumstances of these academic health centers could jeopardize their ability to fulfill the roles society has asked them to play, and because of the numerous and significant contributions of these hospitals to the advancement of the quality of health care, could threaten a very great proportion of the health industry.

SUBSTANTIAL SOCIAL CONTRIBUTION

Major teaching hospitals such as UMHC and the other Coalition members provide an essential public service to the Nation through their health care services. The contributions of these hospitals are unique because of both their enormous volume of patient care services and their advanced tertiary

care services that are available only in a relatively small number of major teaching institutions. Hospitals like UMHC serve as essential backups to community hospitals for services typically available only in the major referral centers. Further, their education programs in the various medical specialties and subspecialties, as well as their contributions to the advancement of medical science and technology, are well-recognized. What will be available in the community hospital in the next decade will be developed in the large research centers today, and passed on to the community during the next several years.

The finest health care in the world is available in the United States due to this country's major teaching institutions. Indeed, these institutions are the essential foundation of the Nation's present and future health care delivery system. Although there are 1,500 teaching hospitals that are involved in graduate medical education, less than 100 of these hospitals train almost half the country's residents. These major teaching hospitals develop most of the innovations in medical care and train the country's physicians in the application of these new technologies and treatment techniques. Unless these institutions continue to play their research and development roles as they have historically, the future of health care in the United States would be unlikely to match the present record of medical progress and achievement.

As a major teaching hospital, UMHC has always been in the forefront of the quest for new and improved patient care services. Its nationally recognized programs in areas such as spinal cord injury, diabetes,

oncology, anorexia nervosa, Neonatology, as well as cystic fibrosis and organ transplantation, demonstrate its importance in meeting health care needs in a large geographical area. These patient care service capabilities are dependent upon, and reflect, UMHC's mixture of outstanding medical and other health professionals, advanced training programs, a broad range of basic and clinical research, unique technological capabilities, and interaction among the various UMHC health sciences units.

UMHC and the other teaching hospitals make indispensable social contributions that must not be threatened by the methodology by which capital is integrated into PPS.

THE UMHC PROJECT IS ESSENTIAL TO REPLACE OBSOLETE STRUCTURES

UMHC is not just another hospital providing care to the people of the Minnesota region, rather it serves the unique role of being the core teaching facility for the discovery oriented medical and health sciences schools. There are other fine teaching hospitals in Minnesota, but only UMHC serves as the site where the basic and clinical researchers come together to develop the new, the different, the improved life saving procedures and patient care patterns. The facility replacement project is necessary to afford this unique organization a building that is contemporary with modern medicine.

For many years, UMHC has been faced with obsolete, inadequate, and substandard facilities. Several buildings of the UMHC campus being replaced are over seventy years old, and planning for this specific project began as early as twenty years ago. In 1974, UMHC undertook an extensive facility study that provided a technical, detailed demonstration of the need for substantial facility improvement due to extensive space deficiencies, inadequate functional relationships, unmet environmental needs, and general impediments to efficient operation. By 1980, the UMHC facilities were determined to be inadequate from the standpoint of design, space, mechanical/plumbing/electrical systems, building codes, vertical transportation, and circulation for acute patient care and support activities. In fact, UMHC was frequently cited by the Joint Commission on Accreditation of Hospitals for serious deficiencies that required renovation in order to comply with accreditation standards. In addition, the structural, mechanical, and utility systems were incapable of accepting many new and needed types of equipment. Further, stopgap remodeling measures had proven to be inadequate and extremely expensive. UMHC was spending $2 - $3 million annually for such palliative measures. Accordingly, after an exhaustive study of renovation and replacement plans, in April 1980 a replacement program was adopted calling for a capital expenditure of $233 million.

Next, the UMHC project was subjected to an extremely rigorous certificate of need (CON) process. At each stage of CON review, UMHC was called upon to demonstrate a compelling need for the replacement

facilities. Based upon the cramped and outmoded facilities, the CON for the replacement project was approved in December 1980. The project has also been subjected to rigorous legislative review by the State of Minnesota. In 1981, demolition and construction for the project began. Due to the major changes taking place in the provision of health care which were reducing admissions and average lengths of stay for inpatient services, in 1982 UMHC significantly reduced the size of the project, reducing the total project cost from $233 million to $126 million, for a savings of over $100 million. In December 1982, UMHC sold $157 million in hospital revenue bonds to finance the project which including interest during construction totaled $217 million. UMHC refinanced the bond debt in the Spring of 1985 to achieve further economies based upon lower interest rates and new financing vehicles. All of these actions were undertaken in good faith reliance upon the existing cost-based Medicare reimbursement system.

UMHC's situation is an example of the kind of case for which we would request that the Senate Finance Committee provide fair transition relief, as the Committee has typically done in comparable instances in the past in order to avoid inequities under PPS. The need for this project has been adequately demonstrated, financial commitments for the project have been made and the building is about to be made operational.

The Administration's proposal completely ignores and Senate File 2121 only partially addresses the circumstances and financial requirements that are associated with projects of this kind. None of the current proposals

provide adequate payments to allow UMHC to repay its debt and provide for reasonable capital replacement in future years. Between 1988 and 1997, UMHC's capital costs will average 14.5% of total operating costs. Under the Administration's current proposal, Medicare payments for capital will be approximately 6.3% of operating costs in 1988 and will drop to approximately 2.8% of operating costs by 1992. The Administration's proposed capital payment system will represent a loss of over $49 million in Medicare reimbursements for UMHC by 1997. Senate File 2121, although less severe, will create a loss of over $27 million in Medicare capital payments between 1988 and 1997. These are extremely severe penalties to impose on hospitals who happen to have been unfortunate enough to be caught in the wrong window of construction time.

NEED FOR EQUITABLE TRANSITION RELIEF

There is general agreement that the incorporation of capital-related costs into PPS could be very harmful in the absence of reasonable transition rules. This will be true particularly with respect to the Coalition hospitals such as UMHC, which have undertaken large capital projects to replace existing structures that are obsolete and desperately in need of renovation. Simple national average cost per discharge add-on formulas threaten to redistribute limited funds from hospitals that presently must make substantial capital expenditures to those hospitals without this need. The risk of harm is especially great during the current period of financial pressure on major teaching hospitals which stems from such factors as reductions in support for graduate medical education,

impending changes in the tax laws which could significantly change the availability of tax-exempt financing and increase capital costs, reductions in research funds, employer initiatives to cut health costs, and the growth of alternative delivery systems (e.g., HMOs, PPOs, and IPAs). Clearly at times like this a fair transition mechanism is warranted and it is imperative that Medicare pay its fair share of these acknowledged facility needs.

Provision must be made in any new Medicare payment system to recognize the unique circumstances of hospitals who have made significant capital commitments prior to the announcement of a new capital payment system for Medicare patients i.e., April 1983 and for hospitals who, by necessity, must replace their facilities during the transition period. UMHC had completed its planning and issued $157 million in long term bonds to complete its renewal project prior to the announcement of a new prospective payment plan by Congress in 1983. These commitments must be honored and all payors whose patients utilize these buildings and equipment must share their responsibility for payment of these commitments. This includes Medicare.

In addition to the need to develop special provisions for payments for capital projects committed prior to the announcement of a new capital payment system, the Administration's and Senate File 2121 proposals are designed around several assumptions which will create an inequitable payment system. The following areas in the respective proposals need to be adjusted to provide a fair and equitable payment system for capital costs.

HIGHER CAPITAL NEEDS IN TEACHING HOSPITALS

Analysis by the Association of American Medical Colleges[1] has indicated that historically, per unit of services, capital costs are higher in tertiary teaching hospitals than they are in non-teaching hospitals. The Administration's and proposed Senate File 2121 use a single average cost per discharge in computing the capital payment for all hospitals. The effect of this approach is to overpay the smaller, less acute facilities for capital, which will create windfall profits for those institutions, while underpaying the larger more acute facilities, which will leave these hospitals without adequate resources to pay their debt service and to provide for reasonable capital replacement funds. This outcome is extremely evident in the case of UMHC. As I mentioned previously, by 1992 under the Administration's proposal, Medicare will be paying about 2.8% as an add-on to the DRG for UMHC capital costs, when effectively UMHC's capital costs will be in excess of 14% of total operating costs. It is obvious that the averaging approach fails to recognize the above average capital costs of tertiary teaching hospitals and will have a major negative impact on hospitals such as UMHC. In addition, the present proposals force losses onto new facilities regardless of efficiency. Unlike operating costs, capital costs are substantially fixed costs and cannot be managed down without sufficient time once the commitments have been made.

(1) Capital costs in COTH hospitals, Bently, James D., Ph.D., 2/9/84.

Conversely, facilities with older assets will be reimbursed the average regardless of efficiency or need. The effect of the current proposals is to jeopardize the future of hospitals which have recently initiated or completed capital projects and may prolong the life of hospitals which are under-utilized by providing them the opportunity to use windfall capital payments to subsidize operating costs. Use of a national average add-on that is not based on a percentage of operating expenses for capital will erode the tertiary care teaching hospitals ability to continue to provide high quality medical care, education and medical advancements.

LONGER TRANSITION PERIODS

The transition period in the Administration's proposal is totally inadequate and although Senate File 2121 lengthens the transition period, it is still not long enough. Bond payment commitments, particularly those of hospitals with recently completed or in process construction, are usually at least twenty years in duration and many have lengthy non-call provisions which were devised to reduce overall interest costs. Without an adequate transition period, many hospitals, particularly those with new capital commitments, may be unable to meet the commitments to their bond holders. H.R.3838 and similar restrictions in tax exempt bond financing under consideration by the senate will exacerbate this problem by restricting a hospital's ability to issue tax exempt debt or to restructure its existing debt through advance refundings. This could create a situation of double jeopardy for hospitals by increasing its cost of capital and reducing its ability to lower its debt.

BASE YEAR

The Administration's proposal use 1983 as a base year for determining the prospective payment system capital costs. Although an inflation adjustment is made in this proposal, 1983 does not include many major capital replacement projects such as UMHC's which are not included in the capital costs until they are put into service and therefore are not included in the national 1983 base year for capital costs.

INTEREST INCOME OFFSET

The present proposals further reduce Medicare payments by offsetting interest income on reserve funds and charitable contributions and yet neither proposal guarantees an increase for medical technology advancement. Interest earned on depreciation funds and gifts is imperative to provide the funds to meet the increasing costs of advancing medical technology. By utilizing interest income on funded depreciation and gifts to offset interest expense, no funds would be provided for technological advancement.

UMHC recognizes that national health policy must reflect changing circumstances and we do not oppose the incorporation of capital payments into the prospective payment system. We do object to the current Administration's proposal and Senate File 2121 because we do not believe they create a fair and equitable payment system.

In order to create a fair and equitable payment system for capital we have five recommendations:

First, it is imperative that the Congress recognize extraordinary capital costs which hospitals have already incurred. Just as there are hospitals with unique operating cost needs recognized under the prospective system, such as sole community providers and cancer hospitals, there are also hospitals with unique capital needs that warrant special consideration. Congress must assure that the projects for which funds were obligated prior to April of 1983 are reimbursed fairly so that bond obligations can continue to be met by the hospitals in these circumstances. We support Senate File 2121 which proposes that Medicare payments for capital costs during the period of transition from a cost pass through payment system to a prospective payment system should be based on a hospital's actual capital costs, and at the end of the transition period all payments for capital costs would be made on a prospective basis.

We would recommend that the flat fee national average add-on per discharge be eliminated from these proposals and replaced with methodology which take high costs of tertiary care, medical education and medical technology into consideration. We believe Senate File 2121 which provides adjustments for medical education and case mix is a step in the right direction but does not adequately correct the problem. UMHC believes that a percentage add-on to the DRG rates adjusted for case mix and indirect medical education, based on the national average of capital costs to

total operating costs, would remove the inequities of the flat rate add-on and at the same time sustain the same incentives and ease of administration that is sought by flat add-on rate proposals.

Second, we would recommend that the transition period be lengthened to allow hospitals the opportunity to restructure debt, utilize available optional call provisions and adjust to a new fund flow for capital. Since most long term financing involving a minimum of twenty to thirty years, we believe that a seven year minimum transition period is quite inadequate.

Third, UMHC believes that a base year calculation for the national rates should be determined using the current year data at the beginning of the transition period.

Fourth, we would recommend that provision must be made for the costs of advancing medical technology. If a medical technology add-on is not provided, then interest income on reserves and contributions should not be used as an offset to interest expense.

UMHC believes that if capital payments are to be included fairly in the prospective payment system they must be adequate and equitable or the present system should be continued. UMHC recognizes this issue is very complex and applauds the efforts of the Congress to fairly resolve the problem rather than allowing the regulatory agencies to use this as a quick deficit reduction measure which knowingly distributes the burden

inequitably. Any new payment policy should be established by Congress. If Congress cannot agree by the October 1, 1986 deadline, we would hope that the current payment system would be continued until Congress reaches resolution on this issue.

CONCLUSION

In summary, as Congress explores methods to incorporate capital-related costs into PPS, we urge that fair and equitable transition rules be adopted to reflect the unique capital projects and extensive social contributions of UMHC and the other Coalition hospitals. The continued success of these major teaching hospitals should not turn upon the vagaries of each hospital's position in the capital cycle. Preeminent institutions should not be penalized for being old, and for taking responsible measures to upgrade their facilities.

UMHC and the Coalition are anxious to work with the Subcommittee to create viable transition rules for major national centers of medical service delivery, education and investigation. UMHC respectfully urges Members of the Subcommittee to proceed carefully on this issue and that the Subcommittee consider transition rules that will incorporate capital costs into PPS equitably. Deserving hospitals need to be allowed to adjust to a new method of health care financing in a way which will not disrupt and threaten this vital component of our health care system.