UNIVERSITY OF MINNESOTA HEALTH SYSTEM AFFILIATED CLINICS
A MINNESOTA NONPROFIT CORPORATION
("UMHSAC")

Information Distributed to Directors in Advance of Meetings of the Board of Directors ("Directors Packets")

Directors Packet for 3/9/94 Meeting	Item 1
Directors Packet for 4/22/94 Meeting	Item 2
Directors Packet for 5/20/94 Meeting	Item 3
Directors Packet for 6/17/94 Meeting	Item 4
Directors Packet for 7/22/94 Meeting	Item 5
Directors Packet for 8/19/94 Meeting	Item 6
Directors Packet for 9/23/94 Meeting	Item 7
Directors Packet for 12/9/94 Meeting	Item 8
Directors Packet for 1/27/95 Meeting	Item 9
Directors Packet for 2/23/95 Meeting	Item 10
Directors Packet for 3/21/95 Meeting	Item 11
Material distributed prior to 3/29/95 teleconference meeting	Item 12
Directors Packet for 4/27/95 Meeting	Item 13
Directors Packet for 5/23/95 Meeting	Item 14
Directors Packet for 6/29/95 Meeting	Item 15
Directors Packet for 12/14/95 Meeting	Item 16

UMHSAC
THE DIRECTORS PACKET FOR THE 3/9/94 MEETING IS INCLUDED IN FULL IN UMHSAC'S MINUTE BOOK

University of Minnesota Health System
Affiliated Clinics, Inc.
420 Delaware St. S.E. Box 704
Minneapolis, MN 55455
Telephone: (612) 626-5559
Facsimile: (612) 624-8128

April 21, 1994

FACSIMILE COVER SHEET

TO: Mr. Thomas Doyle

FAX NUMBER: 222-8905

PHONE NUMBER: 222-6321

Total Transmitted Pages
***(Including Cover Sheet)*:** 10

Copy to follow by U.S. Mail:

☐ **Yes** ☑ **No**

FROM: Stephan C. Grygar

CONFIDENTIALITY NOTICE The document(s) accompanying this fax contain confidential information intended only for the use of the individual or entity named above. If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, copying or distribution of the communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return the original message to us at the above address via the U.S. Postal Service.

MESSAGE:

Attached please find material for the 4/22/94 Meeting of the UMHSAC Board of Governors. Time did not permit me to mail you an original set; I will have an original set for you at the meeting. I will also at the meeting have available, for anyone who wishes to review it, a final draft of the UMHSAC Personnel Policies and Procedures Manual.

Please call me with any questions.

University of Minnesota Health System
Affiliated Clinics, Inc.
420 Delaware St. S.E. Box 704
Minneapolis, MN 55455
Telephone: (612) 626-5559
Facsimile: (612) 624-8128

University of Minnesota Health System
Affiliated Clinics, Inc.
("UMHSAC")
4/22/94 Meeting of the Board of Governors

AGENDA

1. **Approval of 3/9/94 Minutes**

2. **Approval of UMHSAC Personnel Policies and Procedures**

3. **Discussion and Approval of UMHSAC Benefit Structure**

4. **Status of UAFP Management Services Agreement**

5. **Practice Acquisition Status**

6. **Governance Structure Discussion**

7. **Future Meeting Timetable**

University of Minnesota Health System
Affiliated Clinics, Inc.
("UMHSAC")
4/22/94 Meeting of the Board of Governors

TABLE OF CONTENTS

UNIVERSITY OF MINNESOTA
HEALTH SYSTEM AFFILIATED CLINICS, INC. ("UMHSAC")
Minutes of the 3/9/94 Meeting of the Board of Directors

Attendees

In Person	By Telephone Link	Non-Director Attendees
Patrick Board	Michael Fay	Keith A. Dunder, Hospital Counsel
Clifford Fearing		Stephan C. Grygar, UMHC Finance Department
Helen Pitt		Thomas J. Doyle, Attorney

All were present and participating throughout except Clifford Fearing, who left before the conclusion of the meeting.

Location

The conference room at the offices of the Hospital Counsel for University of Minnesota Hospital & Clinic (Room B-324 Mayo Building, University of Minnesota Hospital & Clinic, Harvard Street at East River Road, Minneapolis, Minnesota).

Order of Business

Clifford P. Fearing called the meeting to order at approximately 3:05 o'clock p.m., pursuant to prior notice, after all directors were present in person or by telephone link as noted above. It was confirmed that all directors had received the booklet entitled "University of Minnesota Health Systems Affiliated Clinics, Inc. -- Material for 3/9/94 Board Meeting" (the "Booklet"), a copy of the contents of which is to be filed with these minutes in UMHSAC's corporate records.

Clifford P. Fearing delivered his opening remarks as to the purpose of UMHSAC and the purpose of the Board meeting. He then asked Tom Doyle, legal counsel for UMHSAC, to discuss UMHSAC's structure, governance and proposed funding.

Tom Doyle first went through all the contents of the Booklet, explaining each document. He then described generally the proposed governance of UMHSAC (with reference to the nine-page governance structure outline in the Booklet), and described the proposed means of funding UMHSAC's acquisition of clinics (via a mix of loans from The University of Minnesota Health System and capital contributions from that System).

Steve Grygar then summarized UMHSAC's clinic acquisition processes, by reference to the Clinic Acquisition Processes Outline in the Booklet identified above, and reported on the status of possible acquisitions by UMHSAC. In the course of Tom Doyle's comments, and again in the course of Steve Grygar's comments, the procedure used by UMHSAC in establishing the value of a target clinic for the purpose of formulating an offer to that clinic, was presented and discussed. The directors were advised how the procedure matched up against the stated position of the Internal Revenue Service and what was known of the position of the Office of the Inspector General (as to the tax laws and the Medicare and Medicaid anti-fraud and abuse rules, respectively).

General reference was made to the information in the Booklet as to the following: functional relationships among UMHSAC and The University of Minnesota Health System and University Affiliated Family Practice, Inc. (which is expected to provide clinic management services to UMHSAC); UMHSAC reporting relationships and signature policies and guidelines; and operational matters which will be addressed over the coming months by UMHSAC's officers.

Tom Doyle was then asked to comment specifically on the proposed acquisitions by UMHSAC of assets of Staub Pediatric Group, P.A. and Palen Clinic, P.A. He referred to summary term sheets which had been distributed at the meeting (and which were transmitted to Mr. Fay by telefacsimile during the meeting, receipt of which was confirmed during the meeting). A copy of these summaries will be filed with these minutes in UMHSAC's corporate records. Tom Doyle then went over the proposed resolutions for consideration and possible adoption by the directors. The resolutions were included in the Booklet, except one additional resolution which was distributed at the meeting. On motion duly made by Helen Pitt, and seconded by Patrick Board, all three directors then still present and participating (Helen Pitt, Patrick Board and Michael Fay) voted in favor of the following resolutions, and so adopted the resolutions:

A. RESOLVED, the Articles of Incorporation and Bylaws of the corporation are ratified.

B. FURTHER RESOLVED, the acts of Keith A. Dunder incorporator, in the name of and on behalf of the corporation to the date hereof, including any acts prior to the formal incorporation of the corporation, all such acts being fully known to us, are hereby ratified and approved as acts of the corporation, and the officers of the corporation named below, are authorized and directed to pay out expenses incurred in connection with or as a result of all such acts, including but not limited to fees of legal counsel, and take all other action which the officers may deem necessary or appropriate in view of the ratification and adoption by the corporation of those acts.

C. FURTHER RESOLVED, the initial officers of the corporation shall be:

Name	Office
Clifford P. Fearing	Chief Executive Officer and Chief Financial Officer
Stephan C. Grygar	Assistant Treasurer and Administrator
Keith A. Dunder	Secretary

The officers shall serve until removed by the Directors of the corporation, or until their successors are elected, or until such other time as specified in the Bylaws of the corporation. The officers shall have such powers and duties as is accorded the office by the Bylaws of the corporation.

D. FURTHER RESOLVED, the first fiscal year of the corporation (for accounting and tax purposes) shall be the period ending December 31 each subsequent twelve month period ending on December 31 shall be the succeeding fiscal years of the corporation.

E. FURTHER RESOLVED, the corporation's officers are authorized and directed to establish one or more accounts, credit facilities, and/or any and all other banking relationships, as they deem necessary or appropriate for the conduct for the corporation's present and prospective activities, and to execute and deliver to any bank with which they establish any banking relationship, such instruments as they deem necessary or appropriate to establish, determine and maintain such relationship. The resolutions required by the bank(s) with which the officers determine to establish a banking relationship for the corporation, completed as to authorized signatory(ies) as such officers shall determine (so long as limited to one or more such officers), in connection with opening an account at or establishing another relationship with such bank(s), are hereby incorporated herein and approved, and the Secretary of the corporation is authorized and directed to certify as to our adoption of the same as if set forth here in full.

F. FURTHER RESOLVED, the Signature Policies and Guidelines presented to us at this meeting are approved and adopted by us, and the Secretary of the corporation is authorized and directed to attach a true and correct copy of those Policies to the minutes of this meeting, and/or to certify a true and correct copy of the same as the operating policies of the corporation adopted by this resolution.

G. FURTHER RESOLVED, the officers of the corporation are authorized and directed, in addition to authority and direction conferred above, to:

1. Retain on behalf of the corporation an accountant;

2. Retain on behalf of the corporation legal counsel;

3. Take any and all other action which the officers in their discretion deem necessary or appropriate to complete the above authorized matters, to conduct the normal affairs of the business of the corporation, to obtain identification numbers from appropriate taxing authorities for purposes of such reporting as the corporation may be obligated to make, to secure adequate insurance of all types they deem necessary, from time to time, to protect the corporation and its assets, to purchase assets for and on behalf of the corporation to enable it to undertake its affairs and business, and to carry out the intent of the foregoing directions; and

4. Proceed with organizing acquisitions of clinics by the corporation. Negotiations of acquisitions for several clinics are currently in process and the officers of the corporation are specifically authorized and directed to proceed with those negotiations and report to the Board of Directors with tentative agreements for specific authorization and approval.

H. FURTHER RESOLVED, the officers of the corporation are jointly and singly authorized and directed to proceed with the proposed acquisition of assets of Staub Pediatric Group, P.A. and the employment of its physician and non-physician employees, in general accordance with the report regarding Staub Pediatric Group, P.A. given to us at this meeting, and the officers of the corporation are jointly and singly authorized and directed to negotiate, execute and deliver definitive documentation with respect to the acquisition of such assets and the employment of such employees, in such form and substance as the signatory officer(s) deems necessary and appropriate. The officers of the corporation are by this resolution authorized to deviate from any possible specific terms and conditions of the acquisition of assets and/or employment of employees as reported to this meeting, to the extent they deem necessary and appropriate and in the best interests of the corporation, with the expectation that the transaction will, when finally agreed, be consistent with the overall spirit and intention of the report presented to us at this meeting.

I. FURTHER RESOLVED, the officers and directors of the corporation are jointly and singly authorized and directed to proceed with the proposed acquisition of assets of Palen Clinic, P.A. and the real estate which that Clinic now rents from Dr. Cortez, and the employment of its physician and non-physician employees, in general accordance with the report regarding Palen Clinic given to us at this meeting, and the

officers of the corporation are jointly and singly authorized and directed to negotiate, execute and deliver definitive documentation with respect to the acquisition of such assets and the employment of such employees, in such form and substance as the signatory officer(s) deems necessary and appropriate. The officers of the corporation are by this resolution authorized to deviate from any specific terms and conditions of the acquisition of assets and/or employment of employees as reported to this meeting, to the extent they deem necessary and appropriate and in the best interests of the corporation, with the expectation that the transaction will, when finally agreed, be consistent with the overall spirit and intention of the report presented to us at this meeting.

There being no further business to come before the meeting, the meeting adjourned at approximately 4:25 o'clock p.m.

Respectfully submitted,

Keith A. Dunder, Secretary of University of Minnesota Health System Affiliated Clinics, Inc.

The foregoing minutes were approved by the Board of Directors of UMHSAC at their meeting of April 22, 1994.

Keith A. Dunder, Secretary of
University of Minnesota Health System
Affiliated Clinics, Inc.

stjd3103.min

University of Minnesota Health System

Affiliated Clinics, Inc.

Proposed Benefits Summary*

		Physician Staff	Non-Physician Staff	Comments
Vacation Days:		20 days/year	12 days/year, non-exempt 15 days/year, exempt	
Sick Days:		9 days/year	9 days/year	
Holidays:		10 days/year	10 days/year	
Medical Appointments:		6 hours/year	6 hours/year	1 medical, 2 dental
Insurance:				
Health	- Employee	100 %	100 %	Blue Cross/Blue Shield
	- Dependent	50 %	50 %	
Dental	- Employee	100 %	100 %	Delta Dental
	- Dependent	0 %	0 %	
Life	- Employee	100 %	100 %	$25,000 max per employee
	- Dependent	0 %	0 %	
Medical Care at UMHSAC Clinics:		Discounted	Discounted	If not otherwise covered
Educational Leave:		5 days/year	N/A	
Expense Reimbursement:		$1,000/year	N/A	
Malpractice Insurance:		100% paid	N/A	
Dues:		100% paid	N/A	

* Assumes full time employment

UMHSAC Practice Acquisition Status

	Phase I				Phase II		Phase III		Phase IV	Phase V
	(A)	(B)	(C)	(D)	(A)	(B)	(A)	(B)		
Staub Pediatric Group	X	X	X	X	X	X	X	X	X	Pending
Palen Clinic	X	X	X	X	X	X	X	X	Pending	Pending
Hinckley (New Clinic)	X	X	X	X	X					
Rush City Clinic	X	X	X	X	X					
Pine City Clinic	X	X	X	X						
Fairmont Clinic	X	X	X	X	X	X	X			
Gateway Clinic	X	X	X	X	X					
Wadena Medical Center	X	X	X							
Waconia Professional Bldg	X	X								
Doctors Diagnostic Center	X	X								
Central Internal Medical	X	X	X							
Mesaba Clinic	X	X	X	X	X					
Mora Medical Center	X	X	X							

Definitions:

Phase I (A)	*Introductory Meeting*
Phase I (B)	*UMHSAC follow-up*
Phase I (C)	*Clinic Confirmation; UMHSAC originated Letter-of-Intent, Micro-process outline, detailed financial information request*
Phase I (D)	*Information receipt by UMHSAC*
Phase II (A)	*Tangible and Intangible Valuations (Bldg, Eqpt & Practice)*
Phase II (B)	*UMHSAC offer presentation*
Phase III (A)	*Offer Negotiation*
Phase III (B)	*Offer Agreement*
Phase IV	*UMHSAC Due Diligence*
Phase V	*Closing*

UMHSAC

THE 5/20/94 MEETING WAS CANCELLED. THE DIRECTORS PACKET ORIGINALLY PREPARED FOR THE 5/20/94 MEETING BECAME THE DIRECTORS PACKET FOR THE 6/17/94 MEETING

University of Minnesota Health System
Affiliated Clinics, Inc.
420 Delaware St. S.E. Box 704
Minneapolis, MN 55455
Telephone: (612) 626-5559
Facsimile: (612) 624-8128

June 14, 1994

TO: Pat Board
Tom Doyle
Keith Dunder
Mike Fay
Cliff Fearing
Helen Pitt

FROM: Steve Grygar

SUBJECT: 6/17/94 UMHSAC Board Meeting

There will be no new material distributed in advance of the 6/17/94 meeting; therefore, please remember to bring the 5/20/94 packet of material (also, note that the room has been changed to C-361 Mayo).

Thank you.

University of Minnesota Health System
Affiliated Clinics, Inc.
420 Delaware St. S.E. Box 704
Minneapolis, MN 55455
Telephone: (612) 626-5559
Facsimile: (612) 624-8128

May 17, 1994

TO: Pat Board
Tom Doyle
Keith Dunder
Mike Fay
Cliff Fearing
Helen Pitt

FROM: Steve Grygar

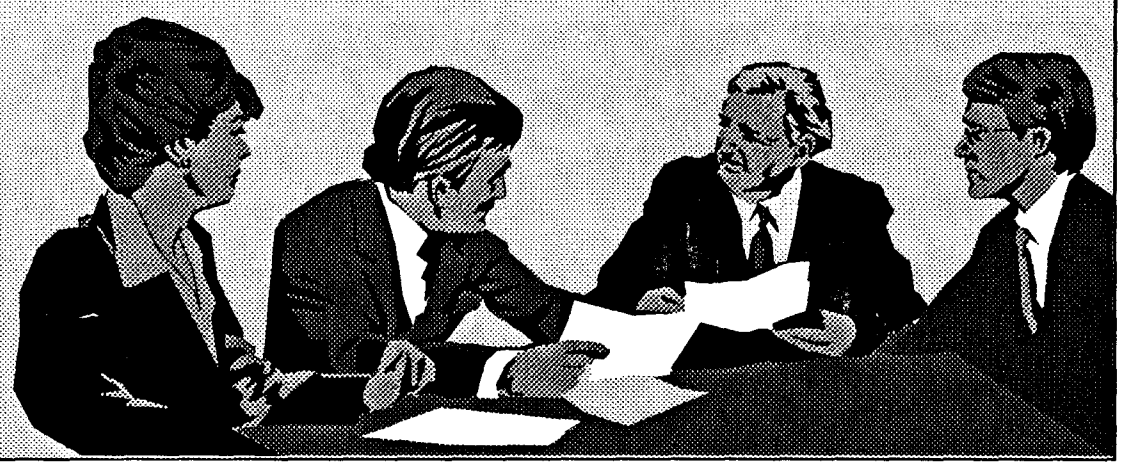
SUBJECT: Material for 5/20/94 UMHSAC Board Meeting

Attached please find the material for the 5/20/94 UMHSAC Board Meeting. The meeting will be held at 7:30 A.M. in the Unit J Board Room.

Attachment

University of Minnesota Health System

Affiliated Clinics, Inc.



Board of Directors Meeting
May 20, 1994

University of Minnesota Health System
Affiliated Clinics, Inc.
420 Delaware St. S.E. Box 704
Minneapolis, MN 55455
Telephone: (612) 626-5559
Facsimile: (612) 624-8128

University of Minnesota Health System
Affiliated Clinics, Inc.
("UMHSAC")
5/20/94 Meeting of the Board of Governors

AGENDA

1. **Approval of 4/22/94 Minutes**

2. **Status of UAFP Management Services Agreement**

3. **Practice Acquisition Status**

4. **Vehicles for Community Input**

5. **Policy Statements**

6. **Next Meeting Date June 17, 1994**

University of Minnesota Health System
Affiliated Clinics, Inc.
("UMHSAC")
5/20/94 Meeting of the Board of Governors

TABLE OF CONTENTS

UNIVERSITY OF MINNESOTA
HEALTH SYSTEM AFFILIATED CLINICS, INC. ("UMHSAC")
Minutes of the 4/22/94 Meeting of the Board of Directors

Attendees

In Person	Non-Director Attendees
Michael Fay	Keith A. Dunder, Hospital Counsel
Clifford Fearing	Stephan C. Grygar, UMHC Finance Department
Helen Pitt	Thomas J. Doyle, Attorney

All of the above were present and participating throughout. Director Patrick Board was absent.

Location

The Board Room of the University of Minnesota Hospital & Clinic (on the 8th floor of the Unit J Building, Harvard Street at East River Road, Minneapolis, Minnesota).

Order of Business

Cliff Fearing called the meeting to order at approximately 7:48 o'clock a.m., pursuant to prior notice, after all attendees were present. It was confirmed that all directors had received the Agenda, the Proposed Benefits Summary and the report on Practice Acquisition Status. (A copy of the latter two items is attached. The Agenda items are reflected as paragraph headings in the following text.)

1. **Approval of 3/9/94 Minutes.** Cliff Fearing noted also that all directors had received a copy of the minutes of the meeting of the Board of Directors on March 9, 1994. He called for any changes. Hearing none, he called for approval. Mike Fay moved approval of the minutes of the March 9, 1994 meeting as presented to the directors, Helen Pitt seconded that motion, and all three directors present voted in favor of approval. Cliff directed Keith Dunder, Secretary of UMHSAC, to note approval on the original minutes and cause them to be entered in the corporate records.

2. **Approval of UMHSAC Personnel Policies and Procedures.** Cliff called upon Steve Grygar to report. Steve reported that he had earlier distributed a draft statement of Personnel Policies and Procedures, had received comments back from the directors, and had incorporated those comments into the revised Policies and Procedures. Steve showed the form of the Policies and Procedures notebook to the meeting, and read the paragraph that had been added to the Policies and Procedures regarding their relationship with terms of written employment contracts. Before action was called for upon the Personnel Policies and Procedures.

Steve Grygar with the consent of all directors present, proceeded to discuss the next item on the agenda.

3. **Discretionary Approval of UMHSAC Benefit Structure.** Steve referred the directors to the Proposed Benefits Summary which had been distributed to all the directors. He noted that the annual number of full-time employee sick leave accrual days had been reduced from 12 to 9 (from what was earlier proposed), but noted that accrued sick leave could be carried over from year to year with certain portions of current sick leave accruals converting to vacation depending upon the amount of an employee's accumulative sick leave. The directors questioned why there was a specific reference to one medical appointment and two dental appointments in the time allotted for medical appointments, and after discussion it was agreed by consensus that this specific reference should be deleted from the Benefits Summary (and from any statement of benefits in the Personnel Policies and Procedures). Some further discussion ensued. Mike Fay then moved for the approval of both the Personnel Policies and Procedures statement as described at the meeting, and the Proposed Benefits Summary with the one change noted with respect to medical appointments. Helen Pitt seconded the motion and it was passed by unanimous voice vote.

4. **Status of UAFP Management Services Agreement.** Cliff Fearing then called upon Steve Grygar to report on the status of UMHSAC's negotiations with University Affiliated Family Physicians ("UAFP") for a management contract. Steve reported that he had just received a complete proposed contract from UAFP and had not had the opportunity to review it so as to be able to present it to the directors. He spoke of the plan that UMHSAC could ever increasingly use its own personnel to perform as many services as possible, with the division of work to be continually reassessed as UMHSAC proceeds. The directors were asked if it might be possible to distribute to them the UAFP contract when it is in form suitable for review by them, and then try to arrange a special conference call meeting for discussion and approval of contract terms. All agreed that would be acceptable.

5. **Practice Acquisition Status.** Steve Grygar next reported on the status of proposed acquisitions and other transactions, as summarized on the Practice Acquisition Status report (a copy of which is attached). There was some detailed discussion about the status of negotiations with Staub Pediatric Group, particularly with respect to the importance of having as much certainty as possible as to the employment of existing physicians. There was some discussion about possible longer term plans with respect to Palen Clinic, with no definitive result. There was some in-depth discussion of UMHSAC's prospects with respect to Rush City and Pine City, in light of developments in nearby communities. Steve was directed to ensure that current plans with respect to Rush City/Pine City are re-evaluated so that the project as it goes forward will be framed in view of the best and most recent information that can be obtained with respect to probable medical care needs for that area.

Steve Grygar also reported on various other potential clinic acquisitions. Some extended discussion was held with respect to Mesaba Clinic, as to which there is to be a meeting between UMHSAC officers and clinic representatives on April 26, 1994.

The directors decided by consensus to not further pursue possibilities with respect to the Waconia Professional Building or Doctors Diagnostic Center, neither being seen as fitting with UMHSAC's overall plans. The directors by consensus felt that possibilities with respect to the Mankato clinic should be added to the list, although the possibility of some relationship between that clinic and UMHSAC is only at the stage of very preliminary discussions.

6. **Governance Structure Discussion.** Tom Doyle raised with the directors certain general policy issues that the directors should consider regarding provision of care by UMHSAC and the prospect of more detail in UMHSAC's bylaws concerning local advisory groups for some or all clinics. Tom Doyle was directed to develop specific proposed policies and specific proposals regarding local advisory groups, and to distribute the same to the directors for consideration prior to and at their next meeting.

Cliff Fearing raised the idea that perhaps a physician from the University of Minnesota Hospital & Clinic should be sought out as the chief executive officer of UMHSAC. Points made in favor of this included the fact that the physician would be knowledgeable as to the medical practice issues that will face UMHSAC, and may better interact with physician and para-professional employees of UMHSAC. The idea met with a good reception among the directors, and all agreed to try to consider who might be a good candidate for this position.

7. **Future Meeting Timetable.** The directors determined that they wished to continue monthly meetings. Steve Grygar was directed to confer with Mike Fay regarding his schedule for being in Minneapolis on a monthly basis, and from that to propose a schedule of monthly meetings for the coming months. The next meeting was set for Friday, May 20, 1994, at 7:30 o'clock a.m. in the same Board room location.

There being no further business to come before the meeting, the meeting adjourned at approximately 9:15 o'clock a.m.

Respectfully submitted,

Keith A. Dunder, Secretary of University of Minnesota Health System Affiliated Clinics, Inc.

stjd3103.dup

The foregoing minutes were approved by the Board of Directors of UMHSAC at their meeting of May 20, 1994.

Keith A. Dunder, Secretary of
University of Minnesota Health System
Affiliated Clinics, Inc.

University of Minnesota Health System

Affiliated Clinics, Inc.

Proposed Benefits Summary*

		Physician Staff	Non-Physician Staff	Comments
Vacation Days:		20 days/year	12 days/year, non-exempt 15 days/year, exempt	
Sick Days:		9 days/year	9 days/year	
Holidays:		10 days/year	10 days/year	
Medical Appointments:		6 hours/year	6 hours/year	1 medical, 2 dental
Insurance:				
Health	- Employee	100 %	100 %	Blue Cross/Blue Shield
	- Dependent	50 %	50 %	
Dental	- Employee	100 %	100 %	Delta Dental
	- Dependent	0 %	0 %	
Life	- Employee	100 %	100 %	$25,000 max per employee
	- Dependent	0 %	0 %	
Medical Care at UMHSAC Clinics:		Discounted	Discounted	If not otherwise covered
Educational Leave:		5 days/year	N/A	
Expense Reimbursement:		$1,000/year	N/A	
Malpractice Insurance:		100% paid	N/A	
Dues:		100% paid	N/A	

* Assumes full time employment

UMHSAC Practice Acquisition Status

	Phase I				Phase II		Phase III		Phase IV	Phase V
	(A)	(B)	(C)	(D)	(A)	(B)	(A)	(B)		
Staub Pediatric Group	X	X	X	X	X	X	X	X	X	Pending
Palen Clinic	X	X	X	X	X	X	X	X	Pending	Pending
Hinckley (New Clinic)	X	X	X	X	X					
Rush City Clinic	X	X	X	X	X					
Pine City Clinic	X	X	X	X						
Fairmont Clinic	X	X	X	X	X	X	X			
Gateway Clinic	X	X	X	X	X					
Wadena Medical Center	X	X	X							
Waconia Professional Bldg	X	X								
Doctors Diagnostic Center	X	X								
Central Internal Medical	X	X	X							
Mesaba Clinic	X	X	X	X	X					
Mora Medical Center	X	X	X							

Definitions:

Phase I (A)	***Introductory Meeting***
Phase I (B)	***UMHSAC follow-up***
Phase I (C)	***Clinic Confirmation; UMHSAC originated Letter-of-Intent, Micro-process outline, detailed financial information request***
Phase I (D)	***Information receipt by UMHSAC***
Phase II (A)	***Tangible and Intangible Valuations (Bldg, Eqpt & Practice)***
Phase II (B)	***UMHSAC offer presentation***
Phase III (A)	***Offer Negotiation***
Phase III (B)	***Offer Agreement***
Phase IV	***UMHSAC Due Diligence***
Phase V	***Closing***

UMHSAC Practice Acquisition Status

Version: 14-May-94

	Phase I				Phase II		Phase III		Phase IV	Phase V
	(A)	(B)	(C)	(D)	(A)	(B)	(A)	(B)		
Staub Pediatric Group	X	X	X	X	X	X	X	X	X	Pending
Palen Clinic	X	X	X	X	X	X	X	X	X	Pending
Hinckley (New Clinic)	X	X	X	X	X					
Rush City Clinic	X	X	X	X	X					
Pine City Clinic	X	X	X	X						
Fairmont Clinic	X	X	X	X	X	X	X			
~~Gateway Clinic~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~					
Wadena Medical Center	X	X	X	X	X					
Central Internal Medical	X	X	X	X	X					
Mesaba Clinic	X	X	X	X	X					
Mora Medical Center	X	X	X							
Mankato										

Definitions:

Phase I (A)	*Introductory Meeting*
Phase I (B)	*UMHSAC follow-up*
Phase I (C)	*Clinic Confirmation; UMHSAC originated Letter-of-Intent, Micro-process outline, detailed financial information request*
Phase I (D)	*Information receipt by UMHSAC*
Phase II (A)	*Tangible and Intangible Valuations (Bldg, Eqpt & Practice)*
Phase II (B)	*UMHSAC offer presentation*
Phase III (A)	*Offer Negotiation*
Phase III (B)	*Offer Agreement*
Phase IV	*UMHSAC Due Diligence*
Phase V	*Closing*

C:\FINPLNNG\VENTURES\CLINICS\UMHSAC\STAT.WK4

MEMORANDUM

TO: KEITH A. DUNDER, ESQ., HOSPITAL COUNSEL
UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

FROM: THOMAS J. DOYLE
FELHABER, LARSON, FENLON & VOGT, P.A.

DATE: MAY 4, 1994

RE: UNIVERSITY OF MINNESOTA HEALTH SYSTEM AFFILIATED CLINICS, INC. ("UMHSAC")
OUR FILE NO: 09506/006

LOCAL ADVISORY COMMITTEES

Introduction

I attended the April 18, 1994 Planning and Strategy Session regarding an Integrated Service Delivery System for Rush City, Pine City and Hinckley. One matter discussed at that session was the possible role of groups from each major community that is served, in connection with the provision of medical services in that community. I was asked to prepare a summary of how local input may be obtained via local advisory committees, or via the use of a separate corporation for each community or grouping of communities, or via a joint venture between UMHSAC (or the University of Minnesota Health System - "UMHS") and some entity created specifically for the community or communities in question.

At the close of the meeting, I asked Mr. Lynn Clayton to provide me with his views as to the role of any local body. We played some telephone tag but finally connected on April 29, 1994. He and I discussed the sort of information that he could provide, which would be helpful

to this analysis. At the time I prepare this Memorandum I have not received any specific information from him, but I did not want to further delay getting this to you.

When I spoke with Mr. Clayton, his emphasis was to not have UMHSAC bring a strictly primary care clinic focus to the Rush City/Pine City/Hinckley system (the "RPH system"). UMHSAC's Articles of Incorporation and bylaws, and the other information he knows about UMHSAC, seem to him to be directed at the provision of primary care services via primary care clinics. But what he envisions for the RPH system goes beyond that. Instead, what he envisions (as I can best reiterate it) is a truly integrated delivery system that would include primary care via community clinics, acute care capacity, and other services, in an integrated system that would permit "seamless" delivery of care as part of a complete system. This system would include long-term care and housing and various community health services. He referred back to his proposed organizational chart, a copy of which I attach for your convenience.

Summary of Applicable Law

1. **Corporate Structure.** UMHSAC is a Minnesota non-profit corporation. It will seek tax-exempt status. I will assume that any additional corporation that would be formed by UMHS, or in which UMHS would play a role, for the provision of health care services would be a non-profit corporation that would be structured with a view to tax-exempt status. Such a structure should avoid corporate practice of medicine issues. It is presumably a more palatable structure, for UMHS, if the organization is in whole or in part a vehicle by which UMHS furthers its own non-profit, tax-exempt purposes.

2. **Minnesota Nonprofit Corporation Law.**

(a) Board Management. Minnesota Statutes Chapter 317A governs the structure and management of Minnesota nonprofit corporations. Section 317A.201 provides that a nonprofit corporation "**must**" be managed by or under the direction of a board of directors. This may be contrasted with Minnesota Statutes Section 302A.201, concerning the board of directors of a for-profit corporation. The latter specifically provides that shareholders of a for-profit corporation may directly manage the corporate affairs. While it seems permissible to have the voting member(s) of a nonprofit corporation vested with some powers to block certain actions, or to override the board of directors in certain respects, there is a strong presumption that a Minnesota nonprofit corporation must be managed by its own board of directors, as opposed to being directly managed by its member(s) (or in the case of a corporate member, by the board of directors of the corporate member).

Minnesota Statutes Section 302A.457 authorizes the shareholders of a Minnesota for-profit corporation to enter into an agreement relating to any control of any phase of the business or affairs of the for-profit corporation. Thus the shareholders can by such agreement, among other things, entirely dispense with the board of directors for the corporation. Or they can provide for any number of affairs concerning the corporation to be taken out of the hands of the corporation's board of directors and decided directly by the shareholders. There is no counterpart in Minnesota Statutes Chapter 317A as to a Minnesota nonprofit corporation. This is further support for the proposition advanced above, that there must be a board of directors to manage the affairs of each Minnesota nonprofit corporation, rather than have management by the member(s). To state it in a different fashion, a Minnesota for-profit corporation can be

formed on the assumption that all rights reside with the shareholders, with a board of directors exercising management rights only to the extent not reserved to the shareholders. By contrast, Minnesota Statutes Chapter 317A seems to establish as to Minnesota nonprofit corporations that the board of directors presumptively has all management rights, with the member(s), if any, having relatively narrow approval or (possibly) veto rights, if and to the extent spelled out for the number(s). Cf. Section 317A.401.

(b) Committees. The board of directors of a Minnesota nonprofit corporation may establish a committee. Section 317A.241. The committee has the authority of the board with respect to the management of the corporation's business, to the extent provided in the resolution by which the committee was established. Id. Committees are at all times subject to the direction and control of the board of a non-profit corporation. Id. Thus there is broad leeway as to committees.

(c) Joint Ventures. A tax-exempt entity may pursue an activity with another organization or entity, via a joint venture in the form of a corporation, a partnership, or by contract. If all of the co-venturers are tax-exempt organizations, and if the joint venture furthers the exempt purposes of both or all of the organizations, then absent extraordinary circumstances, it is unlikely that pursuit of the joint venture will jeopardize the tax-exempt status of any of the co-venturers. If the joint venture is between or among one or more tax-exempt organizations and one or more taxable organizations, then the tax-exempt status of the exempt organization may be jeopardized if:

(1) The joint venture does not further one or more exempt purposes of the exempt organization;

(2) The exempt organization is more than a mere passive investor, but cannot absolutely direct that the joint venture will not become involved in other, non-exempt activities;

(3) The exempt organization has continuing financial risk, or does not have the same prospect for financial return as the taxable organization; or

(4) The taxable organization may obtain excessive or disproportionate financial benefits.

If UMHSAC engages in a joint venture to provide medical services, it is probably reasonably "safe" if the joint ventures with another tax-exempt organization whose purpose is promotion of health. But if any joint venturer is not a tax-exempt organization, UMHSAC must exercise greater care with respect to the structure, purpose and activities of the joint venture, lest UMHSAC's tax-exempt status be at risk.

The above points must be kept in mind in any discussion concerning possible subsidiaries of UMHSAC (or UMHS), committees of UMHSAC's board of directors, and possible joint ventures between UMHSAC and any other organization.

Comparisons

1. **Separate Corporations (Subsidiaries of UMHSAC or UMHS).** Each separate corporation will have a separate board of directors. Given the presumption in Minnesota Statutes Chapter 317A discussed above, the board of directors of each separate corporation presumably will have considerable autonomy. Although it might be possible for UMHSAC or UMHC as the sole member to reserve key rights, such as the right to change Articles of Incorporation or bylaws, or to approve annual budgets or the incurrence of debt above a certain amount, or certain other particular actions or matters, day-to-day management of the corporation's affairs is lodged in the board of directors of that corporation. Thus, for example,

if UMHSAC or UMHS formed a separate corporation for a clinic in Hinckley, and for a clinic in Pine City, and for a clinic in Rush City, each of the separate corporations would have its own board of directors responsible for managing the affairs of that clinic. Presumably UMHSAC or UMHS, as the case may be, would want strong and perhaps even dominant representation on each of those boards. That would require either a significant time commitment from a handful of individuals, or a number of individuals who could serve on those various boards.

Of course UMHSAC or UMHS could forego having dominant (or for that matter, any) representation on these boards. But if UMHSAC and/or UMHS are being asked to extend credit to any of the clinic corporations, and/or to continue to work closely with any of the clinic corporations in the delivery of health care, and/or to lend any part of their names or credibility to the clinic corporations, for UMHSAC and/or UMHS not to have representation on those boards would seem unacceptable.

2. **Local Advisory Committees.** Alternatively, UMHSAC's Board of Directors could establish a committee for each clinic. The committee could consist in large part (perhaps even entirely) of individuals who are familiar with that clinic, or who are served by that clinic, or who live in the community(ies) served by that clinic. Each local committee could be given certain authority of the board of directors, or could be established as a purely advisory body. For example, assume a clinic has five FTE physicians. Presumably the board of directors would set the terms and conditions of the physicians' employment. But the local committee might make recommendations in conjunction with the physicians as to the clinic's schedule. The clinic administrator (or UMHSAC's central administrator, if the clinic does not have its own administrator) might then work with the physicians to establish specific employee (physician and

non-physician) work schedules to accommodate the operational hours suggested by the local committee. This would tend to ensure that the clinic's hours of operation take into account community needs. Yet the setting of hours of operation might be something that UMHSAC's Board of Directors would feel comfortable delegating to a committee, so long as the hours do not require additional employee compensation or other expense.

The use of local committees seems more consistent with the notion of an integrated delivery system that involves several sites. This would permit local input as to each site, but the board of directors of the entire organization would have the "big picture" with respect to all of those sites and how they all fit together as an integrated whole.

3. **Joint Ventures.** Mr. Clayton's proposed organizational chart seemingly implies some sort of joint venture by contract between UMHSAC and East Central Minnesota Health Services ("ECMHS"). As I have noted, Mr. Clayton made the point to me that UMHSAC's Articles of Incorporation seem directed toward the provision of medical services via clinics, as opposed to the provision of acute care, or medical or other services specifically targeted to the aged or nursing home populations, or broader community health services. There are at least three means of addressing Mr. Clayton's apparent concern. One would be to broaden UMHSAC's purposes to go beyond clinical medical services. A second would be to create another organization akin to UMHSAC, but for the purpose of providing any one or more of acute care, aging services and community health services. The third is what I have inferred to be behind Mr. Clayton's suggestions, which is for UMHSAC to enter into some sort of joint venture with ECMHS. So long as the joint venture comports with the general standards noted

above, there should not be material risk to UMHSAC's tax-exempt status. I turn now to some further thoughts on ECMHS.

East Central Minnesota Health Services

What I am sensing at this point is some of the questions as to whether UMHSAC should have separate corporations for one or more of the clinics in the RPH system, or local committees, is due to some lack of definition of ECMHS. The way I would interpret Mr. Clayton's comments to me is that ECMHS is perhaps still a gleam in his eye, as opposed to a fait accompli. I happen to believe that provision for local committees for UMHSAC's clinics makes sense, but that it may not be needed with respect to each and every possible clinic that UMHSAC may have. (For example, I don't recall anyone suggesting that such a committee is needed with respect to Staub Pediatric Group.) What may be needed here is a clearer idea of ECMHS. Will it closely reflect the interests of all communities served by the RPH system? If so, and if there is a forum for regular communications between the boards of UMHSAC and ECMHS, perhaps UMHSAC does not need its own, separate local committees from the communities in question. (This may not be true as to the Hinckley clinic. I think everyone is assuming it will have separate, strong community input from the Ojibwe band.) On the other hand, if the ECMHS board will represent principally only one or two of several communities served by the joint venture, then one or more local committees for UMHSAC, representing interests of the other communities, may well be appropriate.

I note that Mr. Clayton's proposed organizational chart shows some "Integrated System Management, Coordination" between the UMHSAC and ECMHS boards. It may be that the joint venture should have a local advisory group with input at this level. Each clinic may have

its own on-site administrator. Or there may be one administrator for two or all three of the clinics. Presumably the administrator(s) and the medical director(s) would come together with the administrator(s) of the other health services offered by the joint venture, for integrated system management and coordination. Meetings may include input from UMHSAC's central administrator, and/or someone from the boards of UMHSAC and ECMHS. Perhaps representatives of the various communities served by the joint venture could be constituted as an advisory group, and meet with these individuals at some or all of their regular meetings for coordinating management and integrated health care delivery.

Is ECMHS formed yet? Who makes up its board of directors? How will it acquire its assets? What is its source of acquisition and operational bonding? Is ECMHS just an idea on paper at this stage, or something more? If it is still principally at the idea stage, how does it get interpreted into something more concrete?

I am now of the mind that UMHSAC should have answers to these and other questions about ECMHS before UMHSAC decides on a particular course of action as to local committees or other particular aspects of its own governance and management, with respect to the proposed RPH system. If ECMHS is still at the idea stage, it may be that its very existence, and its ultimate status as a joint venturer with UMHSAC, will provide much of the local community input which is seen as desirable. Alternatively, it may be that local community input is appropriate for the relationship of UMHSAC and ECMHS, rather than being specific to UMHSAC.

dzg

stjd3265.mem

MEMORANDUM

TO: CLIFFORD P. FEARING, KEITH A. DUNDER AND STEPHAN C. GRYGAR
UNIVERSITY OF MINNESOTA HEALTH SYSTEM AFFILIATED CLINICS, INC. ("UMHSAC")

FROM: THOMAS J. DOYLE
FELHABER, LARSON, FENLON AND VOGT, P.A.

DATE: MAY 16, 1994

RE: RUSH CITY/PINE CITY
OUR FILE NO: 09506/006
OPERATIONAL STRUCTURE

Precepts

1. There will be a clinic in Hinckley, a clinic in Rush City, and a clinic in Pine City.

2. There will be an ambulatory care facility in or near Rush City, with urgent care services.

3. Local community involvement is desirable.

4. The system should have the ability to expand the range of services provided, to include emergency services, acute care, aging services, community health services, and other services, if and as appropriate.

Observations

1. If UMHSAC is successful, it will have a number of clinics in a number of different areas. If it attempts to have representation of each and every community which is served on its own Board of Directors, its Board of Directors would soon become unwieldy.

2. Rush City, Pine City and Hinckley are being addressed by UMHSAC as a single project for UMHSAC, and for the potential of an integrated service area. This project may be able to expand both the area served, and the health services which it can provide, by contracts with hospitals or other health care providers in Mora, Cambridge, or Chisago/Wyoming.

3. Lynn Clayton's letter of May 5, 1994 (a copy of which is attached) argues the need for a "community based Board." Lynn Clayton's 4/12/94 organizational chart, a copy of which is also attached, contemplated involvement of "East Central Minnesota Health Services" ("ECMHS"). My understanding is that ECMHS does not yet exist. It strikes me that ECMHS can be the "community based Board" desired by Mr. Clayton.

4. It is my understanding that Rush City itself needs to contribute property to a system for a new Rush City clinic/ambulatory care center. It is also my understanding from Lynn Clayton's 5/4/94 memorandum to Steve (a copy of which is attached) that Rush City Clinic & Hospital employees are concerned about benefits, because they are currently covered by Public Employees Retirement Association ("PERA"). I know from other experience and inquiry that PERA almost undoubtedly will not permit current covered employees to remain in PERA once they are employed by a non-governmental employer.

Suggestions

1. First, have ECMHS formed so that it has a community based Board. It might be possible for ECMHS to be formed so that it is technically an instrumentality of Rush City, with its Board members to be appointed by the Rush City city council (but to include representatives of Pine City and any other community served by ECMHS). To do the latter may enable employees of ECMHS to be PERA participants.

2. Have Rush City make its contributions to the project via ECMHS.

3. UMHSAC and ECMHS can then enter into a joint venture. A proposed chart of the joint venture is attached. In brief, note the following:

(a) There would be a Joint Venture Management Committee consisting of three UMHSAC representatives and two ECMHS representatives;

(b) There would be a single administrator reporting to the Joint Venture Management Committee;

(c) Community input would be obtained from the ECMHS Board. The easiest way to do this would be to have the Joint Venture Management Committee meet immediately prior to and/or after a meeting of the ECMHS Board. Input from the ECMHS Board could then be taken into account immediately and directly by the Joint Venture Management Committee;

(d) If it wished, the Joint Venture Management Committee could do one or more of the following: have the Medical Directors report directly to the Committee, or have one of the clinic Medical Directors sit as an ex-officio, non-voting member of the Committee; designate a separate local advisory group from the Mille Lacs Band of Ojibway to advise the Joint Venture Management Committee as to the Hinckley Clinic, or have the Mille Lacs Band of Ojibway designate one ex-officio non-voting Committee member to ensure the concerns of the Band are heard as to the Hinckley Clinic; or institute other steps to ensure that appropriate constituencies have a forum to express their views.

Mr. Clayton's May 5, 1994 letter seems to indicate that clinic Medical Directors should report to a single regional administrator. I do not dispute his point - certainly he knows that better than I. But I note that if it is necessary to give the practitioners some direct input into the Joint Venture Management Committee, a "chief" Medical Director could be permitted to sit-in on all Committee meetings, as a non-voting participant. Similarly, I would expect the administrator would sit-in on all meetings, either as a voting or a non-voting participant, to give needed direction.

3. The joint venture could be by partnership or contract. In either instance, I would suggest that UMHSAC needs to have ultimate control, since for it to have a minority position or an equal position might jeopardize its own tax-exempt status, might very likely raise concerns among physicians in other UMHSAC clinics as to whether UMHSAC is exposing itself to undue risk because some of its assets are not fully under its control, and would seem to overlook the significance of the contributions UMHSAC is proposing to make to the project.

4. If the joint venture is a partnership, employees could presumably be either employees of the partnership, or employees of a partner, whose services are devoted to the joint venture. It may make sense to have the physicians be UMHSAC employees, but if ECMHS can qualify as a PERA employer, have all of the other employees be ECMHS employees. (UMHSAC could, if desired, separately render management services to the joint venture, and thus provide payroll, administrative and other services as to all employees.) **Important caveat:** this structure may require UMHSAC to provide the same level of benefits to its physician employees as PERA benefits available as to ECMHS employees. If this may cause a problem, presumably the physicians could also be ECMHS employees, or possibly the physicians could remain in one or more separate practice groups, which contract with a joint venture on the "foundation model."*

5. The joint venture would accommodate subsequent addition of other health services, if needed.

---

* Before even that is finalized, I must further investigate the possible application of the management function affiliated service group rules of Section 414(m)(5) of the Internal Revenue Code of 1986, as amended, as it may apply to tax-qualified employee benefit plans.

Summary

I would think this sort of structure would address Mr. Clayton's concerns. There would be significant community input via the ECMHS side of the joint venture equation. Integration would be assured because the joint venture would have representation from both UMHSAC and ECMH, and a single regional administrator. Day-to-day management would be addressed by a management committee that would be ultimately responsible to UMHSAC and its Board of Directors, but would include representatives of (and hence be responsive to concerns of) ECMHS. This committee could include the administrator, a medical director, and UMHSAC and ECMHS representatives. Finally, this structure would at least seem on its face to preserve the **possibility** (which must be further investigated) that Rush City Clinic & Hospital employees might be able to maintain PERA coverage.

dzg

Rush City Area
Hospital & Clinic
P.O. Box 636
Rush City, Minnesota 55069

May 5, 1994

Thomas J. Doyle
Felhaber, Larson, Fenlan & Vogt
2100 World Trade Center
30 E. Seventh Street
St. Paul, MN 55101-4901

Dear Tom:

As a follow up to our recent phone conversation, I offer the following comments and suggestions as to the governance structure for UMHSAC.

Background to further explain my suggestions includes a strong belief that for a community health provider to be truly successful in carrying out it's mission, there needs to be local input from that community. The provider needs to blend good business practice with a strong sense of community need. Done properly, greater community support for that provider should result.

Another issue is the question I have raised about non-primary care services (other than those generally found in a physician clinic) that exist, or should be developed, in the community. UMHSAC likely will not wish to be directly involved in many of these (eg. EMS, home-care, health education and prevention, etc.). I believe that a community based board should assume responsibility for the development and/or coordination of these important services.

The other issue is that of health services integration. Some one entity needs to be involved in integrating the whole spectrum of health related services for a community (region).

I don't know if one Board or committee can or should be responsible for all of these activities. But through some mechanism, I think that the above goals should be addressed.

I also think that <u>common management</u> of the primary care and "other health services" could serve to achieve the integration and community input discussed above.

Perhaps a "free-standing", community based Board, including physician and UMHSAC representation, could serve the purposes mentioned above. It could have complete authority for some community type functions and an

advisory role with the clinic(s). The responsibility to the clinic(s) would include taking the community "pulse" as to community perception of services offered, type and scope of services, a general public relations role to spread the word to community members, and to serve as the integrator of the clinic services with other community health services.

I don't believe this type of Board should have any direct involvement in any business matters involving the clinic(s). It might address concerns about staffing levels, hours of service, fees, or staff personality issues, but would not have authority to make changes only to recommend.

Perhaps the local, day to day management issues could be addressed by a management committee that would be responsible to the UMHSAC Board. This committee could be composed of some (or all, depending on clinic size) physicians in the clinic(s), administrator, local medical director, and a UMHSAC Board representative e.g. the "CEO" of UMHSAC.

This group would deal with clinic(s) staffing, scheduling, compensation, etc. and would be advisory to local management and to the UMHSAC Board. (I suspect that, in our case at least, we would manage two or more clinics as one organizational entity - hence, the (s) after clinic.)

You will also note that I am suggesting that the local medical director be subservient to the local, or regional, administrator. I propose this for two reasons: one, the role of medical director would be a relatively small part of the physicians job (most of their time would be spent as a primary care provider) and two, because I think most smaller clinics that I am familiar with, have not been as successful as they might have been because "administrative" functions were relegated to a promoted clerk, and governance issues were handled by the physicians, usually in a reactive, less than satisfactory way.

I think the two functions of a clinic should be integrated and that one person, with the time and training, could more effectively provide the leadership to help that clinic be successful.

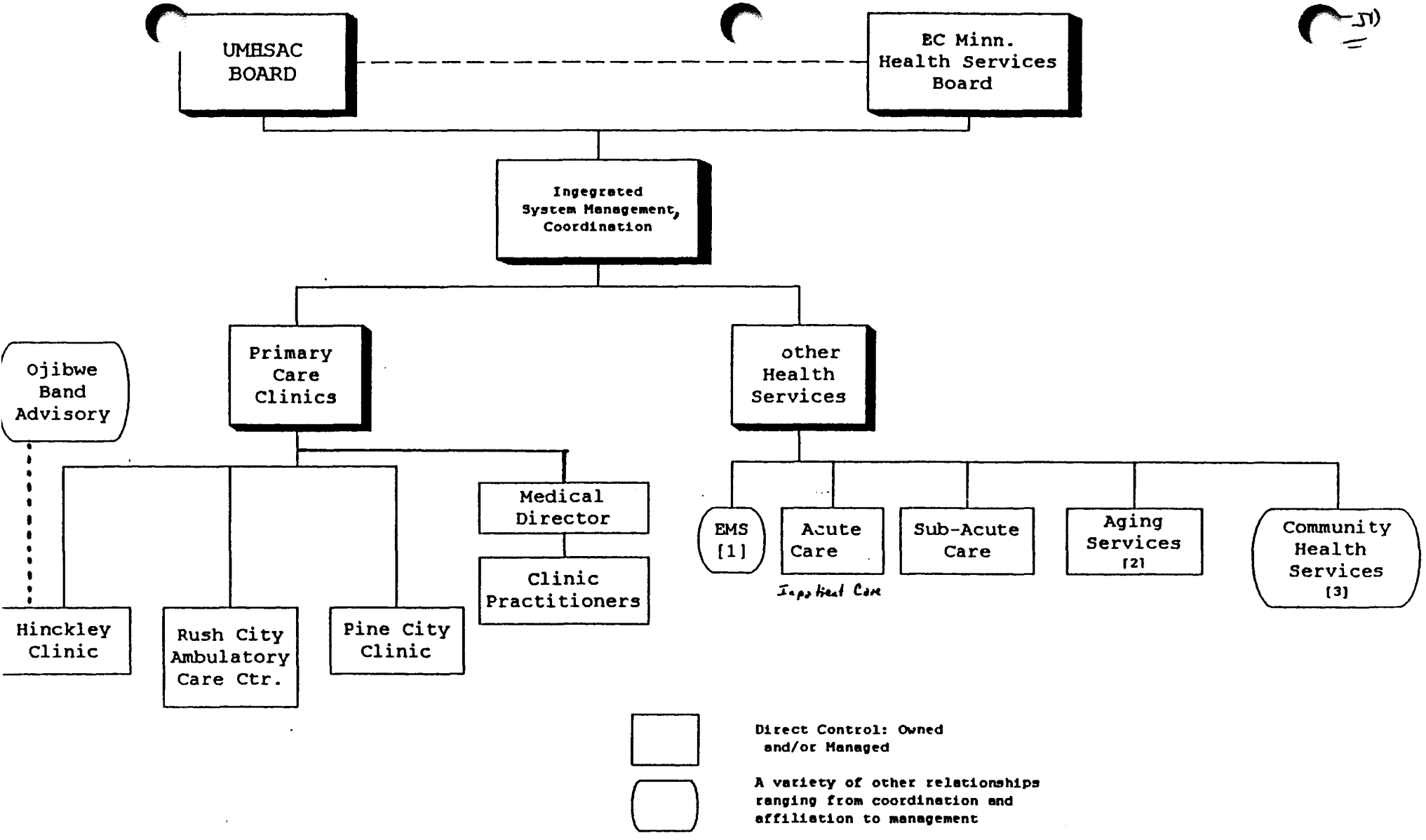
I hope this doesn't sound too self-serving. I think I am being objective in what I think are ways to change some of the weaknesses I have seen in many clinics throughout my career. With health reform moving forward (even if not driven by legislators and Congress), we need to create a system that will be responsive to those customers that will greatly influence the success of a health provider e.g. business and industry, the public, ISN's, HMO's, and others, as well as the "customer" that has driven the system in the past - the physician.

Call if you have questions, (612) 358-4708.

Sincerely,

Lynn S. Clayton
Administrator

LSC/kkh

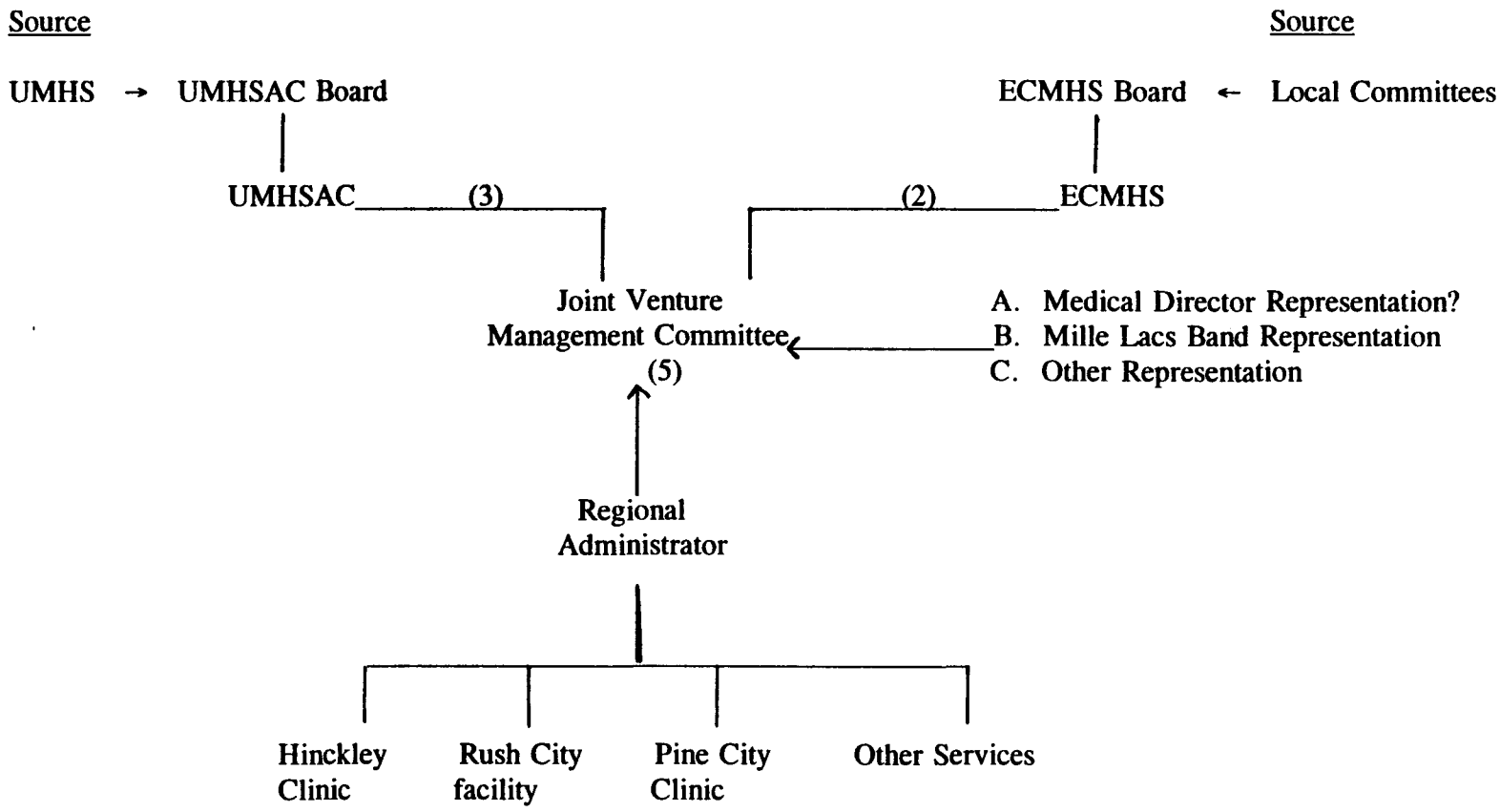


4-12-94
Draft #4

TO: Grygar, Stephen
U of M Hospital & Clinic
Finance
ATTENTION: Steve G.
FROM: Rush City Clinic & Hospital;Box 636
SENT BY: Lynn C.
SUBJECT: UMHSAC Corp. benefits
COPIES:

As we share information about impending changes with our employees (I share almost everything with them), the concern about how these changes will impact them grows. One of the questions that they have asked me is about pension: We are currently part of PERA (Public Employees Retirement Association) because we are owned by the City. They want to know what the plan will be in the new company, and can they roll over their existing balances. This also gives rise to questions about seniority (will any of it move with them to the new employer), and other related questions that result from growing anxiety. I assume you don't have answers to many of these questions yet, but because they will continue to come up, I am asking them now to help you anticipate issues.

RUSH CITY/PINE CITY/HINCKLEY
JOINT VENTURE MODEL



MEMORANDUM

TO: BOARD OF DIRECTORS
UNIVERSITY OF MINNESOTA HEALTH SYSTEM AFFILIATED CLINICS, INC. ("UMHSAC")

FROM: THOMAS J. DOYLE
FELHABER, LARSON, FENLON & VOGT, P.A.

DATE: MAY 16, 1994

RE: PROPOSED POLICY STATEMENTS

The first page following this Memorandum is four proposed policy statement resolutions which I would ask you to consider at your May 20, 1994 meeting. That is followed by a 5/16/94 draft description of UMHSAC. This explanation, when it is complete, will be submitted to the Internal Revenue Service in support of UMHSAC's application for IRS recognition of its tax-exempt status.

The proposed policy statements are intended to ensure that UMHSAC meets IRS requirements for tax-exempt status. I attach the draft description of UMHSAC because it addresses the standards that the IRS likely will apply to UMHSAC, and specifically speaks to the point of how the proposed policy statements enables UMHSAC to meet those standards.

I will be happy to address questions, comments and concerns at the May 20, 1994 meeting.

dzg

Enclosures

POLICY STATEMENT RESOLUTIONS OF THE UNIVERSITY OF MINNESOTA HEALTH SYSTEM AFFILIATED CLINICS, INC.'S DIRECTORS ADOPTED ON _____, 1994

1. Medical care generally provided by the University of Minnesota Health System Affiliated Clinics, Inc. ("UMHSAC") shall be provided to all members of the community who are able to pay for such services, including members of the community paying through Medicare, Medicaid, general assistance or any other governmental payment program. All services provided by UMHSAC clinics shall be available to all such members of the community, regardless of whether the source of payment is private or public.

   UMHSAC may require reasonable cooperation of any patient in establishing right to payment through Medicare, Medicaid, general assistance or any other governmental payment program or from any private payor.

2. Emergency and urgent medical care will be provided by all medical staff employed by UMHSAC, as they are available, to all patients to the extent medically appropriate to overcome or obviate the emergency or urgent need, or to stabilize the patient for further care, to the extent such services can be provided at (and with the equipment at) the UMHSAC facility, regardless of the patient's ability to pay. Upon addressing an emergency or urgent medical need, to the extent the same can be addressed by UMHSAC medical staff, UMHSAC medical staff shall (where the patient's condition warrants further medical care) seek to have the patient admitted for further care at an appropriate facility. UMHSAC may request the patient's reasonable cooperation and assistance in seeking payment through Medicare, Medicaid, general assistance or any other governmental payment program or by a private payor who may be liable for the same, but UMHSAC shall not withhold or delay emergency or urgent medical care, when needed, either to seek the patient's cooperation or assistance or to establish any right to payment.

3. UMHSAC shall reinvest its ~~profits~~ net earnings for the promotion of health, utilizing such ~~profits~~ net earnings to improve patient care and medical facilities, or for other related charitable purposes that further UMHSAC's purposes and principal activities as provided in UMHSAC's Articles of Incorporation (including without limitation the provision of medical care, medical education, community education and outreach, and clinical research and scientific investigation related to health and medicine).

4. UMHSAC shall not operate to the private inurement or private benefit of any individual. To that end, the compensation of all physicians employed by UMHSAC must be determined only after consulting one or more independent surveys regarding physician compensation (and/or other independent information sources), or after such other steps as may be appropriate to establish the reasonableness of the compensation, all so as to enable UMHSAC to determine and set a reasonable level of compensation for its physician-employees. It shall be the policy of UMHSAC to ensure that all compensation is competitive, yet reasonable.

Attachment II-1 to Form 1023 of
University of Minnesota Health System Affiliated Clinics, Inc.

EIN #41-1763975

ACTIVITIES OF THE ORGANIZATION

The University of Minnesota Health System Affiliate Clinics ("UMHSAC") is a corporation that will own and operate several physician clinics in Minnesota. The sole member of UMHSAC is a tax-exempt entity, The Regents of the University of Minnesota, a corporation established and operating in accordance with Minnesota Statutes (the "Regents"), acting by and through the Governing Board of the University of Minnesota Health System (the "Health System"). UMHSAC was formed in order to promote the health of the public in communities served by physician clinics primarily through the delivery of medical services by those clinics, but also through participation in medical and educational programs of the University of Minnesota (and where and as appropriate, community medical education), participation in medical research, and sponsoring, maintaining and promoting community and other outreach programs for the act or promotion of health. **[Insert any information regarding UMHSAC outreach programs that could offer incorporation with UMHS.]**

As of the date of this Application, UMHSAC has not yet acquired any clinics, but is in the process of acquiring two clinics in the Minneapolis and suburban areas. It is anticipated that UMHSAC will have at least two physician clinics operating under its control by the fall of 1994.

UMHSAC is a corporation that will pursue its own charitable goals of promoting health in the communities it serves. In addition, UMHSAC is a vehicle by which its sole member, the Regents, will further their charitable purposes. The Regents are committing capital to UMHSAC via capital contributions and via equipment loans to allow acquisition of physician clinics. It is projected that UMHSAC will thereafter be able to operate from clinic revenues. As the Regents will be so committing capital to UMHSAC, the Regents will need to ensure that the UMHSAC Board of Directors is alert and responsible to the Regents, and the needs and wishes of the communities served by the UMHSAC clinics as expressed by community involvement of each of UMHSAC and the Regents. Each of the Directors of UMHSAC are elected with such responsibility to the Regents and the communities served by UMHSAC in mind. Accordingly, UMHSAC's Board of Directors will in turn be reflective of the communities served by UMHSAC, and responsive to their needs.

The Articles of Incorporation of UMHSAC reserve certain key management decisions to the Regents. These items include, but are not limited to, adoptions of operating budgets and plans of expenditures for UMHSAC, approval of provider

agreements with third-party payors, liquidation and dissolution of UMHSAC, and changes in the general medical services offered by the corporation. In addition, the sole member has the absolute right to take actions necessary to prevent jeopardization of the tax-exempt status of UMHSAC, to remove Directors of UMHSAC, and to amend the Articles of Incorporation and Bylaws of UMHSAC to the extent necessary to obtain or maintain the tax-exempt status of UMHSAC.

It is anticipated that UMHSAC will decrease overall health care costs by centralizing many administrative, management, and other services of each of the clinics it owns and operates. It is also anticipated that such clinics will have greater access to medical information, as well as educational and research information and input in community education programs, allowing such clinics to offer enhanced health services to the communities they serve.

LEGAL ANALYSIS

UMHSAC expects to provide medical care to several communities via several medical clinics. UMHSAC's clinics will operate much like the clinics within hospitals providing outpatient services. Accordingly, the tax-exempt status of UMHSAC should be determined under the same standards, principles and requirements applicable to hospitals. An examination of the application of those standards, principles and requirements to UMHSAC follows.

The general requirements for tax-exempt status under Internal Revenue Code ("IRC") §501(c)(3) are as follows:

1. The corporation must be organized exclusively for one or more exempt purposes stated in the statutes (the "organizational test").

2. The corporation must operate exclusively for one or more of those exempt purposes (the "operational test").

3. No part of the corporation's net earnings may inure to the benefit of any private shareholder individual.

4. No substantial part of the activities of the corporation may be the carrying on of propaganda, or otherwise attempting to influence legislation.

More specifically, the Treasury Regulations under IRC §501(c)(3) and applicable Revenue Rulings together create an organizational test and an operational test, both of which must be met in order to obtain recognition of tax exempt status.

Organizational Test

In order to be tax-exempt, a corporation must limit its purposes to one or more exempt purposes. Treas. Reg. §1.501(c)(3)-1(b)(1)(i)(a). UMHSAC's Articles of Incorporation (Article 2) limit its purpose to:

> ". . . To engage in, assist and contribute to the support of exclusively religious, charitable, scientific, testing for public safety, literary or educational activities and projects, within the meaning of Section 501(c)(3) of the Internal Revenue Code . . . in support of such purposes, the main activities of the corporation shall include . . . Operating multispecialty medical clinics providing healthcare services and promoting health in various locations in the State of Minnesota . . . operating programs for medical education, including medical residency and continuing medical education, as well as community health education and specialty outreach programs . . . engaging in clinical research and scientific investigation relating to health and medicine . . . doing any and all other acts and things and to exercise any and all other rights and powers which may be necessary, advisable, desirable or expedient in the accomplishment of any of the foregoing purposes."

Further, the Articles of Incorporation must not give the corporation the power to engage in activities that are not in furtherance of one or more tax exempt purposes. Treas. Reg. §1.501(c)(3)-1(b)(1)(i)(b). Article 3.3 of UMHSAC's Articles of Incorporation specifically restrict UMHSAC's powers to engage in activities, so that the activities must be limited to ones that further UMHSAC's purposes and otherwise comport with tax-exempt status. Article 3.3 provides as follows:

> 3.3) Notwithstanding any other provisions of these Articles of Incorporation:
>
> > (a) All activities of the corporation shall be carried on and all of its funds shall be used and applied exclusively for the purposes for which this corporation was organized.
> >
> > (b) No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to any officer, director or any other individual (except that reasonable compensation may be paid for services rendered to or for the corporation in furtherance of one or more of its purposes, and except that individuals may benefit from grants, and similar payments or contributions made for the purposes for which this corporation was organized, in furtherance of the purposes of the corporation).

> (c) No substantial part of the activities of the corporation shall be the carrying on of propaganda or otherwise attempting to influence legislation, and the corporation shall not participate or intervene in any political campaign on behalf of any candidate for public office, by publishing or distributing statements or otherwise.
>
> (d) The corporation shall not carry on any other activities not permitted to be carried on by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code.

The Treasury Regulations further require that for a corporation to be a tax-exempt organization, its articles must provide that on dissolution the assets will be distributed for one or more exempt purposes, or to a government for public purposes, or by a court that it determines will best accomplish the general purpose for which the corporation is organized. Treas. Reg. §501(c)(3)-1(b)(4). Article 10 of UMHSAC's Articles of Incorporation provides that on dissolution its assets will be distributed as follows:

> ". . . to the Regents of the University of Minnesota, provided that said distributee is exempt within the meaning of Section 501(c)(3) of the Internal Revenue Code. If said distributee is not then exempt under said section, then the remaining property and assets shall be distributed to another corporation that is exempt under said section, which corporation shall be chosen by the Board of Directors of the corporation."

Accordingly, the assets of UMHSAC shall, upon dissolution of UMHSAC, be distributed for one or more exempt purposes.

Operational Test

A corporation seeking tax-exempt status under IRC §501(c)(3) must also operate exclusively for one or more exempt purposes. Treas. Reg. §1.501(c)(3)-1(c)(1). As discussed above, UMHSAC is an extension of a tax-exempt entity, the Regents of the University of Minnesota acting by and through the Health System, which is not a legally separate entity from the Regents, and one means by which such entity furthers its exempt purpose.* The Health System has retained sufficient control over UMHSAC's management and operations (by the right to appoint directors, and by retaining

---

* Attached are copies of the Internal Revenue Service's letters of June 25, 1941, August 25, 1961 and December 24, 1970, regarding the status of the Regents of the University of Minnesota for tax purposes.

certain powers), so as to ensure that UMHSAC is and will remain responsive to the tax-exempt purposes of its member generally. Specifically, UMHSAC's plan to provide healthcare to a variety of communities in Minnesota is certainly in furtherance not only of its own charitable, community-service purposes, but also those of its member. An organization which operates to further the purpose of, and optimize the provision of health care by, tax-exempt hospitals can itself be said to operate for the same charitable "promotion of health" purposes that justify tax-exempt status under IRC §501(c)(3). E.g. Rev. Rul. 79-358, 1979-2 C.B. 225 and Rev. Rul. 81-28-1981-1 C.B. 328.

Even if UMHSAC is viewed without regard to the identity and purposes of its member, UMHSAC will promote the health of the communities it serves. The law is quite clear that the promotion of health is a charitable purpose. E.g. Rev. Rul. 83-157, 1983-2 C.B. 94. A charitable purpose in turn is a purpose which justifies tax-exempt status for an organization that is organized and operating exclusively to further such purpose. Treas. Reg. §1.501(c)(3)-1(d)(1). In determining whether an organization that operates primarily for the provision of medical care promotes the health of one or more communities, and thus merits tax-exempt status under IRC §501(c)(3), the IRS looks to whether the organization promotes health in a manner that is "deemed beneficial to the community as a whole." Rev. Rul. 69-545, 1969-2 C.B. 117. The IRS does so by measuring the organization against certain "hospital standards" that have been enunciated in Rev. Rul. 56-185, 1956-1 C.B. 203, Rev. Rul. 69-545, supra., Rev. Rul. 83-157, supra. and reviewed in IRS Examination Guidelines for Tax-Exempt Hospitals (Announcement 92-83, I.R.B. 1992-22, 59). To merit tax-exempt status an organization need not meet each and every one of the "hospital standards." E.g. Rev. Rul. 83-157 (a hospital need not operate an emergency room to obtain tax-exempt status if under the circumstances the emergency room would be duplicative, if the hospital's operations do not extend to emergency-care situations). Rather, the standards represent a series of questions which generally are relevant in determining the fundamental issue of whether the organization operates for the promotion of health of a community or communities as a whole. In brief, the "hospital standards" may be read to ask the following questions:

(1) Does the hospital provide hospital care on a non-profit basis for members of the community? Is care available to all community members able to pay, including those who pay via governmental plans, such as Medicare and Medicaid?

(2) If the hospital generally treats emergency-care needs, does it operate an emergency room open to all?

(3) If the hospital does provide emergency services, are they provided to all, regardless of ability to pay?

(4) Does the organization use surplus funds to improve the quality of patient care, expand its facilities, advance medical training, education and research programs, and otherwise to further the promotion of health?

(5) Is the composition of the Board of Directors such that the hospital is responsive to community needs?

(6) Is the organization's medical staff generally open to qualified physicians, consistent with the size and nature of the organization's facilities?

(7) If the organization offers space for lease to physicians, is that space available to all active medical staff (consistent with the size and nature of the facilities) at market rates?

In addressing these questions as to UMHSAC, reference should first be made to the Resolutions of UMHSAC's Directors adopted on _____, 1994 (the "Policy Statement Resolutions"). Although UMHSAC's clinics are not yet operating under UMHSAC, the Policy Statement Resolutions clearly evidence the commitment of UMHSAC's directors to promote the health of the communities served by those clinics, as a whole. Let us address the questions in their order:

(1) Policy Statement Resolution No. 1 provides:

> Medical care generally provided by the University of Minnesota Health System Affiliated Clinics, Inc. ("UMHSAC") shall be provided to all members of the community who are able to pay for such services, including members of the community paying through Medicare, Medicaid, general assistance or any other governmental payment program. All services provided by UMHSAC clinics shall be available to all such members of the community, regardless of whether the source of payment is private or public.
>
> UMHSAC may require reasonable cooperation of any patient in establishing right to payment through Medicare, Medicaid, general assistance or any other governmental payment program or from any private payor.

(2) UMHSAC will not provide any inpatient services. Since it could not admit inpatients for further treatment, UMHSAC will not operate an emergency room.

(3) Because the entities operated by UMHSAC will be clinics and not hospitals with emergency rooms, it is unlikely that individuals with emergency care needs will come to the clinics for emergency medical assistance. However, should an individual requiring critical emergency care come into the clinic, Policy Statement Resolution No. 2 would apply. Such Policy Statement provides as follows:

> Emergency and urgent medical care will be provided by all medical staff employed by UMHSAC, as they are available, to all patients to the extent medically appropriate to overcome or obviate the emergency or urgent need, or to stabilize the patient for further care, to the extent such services can be provided at (and with the equipment at) the UMHSAC facility, regardless of the patient's ability to pay. Upon addressing an emergency or urgent medical need, to the extent the same can be addressed by UMHSAC medical staff, UMHSAC medical staff shall (where the patient's condition warrants further medical care) seek to have the patient admitted for further care at an appropriate facility. UMHSAC may request the patient's reasonable cooperation and assistance in seeking payment through Medicare, Medicaid, general assistance or any other governmental payment program or by a private payor who may be liable for the same, but UMHSAC shall not withhold or delay emergency or urgent medical care, when needed, either to seek the patient's cooperation or assistance or to establish any right to payment.

(4) UMHSAC's directors are committed to the reinvestment of any profits of UMHSAC for the promotion of health. Policy Statement Resolution No. 3 provides:

> UMHSAC shall reinvest its profits for the promotion of health, utilizing such profits to improve patient care and medical facilities, or for other related charitable purposes that further UMHSAC's purposes and principal activities as provided in UMHSAC's Articles of Incorporation (including without limitation the provision of medical care, medical education, community education and outreach, and clinical research and scientific investigation related to health and medicine).

(5) A specific description of the individuals on the Board of Directors for UMHSAC is set forth on Attachment II-4a to this Application. The additional director that is not yet appointed will be the medical director for UMHSAC. He or she will be the only physician on the UMHSAC Board of Directors. In this and other respects, please note that UMHSAC meets the standards which the Internal Revenue Service seems to be applying to "integrated delivery systems," as described in Chapter N of the Technical Instruction Program for Fiscal Year 1994 for Exempt Organizations. More on this below, but the point to be emphasized here is accountability of UMHSAC's directors.

The Health System appoints three of UMHSAC's five directors (the "University Directors"). They and the Physician Director together select the fourth - the "At-Large Community Director." (See Section 3.2 of UMHSAC's Bylaws.) The University Directors are selected by the Board of Governors of the Health System. They represent interests of the State and the region, because they are appointed by a Board of Governors which is in turn representative of the entire State of Minnesota. By way of background, there are 12 Regents of the University of Minnesota. They are elected by the Minnesota Legislature. The Regents in turn appoint the Board of Governors of the Health System. That Board of Governors (when it is fully constituted) will consist of 30 voting members and one non-voting member. Ten of the 30 voting members represent various of the constituencies within the Health System, the University of Minnesota Medical School, and Medical School faculty. In addition, there is one Health Sciences student member, and 19 "public members." The Health System's Bylaws provide in pertinent part as to public members as follows:

> Public members shall be selected for their proven or potential governance skills as evidenced by community leadership, occupation, and current or previous governance experience or otherwise. In selecting public members, the Board of Regents considers it desirable to have broad representation, of women and minority groups. **At least one member of the UMHS Board of Governors shall be representative of each Congressional District** [in Minnesota]. [emphasis in original] No employees of the University shall be eligible to serve on the Board of Governors except as an ex-officio member, or as a student member.

Thus Regents who are elected by the publicly elected representatives of the people of Minnesota in turn must appoint a Health System Board of Governors that is predominantly in turn representatives of the people

of Minnesota. That Board of Governors then selects three of five UMHSAC directors. These directors can certainly be said to represent the interests of Minnesotans, since they are directly accountable to the Board of Governors which certainly represents the interests of Minnesotans. These directors can also be said to represent the interests of the health system, which in turn serves the interests of the people of Minnesota. The Health System is mindful of its own responsibilities to the public, and for application of its resources solely to further its own charitable purposes, so that it would be inappropriate for the Health System to invest funds in, and loan funds to, UMHSAC, for purposes of serving in part as an additional vehicle by which the Health System can further the promotion of health of the people of Minnesota, without ensuring that the Health System maintains direct and dominant representation on UMHSAC's Board of Directors. In addition, however, to further assure that UMHSAC does serve community interests, there is a provision for an At-Large Community Director of UMHSAC.

Moreover, UMHSAC now contemplates the creation of special committees for at least some of the communities serviced by its clinics. Such committees would provide significant input to UMHSAC's Board of Directors as to the operations of the applicable clinic (subject, of course, to limitations of the powers reserved by the UMHSAC Board itself, and those reserved by UMHSAC's member with regard to the budget for the clinic and tax-exempt concerns, policies and status). In this way, the specific communities served by a specific UMHSAC clinic will have significant direct input as to the operations of the clinic in their community.

(6) UMHSAC will be unable to make its facilities available to all qualified physicians, mostly due to size and facility constraints. All of the clinics that would be owned by UMHSAC are currently staffed, or will be staffed at the time the employees of such clinics become employees of UMHSAC. Accordingly, the availability of the office space and the size of the facilities themselves will dictate that the facilities cannot be open to the physician community as a whole. Moreover, the fact that these facilities are simply clinic facilities and not specially equipped facilities makes it unlikely that there would be physicians in the community who would have a particular need to use the UMHSAC facilities, which needs are not currently being met by such physician's own facilities (or those of his or her employer). In addition, as employer of or contractor with the physicians, UMHSAC will be directly responsible for the actions of the physicians staffing its clinics. Accordingly, UMHSAC will need to have more control over the physicians it employs or with whom it contracts for medical services than might

otherwise be the case in a hospital. It is important to note that UMHSAC's ownership of its various clinics will enable the clinics to provide additional services to their patients that they likely otherwise could not provide on site. That is, because of each clinic's affiliation with UMHSAC and ultimately the Health System (and the associated University of Minnesota Hospital and Clinic), the clinics will have an affiliation with many specialists who could make regular visits to the clinics for patient populations requiring specialty services. Availability of such services to such patients might otherwise be impractical, if not impossible.

(7) UMHSAC has no present intention to offer any space for lease to physicians.

Private Inurement/Private Benefit

An organization may not achieve tax-exempt status under Section 501(c)(3) if any part of the organization's net earnings inure in whole or in part, directly or indirectly, to the benefit of any private shareholder or individual. Moreover, an organization must not be organized and operated for the benefit of private interest. The private inurement prohibition is generally concerned with payments to insiders or other persons other than as reasonable compensation for services actually rendered. Private benefit, on the other hand, is a broader concept which generally refers to the scope of a class to be served by the organization's activities.

The private inurement and private benefit concepts overlap to the extent that they insure that an organization serves the public rather than a private interest. The hospital audit guidelines note that private inurement and private benefit differ in two respects:

(1) Even a minimal amount of inurement results in disqualification for exempt status, while private benefit must be more than quantitative or qualitatively incidental in order to jeopardize tax-exempt status; and

(2) Inurement applies only to "insiders" while private benefit may accrue to anyone.

Private inurement/benefit concerns with regard to health care providers are most commonly associated with physician compensation. The commitment of UMHSAC's Board of Directors on this point is evidenced by Policy Statement Resolution No. 4, as follows:

> UMHSAC shall not operate to the private inurement or private benefit of any individual. To that end, the compensation of all physicians employed by UMHSAC must be determined only after consulting one or more

independent surveys regarding physician compensation (and/or other independent information sources), or after such other steps as may be appropriate to establish the reasonableness of the compensation, all so as to enable UMHSAC to determine and set a reasonable level of compensation for its physician-employees. It shall be the policy of UMHSAC to ensure that all compensation is competitive, yet reasonable.

Conclusion

In conclusion, UMHSAC, whose clinics will be similar to outpatient clinics run within hospitals, meets the requirements of the statutes, regulations, IRS rulings and IRS audit guidelines for determination of tax exempt status. UMHSAC exists for the promotion of the health of the communities it will serve. This is quite evident from comparing UMHSAC's characteristics (including specifically its role in furthering the aims of its tax-exempt member organization and its own actual and expected organizational and operational facets, including its fundamental policies as adopted by its Board of Directors) with "hospital standards" by which the IRS gauges whether a medical care provider promotes the health of the community or communities which it serves, as a whole. Plainly UMHSAC will do so. Based on all of the foregoing, UMHSAC should be recognized as a charitable tax exempt entity under IRC §501(c)(3).

APPLICATION OF INTEGRATED DELIVERY SYSTEM GUIDELINES TO UMHSAC

The IRS has certain guidelines for reviewing applications for tax-exempt status by Integrated Delivery Systems. Applying those guidelines to UMHSAC, we conclude that UMHSAC should be granted tax-exempt status.

1. Charity Care. As discussed above, UMHSAC clinics will provide care to both private pay and publicly assisted paying patients, including Medicare, Medicaid, and general assistance patients on a regular basis. UMHSAC has adopted a policy, being Policy Statement Resolution No. 2, with regard to treating all patients regardless of ability to pay in cases of emergency or urgent medical need. That policy is as follows:

> Emergency and urgent medical care will be provided by all medical staff employed by UMHSAC, as they are available, to all patients to the extent medically appropriate to overcome or obviate the emergency or urgent need, or to stabilize the patient for further care, to the extent such services can be provided at (and with the equipment at) the UMHSAC facility, regardless of the patient's ability to pay. Upon addressing an emergency or urgent medical need, to the extent the same can be addressed by UMHSAC medical staff, UMHSAC medical staff shall (where the patient's condition warrants further medical care) seek to have the

patient admitted for further care at an appropriate facility. UMHSAC may request the patient's reasonable cooperation and assistance in seeking payment through Medicare, Medicaid, general assistance or any other governmental payment program or by a private payor who may be liable for the same, but UMHSAC shall not withhold or delay emergency or urgent medical care, when needed, either to seek the patient's cooperation or assistance or to establish any right to payment.

If and when nonpaying patients are treated at UMHSAC clinics, the care given will not be any different from care given to government or private paying patients in similar circumstances.

2. Nondiscriminatory Treatment. UMHSAC clinics will serve Medicare and Medicaid patients, as well as other governmental payor patients, and all such patients will be served in a nondiscriminatory manner, with access to all covered services that are available to paying and privately insured patients. UMHSAC will seek contracts to provide services for Medicare and Medicaid patients, including providing such services to such patients under fee for service arrangements.

3. Board of Director Control. Our analysis above discusses control of the UMHSAC board of directors. UMHSAC will have five directors, one of which will be the "Physician Director" who will be the only physician on the board of directors. One of the five directors will be the "At Large Community Director" as set forth in Section 3.2 of UMHSAC's Bylaws. The remaining three directors will be appointed by the Health System, which represents the interests of the State of Minnesota and regional interests, as they are appointed by the Board of Governors of the University of Minnesota which is representative of the entire State of Minnesota. A combination of the three Health System representative directors representing the interests of the community, the region, and the state, and the At Large Community Director, indicates that the board of directors will be broadly representative of the community.

4. Conflicts of Interest. Article 3 of UMHSAC's Bylaws, Section 3.7, requires that every director shall disclose conflicts of interest the director has with respect to any matter that may come before the board of directors. Such section further provides that, "except with the consent of the majority of the disinterested directors, after disclosure of a conflict of interest, no director may vote on any issue, motion, resolution or other matter which directly or indirectly may inure to his or her benefit." The Bylaws also prohibit the corporation entering into contracts or transactions between a director and a corporation or a related corporation, between a director and a member of the physicians committee of UMHSAC and UMHSAC and an organization in which a director or member of the physicians committee of UMHSAC is a director, officer or legal representative or has a material financial interest, except in accordance with Minnesota statutes.

5. Financial Information Regarding Clinics to be Purchased. UMHSAC has not yet purchased any clinics. For purposes of review, financial information on two clinics proposed to be purchased could be supplied at a later date; however, confidentiality requirements require at this point that such information not be divulged since those acquisitions are not yet final.

6. Other Offers. **[Insert whether to our knowledge any other offers were made to purchase Staub or Palen or state not applicable at this point].**

7. Present Value of Discounted Future Cash Flows. **[Insert information regarding present value valuation or state not applicable at this point].**

8. Sublease of Equipment. UMHSAC will not sublease any interest in equipment from any of the clinics it is contemplating purchasing.

9. Real Estate Rental. UMHSAC intends to continue to lease the real estate currently leased by the clinics which it purchases. Where such clinics own real estate, in which case UMHSAC will own the real estate rather than lease it. Lease rates will presumably be the same as those for the clinics acquired until the end of the lease term, at which point UMHSAC will negotiate the terms at arms-length with the applicable landlords.

10. Real Estate Purchases.

11. Buy-Ins. No physicians will be required to buy-in to a physician group in anticipation of an acquisition of a clinic by UMHSAC. **[Need to discuss prior buy-in requirements.]**

12. Retiring Physicians. **[Insert the information, if applicable, regarding financial information of the group and how retiring physicians are treated or state not applicable at this point].**

13. Ownership of Leased Real Estate and Equipment. To the best of UMHSAC's knowledge, after due inquiry, there is no relationship between any of the officers, directors, employees, independent contractors or managers of UMHSAC and any of the lessors of real estate or equipment to be leased by UMHSAC or that were previously leased by the clinics to be purchased by UMHSAC.

14. Assets Owned By Related Individuals. None of the assets to be purchased by UMHSAC is currently owned by persons related to UMHSAC.

15. Officers of Applicant. None of the officers of the applicant are present or former partners or employees of the physician's organizations to be purchased.

16. Affiliated Hospital Relationship. UMHSAC will not own a hospital. Although physicians employed by UMHSAC will have access to additional amenities by virtue of affiliation through UMHSAC with the University of Minnesota Hospital and Clinic, the physicians will not be admitted to the staff of that hospital.

17. Subordination of Debt. Compensation payable to UMHSAC's physician employees will not be expressly secured or preferred as to other obligations of UMHSAC. Thus it will be presumptively subordinate to UMHSAC's secured debt. But Minnesota, like many other states, accords some statutory protection to some unpaid wages. (So, too, does the United States Bankruptcy Code.) This protection cannot be removed by any agreement between UMHSAC and any physician-employee. See Minnesota Statutes Sections 514.59 through 514.61, copies of which are attached. Minnesota law also expressly requires that wages be paid at least every 30 days. An employer's failure to do so is grounds for penalty. Minnesota Statutes Section 181.101, a copy of which is attached. True subordination of compensation to physician employees would require a purported waiver of the lien (which would be null and void), withholding of payment until all general creditors are paid (which would violate the law if beyond 30 days) or payment in scrip, redeemable only when general creditors have been paid. The latter would be a crime in Minnesota. Minnesota Statutes Section 181.02, a copy of which is attached. Moreover, subordination of wage claims to claims of general creditors is likely void as against public policy in Minnesota. Wage claims of UMHSAC physician employees will be subordinate to debt owing prior secured creditors — that is the most that can be done in this State.

18. Research. Although the UMHSAC clinics may participate to some extent in research being carried on by or through the University of Minnesota Hospital and Clinics, UMHSAC and its clinics themselves will not carry on research.

19. Educational Programs. It is the intention of UMHSAC to have its clinics provide educational programs to the general public, focusing particularly on the applicable community. No fees will be charged for any such programs, and all such programs would be available to the general public and not just patients of UMHSAC clinics.

20. Renovations. It is not currently the intention of UMHSAC to renovate any of the clinics that it will purchase.

21. Fee Committee. UMHSAC's Bylaws do not currently provide for a fee committee, and UMHSAC does not currently intend to create a fee committee.

22. Compensation Advisory Committee. The Compensation Advisory Committee of UMHSAC will not make any final determinations with regard to physician compensation, but rather those decisions will be made by the Board of Directors. The Compensation Advisory Committee will be made up of an appointee of Health System, an outside advisor selected by UMHSAC's board of directors, and a member of UMHSAC's

physicians committee (the physicians committee is composed of the medical directors of each clinic owned by UMHSAC). Accordingly, there will be one physician member of the Compensation Advisory Committee, that that individual will only be a former employee of an acquired clinic and a current employee of one of the clinics to be owned by UMHSAC, and it is intended that UMHSAC will own and operate several clinics. Therefore, any concern regarding conflict of interest in having a former clinic physician on the committee would be diffused.

23. Comparison of Salaries. **[Insert information regarding comparison of physician salaries to prior income and reconciliation with nonpayment from capital assets or state not applicable at this point].**

24. Internship and Residency Programs. Although UMHSAC will not itself conduct an internship or residency program, because of its affiliation with the University of Minnesota Hospital and Clinic, it is anticipated and intended that interns and residences will be placed at UMHSAC clinics for periods of time.

25. Courtesy Care. UMHSAC will not provide courtesy medical care to individuals associated or related to its employee physicians.

University of Minnesota Health System

Affiliated Clinics, Inc.

Board of Directors Meeting
July 22, 1994

University of Minnesota Health System
Affiliated Clinics, Inc.
420 Delaware St. S.E. Box 704
Minneapolis, MN 55455
Telephone: (612) 626-5559
Facsimile: (612) 624-8128

University of Minnesota Health System
Affiliated Clinics, Inc.
("UMHSAC")
7/22/94 Meeting of the Board of Governors

AGENDA

1. **Approval of 6/17/94 Minutes**

2. **Status of UAFP Management Services Agreement**

3. Staub Pediatric Clinic, *one of the University of Minnesota Health System Affiliated Clinics* (8/1/94)

4. Heights Medical Clinic, *one of the University of Minnesota Health System Affiliated Clinics* (9/1/94)

5. **Rush City Clinic**

6. **Hinckley Clinic**

7. **Central Internal Medicine, P.A. Contingent Purchase Offer**

8. **Wadena Medical Center, Ltd. Contingent Purchase Offer**

9. **Practice Acquisition Status**

10. **Next Meeting Date August 19, 1994**

University of Minnesota Health System
Affiliated Clinics, Inc.
("UMHSAC")
7/22/94 Meeting of the Board of Governors

TABLE OF CONTENTS

UNIVERSITY OF MINNESOTA
HEALTH SYSTEM AFFILIATED CLINICS, INC. ("UMHSAC")
Minutes of the 6/17/94 Meeting of the Board of Directors

Attendees

In Person	Non-Director Attendees
Patrick Board	
Michael Fay	Keith A. Dunder, Hospital Counsel
Clifford Fearing	Stephan C. Grygar, UMHC Finance Department
Helen Pitt	Thomas J. Doyle, Attorney

Location

The Board Room of the University of Minnesota Hospital & Clinic (in Room C-361 of the Mayo Building, Harvard Street at East River Road, Minneapolis, Minnesota).

Order of Business

Steve Grygar called the meeting to order at approximately 7:40 o'clock a.m., pursuant to prior notice, after all attendees other than Mr. Fearing were present. It was confirmed that all directors had received the Agenda, and packet including the minutes of the April 22, 1994 meeting of the Board of Directors, a report on Practice Acquisition Status, memoranda and other material regarding the possibility of a local advisory board or other vehicle for community input, particularly in connection with the proposed Rush City Clinic, and proposed Policy Statement Resolutions (collectively the "Directors' Packet").

1. **Approval of 4/22/94 Minutes.** Steve Grygar called for any changes to the minutes of the meeting of the Board of Directors on April 22, 1994. Hearing none, he called for approval. Mike Fay moved approval of the minutes of the April 22, 1994 meeting as presented to the directors, Pat Board seconded that motion, and all three directors present voted in favor of approval. Steve directed Keith Dunder, Secretary of UMHSAC, to note approval on the original minutes and cause them to be entered in the corporate records. Mr. Fearing arrived at this point.

2. **Practice Acquisition Status.** Steve Grygar next reported on the status of proposed acquisitions and other transactions, as summarized on the Practice Acquisition Status report (a copy of which was contained in the Director's Packet). To summarize Mr. Grygar's report, he advised that UMHSAC is expecting to acquire the assets of Staub Pediatric Group, P.A. effective as of August 1, 1994, and thereafter operate on the two clinic sites at which Staub Pediatric Group, P.A. now operates. In connection with that discussion, Mr. Grygar also

reported on the status of a contract between UMHSAC and University Affiliated Family Physicians ("UAFP"). Mr. Grygar reported that the contract would initially have a minimum term of one year, and would renew thereafter but after the first year can be terminated on 120 days notice (or on 30 days notice for cause). Certain other aspects of the relationship between UMHSAC and UAFP were reported. Mr. Grygar then reported on the other proposed acquisitions and other transactions reflected on the Practice Acquisition Status report. Those as to which he made in-depth comment included the following:

(a) the proposed transaction with the Mille Lacs Band of Ojibwe as to the Hinckley Clinic (as to which he noted that there had been an expression of interest in some collaboration from the Mora Clinic, which by consensus of the Board was not to be pursued, and he further noted the need to get physicians from Gateway Family Medical Clinic in Moose Lake, Minnesota, lined up to provide staffing for the clinic in Hinckley, which seemed to meet with the approval of the Board);

(b) the possibility of an acquisition of the assets of Mesaba Clinic (as to which it was pointed out that the acquisition may need to be done by an organization other than UMHSAC, since it did not seem that the physicians would go through with the transaction if the purchaser had UMHSAC's governance structure);

(c) Wadena Medical Center and Central Internal Medicine Associates (as to both of which Mr. Grygar noted that valuations were proceeding; and

(d) Pine City Clinic, Gateway Clinic and Mora Medical Center (which the Board by consensus agreed it would not be in the best interests of UMHSAC to pursue). In connection with the discussion of the status of proposed acquisitions and other transactions, there was some discussion of the possibility of acquiring clinic operations in Grand Rapids and/or Granite Falls, Minnesota, and also some discussion about the possibility of an affiliation between The University of Minnesota Health System and Mesabi Regional Medical Center in Hibbing, Minnesota. Beyond discussion of those as possibilities, however, no particular action was recommended or settled upon.

Director Pat Board had to leave during the Practice Acquisition Status report.

3. **Policies.** Tom Doyle was called upon to comment upon the memoranda and other material on local advisory groups/vehicles for community input. He briefly noted that the existence of local input was an issue in connection with Rush City Clinic, and that the material included in the Director's Packet had been provided to Rush City Clinic for review and comment. Tom Doyle also noted that in the Director's Packet were proposed Policy Statement Resolutions, the adoption of which is intended to establish fundamental guiding policies for UMHSAC. Tom Doyle advised that these policies, if adopted, will be submitted to the Internal

Revenue Service in due course, in support of the application to the Internal Revenue Service for recognition of the tax-exempt status of UMHSAC. Tom also noted that in the Director's Packet was a preliminary draft of a memorandum in support of the eventual application to the Internal Revenue Service.

It was noted that there was some anomaly in proposed Policy Statement Resolution No. 3, in that it referred to profits of UMHSAC even though UMHSAC is a non-profit corporation. It was determined that the word "profits" in that Resolution should be changed to "net earnings." With that change, Cliff Fearing moved that the Policy Statement Resolutions be adopted. Mike Fay seconded that motion. It was adopted by the voice vote of all three directors then present, with no dissenting votes being heard. The full text of the Policy Statement Resolutions as adopted is as follows:

1. Medical care generally provided by the University of Minnesota Health System Affiliated Clinics, Inc. ("UMHSAC") shall be provided to all members of the community who are able to pay for such services, including members of the community paying through Medicare, Medicaid, general assistance or any other governmental payment program. All services provided by UMHSAC clinics shall be available to all such members of the community, regardless of whether the source of payment is private or public.

   UMHSAC may require reasonable cooperation of any patient in establishing right to payment through Medicare, Medicaid, general assistance or any other governmental payment program or from any private payor.

2. Emergency and urgent medical care will be provided by all medical staff employed by UMHSAC, as they are available, to all patients to the extent medically appropriate to overcome or obviate the emergency or urgent need, or to stabilize the patient for further care, to the extent such services can be provided at (and with the equipment at) the UMHSAC facility, regardless of the patient's ability to pay. Upon addressing an emergency or urgent medical need, to the extent the same can be addressed by UMHSAC medical staff, UMHSAC medical staff shall (where the patient's condition warrants further medical care) seek to have the patient admitted for further care at an appropriate facility. UMHSAC may request the patient's reasonable cooperation and assistance in seeking payment through Medicare, Medicaid, general assistance or any other governmental payment program or by a private payor who may be liable for the same, but UMHSAC shall not withhold or delay emergency or urgent medical care, when needed, either to seek the patient's cooperation or assistance or to establish any right to payment.

3. UMHSAC shall reinvest its net earnings for the promotion of health, utilizing such net earnings to improve patient care and medical facilities, or for other related charitable purposes that further UMHSAC's purposes and principal activities as provided in UMHSAC's Articles of Incorporation (including without limitation the provision of

medical care, medical education, community education and outreach, and clinical research and scientific investigation related to health and medicine).

4. UMHSAC shall not operate to the private inurement or private benefit of any individual. To that end, the compensation of all physicians employed by UMHSAC must be determined only after consulting one or more independent surveys regarding physician compensation (and/or other independent information sources), or after such other steps as may be appropriate to establish the reasonableness of the compensation, all so as to enable UMHSAC to determine and set a reasonable level of compensation for its physician-employees. It shall be the policy of UMHSAC to ensure that all compensation is competitive, yet reasonable.

4. Next Meeting. The next meeting was set for Friday, July 22, 1994, at 7:30 o'clock a.m. in the same location, and that date, time and location were announced.

There being no further business to come before the meeting, the meeting adjourned at approximately 8:50 o'clock a.m.

Respectfully submitted,

Keith A. Dunder, Secretary of University of Minnesota Health System Affiliated Clinics, Inc.

The foregoing minutes were approved by the Board of Directors of UMHSAC at their meeting of July 22, 1994.

Keith A. Dunder, Secretary of
University of Minnesota Health System
Affiliated Clinics, Inc.

Staub Pediatric Clinic
Pre-Closing Activities

UMHSAC and Staub

- **Finalize Asset Purchase Agreement**
- **Finalize Bill of Sale**
- **Finalize Promissory Note**
- **Sign closing documents**

UMHS and UMHSAC

- **Finalize Master Loan and Security Agreement**
- **Finalize Term Sheets**
- **Finalize Term Note**
- **Finalize Revolving Note**
- **Finalize Mortgage**
- **Finalize Indemnity and Hold Harmless Agreement**

UMHS Operational Activities

- **7/18/94 Orientation Session with new employees**
- **Initiate integration with UAFP Billing/Collection and Human Resource functions**
- **Initiate contract with ADP for Payroll Services**
- **Initiate contracts for Health Insurance, Life Insurance, Workers Comp and General Comprehensive Liability (includes Employee Dishonesty, Property Insurance and Business Interruption)**
- **Third Party Payor Interface**

Heights Medical Clinic
Pre-Closing Activities

UMHSAC and Heights

- **Complete due diligence checklist and receipt of information**
- **Draft Physician Employment Agreements**

UMHS and UMHSAC

UMHS Operational Activities

- **Schedule Orientation Session with new employees**
- **Schedule integration with UAFP Billing/Collection and Human Resource functions**
- **Third Party Payor Interface**

University of Minnesota Health System
Affiliated Clinics, Inc.
420 Delaware St. S.E. Box 704
Minneapolis, MN 55455
Telephone: (612) 626-5559
Facsimile: (612) 624-8128

Proposed Transaction Among the University of Minnesota by and Through the University of Minnesota Health System ("UMHS"), University of Minnesota Health System Affiliated Clinics, Inc. ("UMHSAC") and Rush City Area Hospital and Clinic ("RCA").

UMHSAC Responsibilities

1. UMHS will loan funds to UMHSAC for the purpose of acquiring land, constructing and equipping a new Clinic Facility in Rush City.

2. UMHSAC will purchase certain assets of the existing hospital and clinic for use within the new Clinic Facility. The exact assets will be mutually determined by RCA and UMHSAC staff. The purchase value of the assets will be based upon an independent Fair Market Value appraisal.

   - The purchase price for the assets will be paid in cash at the time of closing
   - UMHSAC will be responsible for transporting assets from old site to new site.
   - The precise terms on which UMHSAC will acquire clinic assets must be spelled out in a definitive asset purchase agreement.

3. UMHSAC will perform or cause to be performed financial analysis that will determine the most appropriate size of the new Clinic Facility.

4. UMHSAC will not purchase the existing hospital facility or its associated equipment (except for certain assets as referenced above).

5. UMHSAC will not purchase the existing clinic facility or its associated equipment (except for certain assets as referenced above).

6. UMHSAC will not purchase any other assets of the existing hospital or clinic, e.g., cash, accounts receivable (although, supply inventory may be purchased and used during construction of the new Clinic Facility). Since UMHSAC will not purchase existing accounts receivable, UMHS will loan start-up working capital funds to UMHSAC.

7. UMHSAC will not assume any responsibility for accounts payable or other liabilities of the hospital or clinic, to the extent the same exist at the closing, or are attributable to any action or period of time prior to the closing. Without limiting the generality of the term "liabilities," liabilities which UMHSAC will not assume include any liabilities or obligations related to existing debt, hospital or clinic pension, retirement or deferred compensation plans, or any liabilities in connection with any existing employment contracts or relationships to which the hospital or clinic is now a party. All of those accounts and liabilities will remain the responsibility of the pre-closing owner of the assets.

8. UMHSAC proposes to enter into long-term employment contracts with the clinic's physicians. UMHSAC aims to provide compensation that is: (a) reasonable in amount, (b) competitive with what the clinic's physicians could earn in the same specialty practice in the clinic's geographic area in a practice serving a similar population, and (c) fairly rewards each of the clinic's physicians for her or his patient care efforts. UMHSAC may call upon each clinic physician to participate in medical education, research and/or community outreach and education programs which further UMHSAC's purposes and aims.

9. After closing, the new Clinic Facility will be operated, in effect, as a division of UMHSAC. It will be a separate cost/profit center. All expenses attributable to the clinic, including compensation for its employees, other operational expense, and debt service of the debt which UMHSAC incurs to construct and equip the clinic and provide initial operating capital, and other expenses attributable to the clinic, will be charged against the clinic's operational revenues. In addition, a ratable share of UMHSAC's central or overall administrative and other expenses will be charged against the clinic's operational revenues. Net such revenues, if any, shall of course be the property of UMHSAC subject to use as determined by its Board of Directors.

10. UMHSAC's governance provides for the existence of a "Clinic-Specific" committee of the Board whose function will be to advise UMHSAC's Board on clinic matters. The composition of this local advisory committee will include some representation from UMHSAC, Rush City and the community at large.

11. UMHSAC would employ the existing physician and nurse practitioner employees of the hospital and clinic prior to the initiation of construction, on terms set by UMHSAC. UMHSAC would do so under some management contract by which it would take over the operation of the hospital and clinic. UMHSAC may put Mr. Lynn Clayton on its payroll during this period.

- UMHSAC, during construction, would manage the existing operation and pay day to day operating expenses of the hospital and clinic solely from hospital and clinic revenues. UMHSAC would not be responsible for any "liabilities" as described above.

- Rush City, during construction, would pay UMHSAC some management fee.

12. Post-construction, UMHSAC will continue to employ clinic physicians and nurse practitioner(s). UMHSAC, at its option, may choose to hire other present employees whose function is necessary to staff the new Clinic Facility, on terms set by UMHSAC.

13. UMHS will assist Rush City in defining an optimal structure for the provision of Rush City area Emergency Medical Services (EMS). UMHS will also assist Rush City in identifying potential funding sources for EMS.

Rush City and Rush City Hospital and Clinic Board Responsibilities

1. Post-construction, Rush City will be responsible for the existing hospital and clinic building structures.

2. Post-construction, Rush City will be responsible for any residual hospital and clinic equipment and supplies (equipment and supplies not purchased by UMHSAC for use in the new Clinic Facility).

3. Post-construction, Rush City will be responsible for any expenses associated with maintaining the existing structures, e.g., maintenance, utilities, insurance, etc.

4. Post-construction, Rush City will be financially responsible for those employees not continuing employment with UMHSAC in the new Clinic Facility.

5. At the time UMHSAC takes responsibility for existing hospital and clinic operations, per the management contract, the existing Rush City Hospital and Clinic Board will cease to have day-to-day management authority. It would be appropriate that some number of Board members become members of the UMHSAC Local Advisory Committee.

6. Post-construction, Rush City will be responsible for liquidating/re-selling any residual assets and paying off any liabilities not assumed or purchased by UMHSAC. The management contract, or other agreement, will require the cessation of all health care operations at the existing hospital and clinic once the new Clinic Facility opens.

7. Rush City will be responsible for collecting accounts receivable associated with dates of service occurring prior to the date that UMHSAC assumes responsibility for management of the existing hospital and clinic.

8. Rush City will obtain all necessary approvals to transfer ownership of the existing hospital and clinic operations to UMHSAC.

9. Rush City will assist UMHSAC in transferring the existing operations as the new Clinic Facility opens.

C:\FINPLAN\JOVENTURES\CLINICS\RUSHCITY\OUTLINE2.SAM

University of Minnesota Health System
Affiliated Clinics, Inc.
420 Delaware St. S.E. Box 704
Minneapolis, MN 55455
Telephone: (612) 626-5559
Facsimile: (612) 624-8128

Proposed Transaction Among the University of Minnesota by and Through the University of Minnesota Health System ("UMHS"), University of Minnesota Health System Affiliated Clinics, Inc. ("UMHSAC") and the Corporate Commission of the Mille Lacs Band of Chippewa Indians ("Commission").

Commission Responsibilities:

1. The Commission will capitalize all or part of the clinic's construction and furnishings in Hinckley, but to the extent that the Commission chooses not to capitalize the facility, UMHS will have the first option to do so.

2. If the clinic facility is capitalized and owned by the Commission, UMHS, through UMHSAC, will be granted a long-term facility lease and associated equipment leases at terms to be negotiated between the parties (but with financial terms to be consistent with "Financial Structure" described below).

3. If the clinic facility is capitalized and owned by the Commission, and if, at some future date, the Commission elects to sell or assign the ownership of the clinic and associated equipment, UMHS, through UMHSAC, will be given the first option to acquire the building and equipment.

4. Provide UMHSAC with input into the clinic design and construction process; allow UMHSAC input into the relative sizing decisions of the facility.

5. Work with UMHSAC in structuring a Casino employee Benefit Plan as to which the Hinckley Clinic will be the preferred provider.

UMHSAC Responsibilities:

1. UMHS, through UMHSAC, will manage the clinic practice in Hinckley and, through representation at the local governance level, the Commission will have a role in regard to the management and operation of the Hinckley site.

2. The management of the practice in Hinckley will be administered in conjunction with other area clinic practices in order to achieve maximum efficiencies and administrative cost savings, so long as nothing in management or operation will adversely impact on the potential revenues, profitability or future growth of the Hinckley clinic.

3. That the Hinckley clinic will be a full provider, providing services to the general population, as well as members of the Band, and will endeavor to provide care, and/or create programs which will address the special needs of the Band, and the local community.

4. That the Hinckley clinic will be operated in a commercially viable manner and is expected to be self-sustaining, but will provide appropriate levels of community support and charity care, consistent with tax and health care regulations.

5. That the Hinckley clinic, to the maximum extent possible consistent with its effective and efficient operations, and consistent with state and federal law, will provide training and employment opportunities for Band members who wish such opportunities in the health care field.

Financial Structure:

1. UMHSAC and Commission will enter into a 30 year Facility Lease and an initial 7 year equipment lease.

2. To provide start-up cash flow to the clinic practice, Commission will waive facility lease payments for the first four full years of operation. UMHSAC will, on a 30 year basis for facility and on a 7 years basis for equipment, provide the Band with an overall 4% Return-on-Investment (ROI) on the leases. This 4% ROI is based upon the following assumptions:

    - That the Band will contribute capital on a 50/50 debt/equity basis.

- UMHSAC and Commission will structure a facility and equipment lease agreement that provide Commission with an 8% ROI on the debt portion and 0% ROI on the equity portion (thereby providing a 4% overall ROI).

- The ROI associated with the equity portion is waived in lieu of "Community Benefit" returns associated with the clinic practice.

- The facility lease rate will be increased 15% every five years over the remaining 26 year life of the lease.

ROUGH DRAFT

July 14, 1994

University of Minnesota Health System (UMHS) , Mille Lacs Band of Ojibwe Indians (MLBOI) and Ryan Companies (RYAN) - Hinckley Clinic Project Tasks Outline

AGREEMENTS

1. UMHS/MLBOI modify and extend the letter of intent which expires on 7-31-94.
2. UMHS/Gateway Health Clinic (Moose Lake) finalize letter of understanding.
3. MLBOI - issue Ryan confirmation letter authorizing financial analysis assistance and master lease negotiations.
4. UMHS - Prepare and issue first draft of Master lease agreement to MLBOI and Ryan.
5. UMHS- Prepare a health benefits package for employees of Hinckley casino and Hinckley area band members.
6. MLBOI- Prepare request for proposals from at least 3 design and construction companies, conduct interviews and make selection.
7. MLBOI - Prepare appropriate agreement for design and construction of the clinic facility with selected design and construction company.

LAND

1. UMHS/MLBOI - select preferred site location for new clinic.
2. UMHS - determine if it is appropriate to purchase additional land for future hospital needs.
3. MLBOI - begin negotiations for purchase of land; secure all appropriate environmental tests, soil tests, legal and topography survey(s).
4. MLBOI- begin discussions and any necessary negotiations with Hinckley city management on zoning and public improvement issues associated with selected site location.
5. MLBOI- identify specific governmental requirements that might be imposed depending on site location selected; watershed issues, environmental issues, state health board reviews, etc.

FINANCING

1. UMHS- prepare financial analysis that takes into consideration a higher ROI for MLBOI. Utilizing data from the April 1994 financial analysis report give consideration to an adjustable rate lease which provides the LMBOI with a higher rent payment which would be pegged to the specific performance of the clinic itself.
2. MLBOI - determine if the Hinckley clinic project qualifies as a tax exempt property per federal government guidelines and band commission guidelines.
3. MLBOI - establish preference for securing any cash required to capitalize the project.
4. Ryan- assist MLBOI in reviewing taxable and tax exempt financing options that might be available to fund both the debt and equity components of this project.

5. Ryan- assist MLBOI in evaluating and determining which financial vehicle(s) fit the overall preferences and needs of the band and the financial goals and objectives of UMHS.
6. Ryan - prepare a financing package for LMBOI use in seeking financing for the project.

PROGRAMMING, SPACE PLANNING and SITE PLANNING

1. Begin review of space program needs for clinic facility. Participants: UMHS, MLBOI, Gateway clinic group; Rush City medical staff representative(s), and design team members.
2. MLBOI & Designer - Convert programming efforts into realistic space plan.
3. MLBOI & Designer - Begin planning of selected site to meet the current and future space needs of UMHS.

PROJECT DESIGN

1. MLBOI finalize design agreement.
2. Develop schematic design.
3. Prepare project design development drawings.
4. Prepare construction specifications.
5. Prepare special medical equipment specifications.
6. Obtain all public approvals required for project so that building permit is available for pick-up by the contractor.

PROJECT CONSTRUCTION

1. MLBOI finalize construction agreement.
2. Contractor constructs building.
3. Substantial completion of construction of clinic building.
4. Move-in and set-up of special medical equipment and all FF&E items.
5. Obtain certification of facility from State Health Dept. (If required).

OCCUPANCY OF CLINIC

1. Prepare clinic for occupancy and operation.
2. Open clinic for patient visitation.

University of Minnesota Health System
Affiliated Clinics, Inc.

Clinic Acquisition Central Internal Medicine Associates, P.A.

Coordinated Management Committee of UMHS
July 1994

Introduction

Central Internal Medicine Associates, P.A., established in November 1968, is a Minnesota professional corporation, specializing in internal medicine. The staff of well-qualified and licensed physicians include four internists, one trained in critical care, and one family practitioner; other clinic support staff total approximately ten.

Medical services include radiology, laboratory, EKG, critical care, pulmonary, cardiovascular stress testing, allergy treatment and home health care.

The Central Internal Medicine Group has one clinic site that it rents; the clinic is located at the intersection of Interstate 94 and Snelling Ave; Suite 203 - Hamline Park Plaza, 570 Asbury Street, St. Paul.

The clinic has approximately 15,000 clinic visits per year with annual net revenues of $1,100,000.

UMHSAC sees this Group location as a good geographic base for the St. Paul market. In addition, this location will allow the Health System, through UMHSAC, to provide medical education, medical research and community outreach to this St. Paul region.

UMHSAC has, for purposes of Practice Acquisition, performed and/or has had performed ***Practice Valuations*** for the Central Internal Medicine Group. The practice valuations encompass a variety of alternative methodologies including Discounted Cash Flow Method, Market Comparison Method and Comparative Transaction Method. By performing and using the results of the various valuation techniques, UMHSAC has established a credible range of practice valuations that served as the basis for the intangible price offer to the Central Internal Medicine Group.

Practice Purchase Offer

UMHSAC has proposed to acquire the intangible assets of Central Internal Medicine Group. These include assets such as physician and non-physician work force in place, medical and patient records, contracts, the name(s) and logo(s) used by Central Internal Medicine Group, along with all signage, all information in books and records relating to the business of Central Internal Medicine Group, and the rights to use all such information, goodwill, and any and all other intangible assets of Central Internal Medicine Group. UMHSAC would propose to make payments to the Group in consideration of all practice value and intangible assets of Central Internal Medicine Group as follows: **$80,000 on the first anniversary of the closing, and a like amount on each of the seven following such anniversaries. (Total value of $640,000).**

Working Capital Loan

UMHSAC, as part of the clinic asset acquisition, is not purchasing Central Internal Medicine Group's patient accounts receivable. Given that the P.A. will retain it's collected receivables, a working capital loan will be necessary to provide cash flow during the initial post-closing collection period. UMHSAC estimates that the amount of this loan is approximately $225,000.

Covenant Not-to-Compete

Each employment agreement will have a post-termination covenant not to compete, of a minimum of six (6) months, plus two (2) months for every annual assured compensation payment received by the physician. For all physicians UMHSAC would propose a covenant not-to-compete that extends for five to ten miles from each location where the physician is regularly practicing medicine at the time of his or her termination of employment. The covenant not-to-compete would "kick in" if a physician voluntarily terminates employment or voluntarily elects not to renew his or her Employment Agreement, or if the physician is terminated for "Cause." There would be no covenant not-to-compete if the physician is terminated by UMHSAC without cause, or if UMHSAC elects not to renew the Employment Agreement.

Tangible Assets

Building

Central Internal Medicine leases space; accordingly, UMHSAC has not performed building appraisals and has not included any real estate component within its asset purchase offer.

Equipment

UMHSAC has secured an independent appraisal for the value of Central Internal Medicine's furniture, equipment, and all other tangible assets. The appraised fair market value is **$160,140**, which is the amount UMHSAC proposes to pay for the furniture, equipment and all other tangible assets of Central Internal Medicine Associates.

Purchase Summary

Intangible Assets	$ 640,000
Tangible Assets:	
Building	0
Equipment	160,140
Total	$ 800,140
Working Capital	
Loan	$225,000

DRAFT

University of Minnesota Health System
Affiliated Clinics, Inc.

420 Delaware St. S.E. Box 704
Minneapolis, MN 55455

July __, 1994

Frederick O. Ferris, M.D.
Central Internal Medicine Associates
570 Asbury
St. Paul, Minnesota 55104

RE: Central Internal Medicine Associates (the "Clinic")

Dear Dr. Ferris:

We refer to our May 4, 1994 letter of intent. University of Minnesota Health System Affiliated Clinics,Inc. ("UMHSAC") has completed the appraisal, financial analyses and evaluations contemplated by that letter. As a consequence, and subject to the caveat stated below, UMHSAC offers to purchase all of the assets of the Clinic other than cash and accounts receivable for the amounts on the attached Purchase Price Summary, payable as stated on that Summary. The following caveat from our May 4, 1994 letter of intent continues to apply as to this offer:

> The value of the Clinic's intangible assets - the practice value - is dependent in a large part on revenues that UMHSAC can expect from Clinic operations in the future. Such revenues in turn are dependent upon maintaining existing contracts or other relationships with payors, and ensuring the employment by UMHSAC of existing Clinic physicians. A refusal by an existing Clinic payor to contract or continue the existing relationship with UMHSAC, or a refusal by a physician-employee of the Clinic to continue employment with UMHSAC, and possibly one or more other changes that would reduce clinic revenues, will result in a reduction in that amount that UMHSAC will pay for practice value, and may cause UMHSAC to re-examine its level of interest in the Clinic.

At your request, our letter of intent gives you the right to terminate our exclusive dealing period upon 21 days' notice. Consistent with that, UMHSAC extends this offer for acceptance within 21 days of this letter; if the offer has not been accepted within that period, UMHSAC reserves the right to thereafter withdraw the offer by written notice to you at any time before the offer is accepted. (However, as stated in the letter of intent, if the Clinic gives notice of termination of the exclusive dealing period, but thereafter resumes negotiations with UMHSAC, UMHSAC would need to reassess this offer.) This offer may be accepted by your execution of the enclosed counterpart of this letter, where noted below, and return of the executed counterpart to UMHSAC.

DRAFT

We reiterate, on behalf of UMHSAC,both the non-binding statements of intention and the binding provisions of our letter of intent. That letter will continue to guide our conduct and negotiations going forward. Per that letter, if the Clinic accepts UMHSAC's offer, we will then work for a definitive asset purchase agreement, and physician employment agreements.

We enclose a copy of UMHSAC's Articles of Incorporation and bylaws. As stated in the letter of intent, UMHSAC intends to seek Internal Revenue Service recognition of its tax-exempt status. IRS determinations and statements since UMHSAC's bylaws were adopted lead us to believe that the IRS will not recognize UMHSAC's tax-exempt status if a physician is on the Compensation Committee; therefore, a change to the bylaws may be required in that respect. We cannot know whether the IRS might insist on other changes.

UMHSAC sincerely hopes this offer will form the basis on which we can go forward together, as contemplated by the letter of intent. Of course we would be pleased to discuss any of your questions, comments and concerns. We look forward to your response.

Very truly yours,

UNIVERSITY OF MINNESOTA HEALTH SYSTEM AFFILIATED CLINICS, INC. ("UMHSAC")

By_____
Clifford P. Fearing, Chief Executive Officer

Address:
420 Delaware Street S.E.
Box 704
Minneapolis, Minnesota 55455
Attention: Stephan C. Grygar

[See page 3 for Clinic countersignature to accept the above offer.]

DRAFT

We accept the foregoing offer, intending to negotiate as contemplated by the May 4, 1994 letter of intent for our sale of our assets (other than cash on hand and accounts receivable) for the amount offered, payable as provided on the Purchase Price Summary. While we cannot commit for each and every physician employed by the Clinic, at this point the Clinic believes its physicians are interested in being employed by UMHSAC after UMHSAC's acquisition of Clinic assets.

Dated:_____, 1994.

Central Internal Medicine Associates (the "Clinic")

By_____

Its_____

Address:
Central Internal Medicine Associates
570 Asbury
Saint Paul, Minnesota 55104
Attention: Frederick O. Ferris, M.D.

DRAFT

PURCHASE PRICE SUMMARY
Attached to UMHSAC's July ____, 1994
Letter of Intent to Central Internal Medicine Associates

Item	Price	Payment Terms
Equipment[1] and leasehold improvements, assumption of lease and all tangible assets	$160,140	Cash at Closing
Practice Value	(See "Payment Terms" column)	$20,000 for each existing physician-shareholder (four), to a maximum of $80,000, on the first anniversary of the closing. A like amount on each of the seven following such anniversaries.[2] A physician's departure before all annual payments are made will result in his or her forfeiture of any remaining payments.

NOTE WELL: UMHSAC will not assume any responsibility for accounts payable or other liabilities of the clinic (or of the seller of any of the assets in use by the Clinic, which UMHSAC purchases), to the extent the same exist at the closing, or are attributable to any action or period of time prior to the closing. Without limiting the generality of the term "liabilities," liabilities which UMHSAC will not assume include any liabilities or obligation related to existing Clinic pension, retirement or deferred compensation plans, or any liabilities in connection with any existing employment contracts or relationships to which the clinic is now a party. All of those accounts and liabilities will remain the responsibility of the pre-closing owner of the assets.

---

1 "Equipment " is used here to include all furniture, fixtures, clinic and miscellaneous equipment, artwork, mechanical devices, office items and supplies, roughly the current level of medical supplies inventory, and any and all other tangible assets of the Clinic.

2 Any different payment schedule would require discounting to reflect any acceleration of any payments.

University of Minnesota Health System

Affiliated Clinics, Inc.

Clinic Acquisition
Wadena Medical Center, Ltd.

Coordinated Management Committee of UMHS
July 1994

Introduction

The Wadena Medical Center, Ltd. is a family-centered health facility designed to deliver complete and continuing family health care. The medical staff in Wadena includes five family practitioners, one general surgeon and one certified physicians assistant; other clinic support staff total approximately twenty-eight.

Medical services provided by the Wadena Medical Center include general surgery (including laparoscopic procedures), infant and child care, gynecology, maternity care (including delivery), minor surgery, sports injuries, family planning, weight management and nutritional guidance and geriatric care.

The Wadena Medical Center, Ltd. leases space from the Tri-county hospital (the clinic is attached to the hospital). The clinic is located at 4 N.W. Deerwood Avenue, Wadena Minnesota.

The clinic has approximately 26,000 clinic visits per year with annual net revenues of $2,700,000.

UMHSAC sees this Group location as a good geographic base for the Central Minnesota market. In addition, this location will allow the Health System, through UMHSAC, to provide medical education, medical research and community outreach to this region.

UMHSAC has, for purposes of Practice Acquisition, performed and/or has had performed ***Practice Valuations*** for the Wadena Medical Center Group. The practice valuations encompass a variety of alternative methodologies including Discounted Cash Flow Method, Market Comparison Method and Comparative Transaction Method. By performing and using the results of the various valuation techniques, UMHSAC has established a credible range of practice valuations that served as the basis for the intangible price offer to the Wadena Medical Center Group.

Practice Purchase Offer

UMHSAC has proposed to acquire the intangible assets of Wadena Medical Center, Ltd. These include assets such as physician and non-physician work force in place, medical and patient records, contracts, the name(s) and logo(s) used by Wadena Medical Center, Ltd., along with all signage, all information in books and records relating to the business of Wadena Medical Center, Ltd., and the rights to use all such information, goodwill, and any and all other intangible assets of Wadena Medical Center, Ltd. UMHSAC would propose to make payments to the Group in consideration of all practice value and intangible assets of Wadena Medical Center, Ltd. as follows: **$124,250 on the first anniversary of the closing, and a like amount on each of the seven following such anniversaries. (Total value of $994,000).**

Working Capital Loan

UMHSAC, as part of the clinic asset acquisition, is not purchasing Wadena Medical Center's patient accounts receivable. Given that the P.A. will retain it's collected receivables, a working capital loan will be necessary to provide cash flow during the initial post-closing collection period. UMHSAC estimates that the amount of this loan is approximately $600,000.

Covenant Not-to-Compete

Each employment agreement will have a post-termination covenant not to compete, of a minimum of six (6) months, plus two (2) months for every annual assured compensation payment received by the physician. For all physicians UMHSAC would propose a covenant not-to-compete that extends for five to ten miles from each location where the physician is regularly practicing medicine at the time of his or her termination of employment. The covenant not-to-compete would "kick in" if a physician voluntarily terminates employment or voluntarily elects not to renew his or her Employment Agreement, or if the physician is terminated for "Cause." There would be no covenant not-to-compete if the physician is terminated by UMHSAC without cause, or if UMHSAC elects not to renew the Employment Agreement.

Tangible Assets

Building

Wadena Medical Center, Ltd. leases space; accordingly, UMHSAC has not performed building appraisals and has not included any real estate component within its asset purchase offer.

Equipment

UMHSAC has secured an independent appraisal for the value of Wadena Medical Center's furniture, equipment, and all other tangible assets. The appraised fair market value is **$229,825**, which is the amount UMHSAC proposes to pay for the furniture, equipment and all other tangible assets of Wadena Medical Center, Ltd.

Purchase Summary

Intangible Assets	$ 994,000
Tangible Assets:	
Building	0
Equipment	229,825
Total	$ 1,223,825
Working Capital	
Loan	$600,000

University of Minnesota Health System
Affiliated Clinics, Inc.

420 Delaware St. S.E. Box 704
Minneapolis, MN 55455

July , 1994

Tim B. Schmitt, M.D.
Wadena Medical Center, Ltd.
4 N.W. Deerwood Avenue
Wadena, Minnesota 56482

RE: Wadena Medical Center, Ltd. (the "Clinic")

Dear Dr. Schmitt:

We refer to our February 16, 1994 letter of intent. University of Minnesota Health System Affiliated Clinics,Inc. ("UMHSAC") has completed the appraisal, financial analyses and evaluations contemplated by that letter. As a consequence, and subject to the caveat stated below, UMHSAC offers to purchase all of the assets of the Clinic other than cash and accounts receivable for the amounts on the attached Purchase Price Summary, payable as stated on that Summary. The following caveat from our February 16, 1994 letter of intent continues to apply as to this offer:

> The value of the Clinic's intangible assets - the practice value - is dependent in a large part on revenues that UMHSAC can expect from Clinic operations in the future. Such revenues in turn are dependent upon maintaining existing contracts or other relationships with payors, and ensuring the employment by UMHSAC of existing Clinic physicians. A refusal by an existing Clinic payor to contract or continue the existing relationship with UMHSAC, or a refusal by a physician-employee of the Clinic to continue employment with UMHSAC, and possibly one or more other changes that would reduce clinic revenues, will result in a reduction in that amount that UMHSAC will pay for practice value, and may cause UMHSAC to re-examine its level of interest in the Clinic.

Consistent with that, UMHSAC extends this offer for acceptance within 60 days of this letter; if the offer has not been accepted within that period, UMHSAC reserves the right to thereafter withdraw the offer by written notice to you at any time before the offer is accepted. This offer may be accepted by your execution of the enclosed counterpart of this letter, where noted below, and return of the executed counterpart to UMHSAC.

We reiterate, on behalf of UMHSAC,both the non-binding statements of intention and the binding provisions of our letter of intent. That letter will continue to guide our conduct and negotiations going forward. Per that letter, if the Clinic accepts UMHSAC's offer, we will then work for a definitive asset purchase agreement, and physician employment agreements.

As stated in the letter of intent, UMHSAC intends to seek Internal Revenue Service recognition of its tax-exempt status. IRS determinations and statements since UMHSAC's bylaws were adopted lead us to believe that the IRS will not recognize UMHSAC's tax-exempt status if a physician is on the Compensation Committee; therefore, a change to the bylaws may be required in that respect. We cannot know whether the IRS might insist on other changes.

UMHSAC sincerely hopes this offer will form the basis on which we can go forward together, as contemplated by the letter of intent. Of course we would be pleased to discuss any of your questions, comments and concerns. We look forward to your response.

Very truly yours,

UNIVERSITY OF MINNESOTA HEALTH SYSTEM AFFILIATED CLINICS, INC.
("UMHSAC")

By_____
Clifford P. Fearing, Chief
Executive Officer

Address:
420 Delaware Street S.E.
Box 704
Minneapolis, Minnesota 55455
Attention: Stephan C. Grygar

[See page 3 for Clinic countersignature to accept the above offer.]

We accept the foregoing offer, intending to negotiate as contemplated by the February 16, 1994 letter of intent for our sale of our assets (other than cash on hand and accounts receivable) for the amount offered, payable as provided on the Purchase Price Summary. While we cannot commit for each and every physician employed by the Clinic, at this point the Clinic believes its physicians are interested in being employed by UMHSAC after UMHSAC's acquisition of Clinic assets.

Dated:_____, 1994.

Wadena Medical Center, Ltd. (the "Clinic")

By_____

Its_____

Address:
Wadena Medical Center, Ltd.
4 N.W. Deerwood Avenue
Wadena, Minnesota 56482
Attention: Tim B. Schmitt, M.D.

PURCHASE PRICE SUMMARY
Attached to UMHSAC's July ____, 1994
Letter of Intent to Wadena Medical Center, Ltd.

Item	Price	Payment Terms
Equipment[1] and leasehold improvements, assumption of lease and all tangible assets	$229,825	Cash at Closing
Practice Value	(See "Payment Terms" column)	$17,750 for each existing physician-shareholder (seven), to a maximum of $124,250, on the first anniversary of the closing. A like amount on each of the seven following such anniversaries.[2] A physician's departure before all annual payments are made will result in his or her forfeiture of any remaining payments.

NOTE WELL, as stated in the February 16, 1994 letter of intent: UMHSAC will not assume any responsibility for accounts payable or other liabilities of the clinic (or of the seller of any of the assets in use by the Clinic, which UMHSAC purchases), to the extent the same exist at the closing, or are attributable to any action or period of time prior to the closing. Without limiting the generality of the term "liabilities," liabilities which UMHSAC will not assume include any liabilities or obligation related to existing Clinic pension, retirement or deferred compensation plans, or any liabilities in connection with any existing employment contracts or relationships to which the clinic is now a party. All of those accounts and liabilities will remain the responsibility of the pre-closing owner of the assets.

---

1 "Equipment " is used here to include all furniture, fixtures, clinic and miscellaneous equipment, artwork, mechanical devices, office items and supplies, roughly the current level of medical supplies inventory, and any and all other tangible assets of the Clinic.

2 Any different payment schedule would require discounting to reflect any acceleration of any payments.

UMHSAC Practice Acquisition Status

Version: 18-Jul-94

	Phase I				Phase II		Phase III		Phase IV	Phase V
	(A)	(B)	(C)	(D)	(A)	(B)	(A)	(B)		
Staub Pediatric Group	X	X	X	X	X	X	X	X	X	8/01/94
Palen Clinic	X	X	X	X	X	X	X	X	X	9/01/94
Hinckley (New Clinic)	X	X	X	X	X	X	X			
Rush City Clinic	X	X	X	X	X	X				
Pine City Clinic	X	X	X	X						
Fairmont Clinic	X	X	X	X	X	X	X			
Grand Rapids										
Wadena Medical Center	X	X	X	X	X	X				
Central Internal Medicine	X	X	X	X	X	X				
Mesaba Clinic	X	X	X	X	X					
Granite Falls	X	X								
Mankato										
Mesabi Regional Medical Cntr										

Definitions:

Phase I (A)	*Introductory Meeting*
Phase I (B)	*UMHSAC follow-up*
Phase I (C)	*Clinic Confirmation; UMHSAC originated Letter-of-Intent, Micro-process outline, detailed financial information request*
Phase I (D)	*Information receipt by UMHSAC*
Phase II (A)	*Tangible and Intangible Valuations (Bldg, Eqpt & Practice)*
Phase II (B)	*UMHSAC offer presentation*
Phase III (A)	*Offer Negotiation*
Phase III (B)	*Offer Agreement*
Phase IV	*UMHSAC Due Diligence*
Phase V	*Closing*