A non-public meeting of the Board of Governors Executive Committee of the University of Minnesota Health System was held on Wednesday, August 10, 1994 at 09:24 a.m. in the Board Room, pursuant to the following resolution adopted at a public meeting of the Board of Governors.

> RESOLVED, that on the recommendation of the President and as provided by Minnesota State Statute, a non-public meeting of the Board of Governors Executive Committee be held on Wednesday, August 10, 1994, in the Board Room, for the purpose of discussing specific marketing and contracting matters.

Board members Present: Michael Dougherty, Nellie Johnson, Greg Hart, Arthur Kydd, John Morrison, Shelley Chou, M.D., Roby Thompson, M.D., Thomas Madison, Stephen Hansen.

Guests: Roberto Heros, M.D., Kevin Sexton, Rosanne Pijca, Keith Hurl, Scott Roncace, and Don Wegmiller.

The meeting was adjourned at 12 Noon.

Vaman Pai
Board of Governors

Staff: Clifford Fearing and Vaman Pai

A non-public meeting of the Board of Governors Executive Committee of the University of Minnesota Health System was held on Wednesday, August 17, 1994 at 10:42 a.m. in the Board Room, pursuant to the following resolution adopted at a public meeting of the Board of Governors.

> RESOLVED, that on the recommendation of the President and as provided by Minnesota State Statute, a non-public meeting of the Board of Governors Executive Committee be held on Wednesday, August 17, 1994, in the Board Room, for the purpose of discussing specific marketing and contracting matters.

Present: Michael Dougherty, Nellie Johnson, Greg Hart, Arthur Kydd, John Morrison, Shelley Chou, M.D., Roberto Heros, M.D., Al Hanser, Stephen Hansen, Peter Rapp.

Guests: Cherie Perlmutter, Rosanne Pijca, Win Wallin and Don Wegmiller.

The meeting was adjourned at 11:18 a.m..

Vaman Pai
Board of Governors

Staff: Clifford Fearing and Vaman Pai

Board of Governors
Executive Committee
August 17, 1994
8:30 a.m. - 12:00 Noon
Board Room

Agenda

1. Revised Agenda

2. Medical School Infrastructure

3. Technology Program Development

4. Market Strategies

University of Minnesota Health System
Board of Governors
Retreat

DRAFT II

August 24 & 25, 1994

IDS Oakridge Conference Center

8:00 - 8:30 a.m.	Welcome and Introductions -Introductory Comments (Dougherty, Wallin, Brody) -Overview of Agenda (Hart)
8:30 - 9:15 a.m.	Long Range Financial Plan Model (Fearing) -Baseline Assumptions -Baseline Financial Picture -Investment Evaluation Model
9:15 - 10:45 a.m.	Medical School Financial Status (Chou/Thompson/Hart) -Medical School Economics -Clinical Department Recovery Plans -Transition Infrastructure Rebuilding Needs -Solution Beyond Transition Period -Infrastructure Investment Plan (action)
10:45 - 11:00 a.m.	Break
11:00 - 12:00 Noon	Translational Research and Clinical Program Development -R & D Investment Principles -Case Study: Breast Cancer -R & D Investment Fund (action)
12:00 - 1:00 p.m.	Lunch
1:00 - 5:00 p.m.	Market Strategies (closed session) (Hart, Lewin, Wegmiller) -Mission and Absolutes -Overview of Strategies -Blue Cross/Fairview Analysis -Greater Minnesota Strategies -Hibbing & Red Wing (action) -Other Market Initiatives -Public Utility

5:00 - 6:00 p.m.	Free Time
6:00 p.m.	Social Hour & Dinner

Thursday, August 25, 1994

8:00 - 9:30 a.m.	Market Strategies - continued -Action Items
9:30 - 10:30 a.m.	Financial Plan Revisited
10:30 - 10:45 a.m.	Break
10:45 - 11:30 a.m.	Board of Governors Work Plan
11:30 - 12:00 Noon	Formal Board Meeting
Noon	Adjourn and Lunch

Mission and Absolutes

The University of Minnesota Health System has a three-part mission: patient care, education, and research. UMHS is the primary clinical organization for carrying out the education and research mission of the University of Minnesota Medical School and Health Sciences. The distinctive difference between UMHS and other community patient care providers is our mission-level commitment to education and research.

UMHS's vision is to be part of one of the nation's leading academic medical centers. As such, the Academic Health Center will be nationally competitive for externally funded research, attract the highest quality health professional students, and deliver cutting edge patient care.

To fulfill that vision, we must maintain a broad-based core of clinical faculty, committed to excellence in teaching, research, and patient care. We must also maintain a core teaching hospital and other care settings which must be continually accountable as the primary patient care environment supportive of our teaching and research missions.

UMHS must be a financially viable organization. Sufficient patient care activity, mix and revenue are essential to both economic viability and our academic mission. The core clinical faculty and teaching hospital cannot be maintained without patient care revenue; the dependence upon patient care revenue is likely to increase, and UMHS will need to be increasingly responsive to the changing healthcare marketplace.

Being responsive to the changing healthcare marketplace will mean we will need to accept change as a fact of life. The community needs more primary care physicians: we will need to base our educational programs more in community ambulatory settings. Our traditional teaching hospitals will play different roles: more of our educational and patient care programs will be in other hospital settings. The University Hospital will become more linked with other community organizations: non full-time faculty physicians will become increasingly part of our system. We will need to make choices about what we must do ourselves: some things that we now control will be done in collaboration with others. The financing of our national health care system is changing our traditional methods of financing our education, research, and patient care programs will need to be altered.

In that environment of change, however, we will remain committed to:

Our mission: Patient Care, Education, and Research, and

The essentials: A core of excellent, dedicated clinical faculty, and an outstanding University Hospital.

Technology, Translational Research, and Clinical Program Development

Academic medical centers, including the University of Minnesota, have long depended on their research and development missions to provide them with their distinctive differences from other health care providers. The ability to produce the medical "firsts", to be on the cutting edge of new knowledge, to be the first to invest in new technology, and to be able to do what community providers cannot yet do have been the competitive advantages of academic medical centers for decades.

Often those unique capabilities have been the "trademark" around which much of the institution's reputation has been built. At the University of Minnesota, pioneering work in open heart surgery put the institution "on the map" in the 1950's and 1960's. Organ transplantation did the same thing in the 1970's and 1980's.

Typically the cutting edge patient care methodologies have gradually migrated from being in the exclusive purview of the University to being adopted as common community practice over a period of years. As techniques become perfected, as new physicians are trained, and as insurance companies agree to payment, community hospitals can replicate those clinical programs. Open heart surgery is now common; organ transplants are done at five or six Twin Cities hospitals; there are several bone marrow transplant units in operation in Minneapolis-St. Paul.

In the past, the time lag for this technology transfer process may have been several years, or even a decade. It now appears that this process is shortening significantly (although, arguably, health care reform may cause less duplication to occur). This decreased time lag leads to two related phenomena at the University: First, faculty must work even harder to "pull the next rabbit out of the hat" - to find something new and different; and, second, Universities are being forced to invest large amounts of money in "translational research", or the process of bringing a new technology or procedure from the clinical (or even basic) research phase to clinical application. Increasingly, the funds for such investments are coming from the reserves or income stream of the clinical enterprise, i.e., the University Hospital and the clinical departments/practice plans.

The pressure to invest in translational research as a means of maintaining marketshare grows as managed care plans increasingly channel patients within their own systems, of which the academic medical center is not a part. If the managed care plans only

want to use the University as a place to do things that cannot be done elsewhere, the academic medical center has to work even harder and spend more money on unique clinical capabilities, often those things which are still in the research phase of their development.

The resources of the clinical enterprise also become more important for this purpose as external funding becomes more difficult to obtain. The NIH and others are increasingly focused on what they can fund, and that focus tends to be away from applied research and clinical applications. Thus the clinical enterprise is under increasing pressure to fill this funding void.

The return on investment formula for such expenditures is getting increasingly complex. Should such investments be justified on their return of patient revenue over a period of time? Should the institution seek to protect it's investments through patent, license, and other return on investment mechanisms, outside of clinical revenue? Where does institutional and individual conflict of interest fit into such strategies? If the latter pursued, are device and product oriented initiatives inherently more worthy than those which create new knowledge and individual faculty expertise? Should the institution seek to protect it's interests in such "human capital" with aggressive and business-like no-compete employment agreements for faculty?

The decisive equation is complex in another regard. How does the institution select those projects designated for special translational research support? Based upon the academic priorities of the Medical School? Based purely around return on investment from a financial standpoint? Based upon its existing strengths? Are academic medical centers ever able to prioritize their scientific interests and align those with the interests of the clinical enterprise and the marketplace? From where in the organization should such a process be driven?

We have had some experience at the University of Minnesota with such projects and issues. Significant, and largely successful, clinical program development initiatives have been undertaken over the years. Organ transplantation and bone marrow transplantation have received developmental support, typically through waiver of changes for initial transplant procedures, provision of support personnel, and provision of faculty salary support. More recently, we have gone a step or two deeper into the translational research phase, and provided funding for stem-cell transplant and biotech product (B43-PAP) initiatives. We have made commitments in the past several months, driven by key faculty retention needs, to provide translational research funding in diabetic immunology and pancreas transplantation.

We are seeing rapidly increasing growth in requests for

translational research support. Gene therapy, bone marrow transplant, cancer and others are areas of great scientific growth and current or potential major clinical impact. Staying on the cutting edge, compared to both the community and other academic centers, will be critical to our success in maintaining a competitive clinical advantage and fulfilling our mission. At the same time, our resources are not sufficient to meet all of the translational research needs, and we are under increasing pressure to reduce costs in order to be market competitive.

Given this situation, we are in need of a set of principles, priorities and a plan for strategic investements in translational research and clinical program development initiatives:

PRINCIPLES AND PRIORITIES

1. The financial resources of UMHS, i.e., the reserves and clinical income of the University Hospital and UMCA/the clinical departments should first be used to support direct patient care and development efforts which are clearly clinical program development initiatives. There should be incentives for new, high quality, financially-wise investments of this sort.

2. UMHS cannot be both a competitive clinical enterprise and be the NIH. Projects which have little or no near-term clinical applicability should not be funded from UMHC reserves.

3. The clinical departments may choose to invest some portion of their clinical income stream in basic, clinical, or translational research initiatives at their own discretion. However, the financial impact of such decisions should not be translated to a non-competitive position for UMHS.

4. It is necessary and appropriate that UMHS resources be invested in select translational research initiatives. The criteria for selecting those initiatives should be as follows:

    - The program should reflect a major academic priority of the Medical School/Health Sciences.

    - The program should have clinical application within a 2-3 year time frame.

    - The program should have major market impact, offering the potential of improving the health of large numbers of patients.

    - The program should offer return on consistent potential of greater than 15% over a five to ten year time

period.

- There should be a track record of demonstrated scientific, translational research, and clinical success among the program's leaders.

- The program should enhance the image and reputation of the institution broadly, sufficient to create a regional, if not national and international, presence.

RECOMMENDED PLAN

A. Clinical Program Development Fund

UMHS should establish a Clinical Program Development Fund of $2 million, funded initially from UMHC reserves.

The purpose of this fund will be to advance small to moderate sized ($50,000-$200,000) clinical program developments efforts which have immediate clinical application and which can be better than self-supporting in less than one year.

This initiative is already being organized through UMCA's Program Development Committee, chaired by Dr. Chip Bolman.

B. Major Initiative Fund

UMHS should establish a Major Initiative Fund to support a small number of programs which meet the criteria in #4, above. This initiative should be established for an initial three year period, with first year funding in the amount of $1 million, and second and third year funding in the amount of $2 million each. Source of funding should be from UMHC reserves.

Projects considered should be the scope, magnitude, and impact as outlined above, and be in the 200,000 - 2,000,000 range.

Programs funded through this mechanism should receive explicit approval from the UMHS Board of Governors, upon recommendation of the UMHS President, Medical School Dean, and Health Sciences Provost.

C. Risk and Reward Sharing Models

UMHS should continue to pursue risk and reward sharing models of financing clinical program growth and development. Under these kinds of models, program-wide financial performance is assessed, objectives for growth and improved financial performance are established, and achievement of those objectives results in reward sharing among the program participants (hospital, UMCA, and clinical departments). This approach is already under investigation with a number of clinical programs. No specific funding allocation is required.

UNIVERSITY OF MINNESOTA HEALTH SYSTEM

Strategic Actions

Presented by Lewin-VHI, Inc.

Executive Committee Meeting

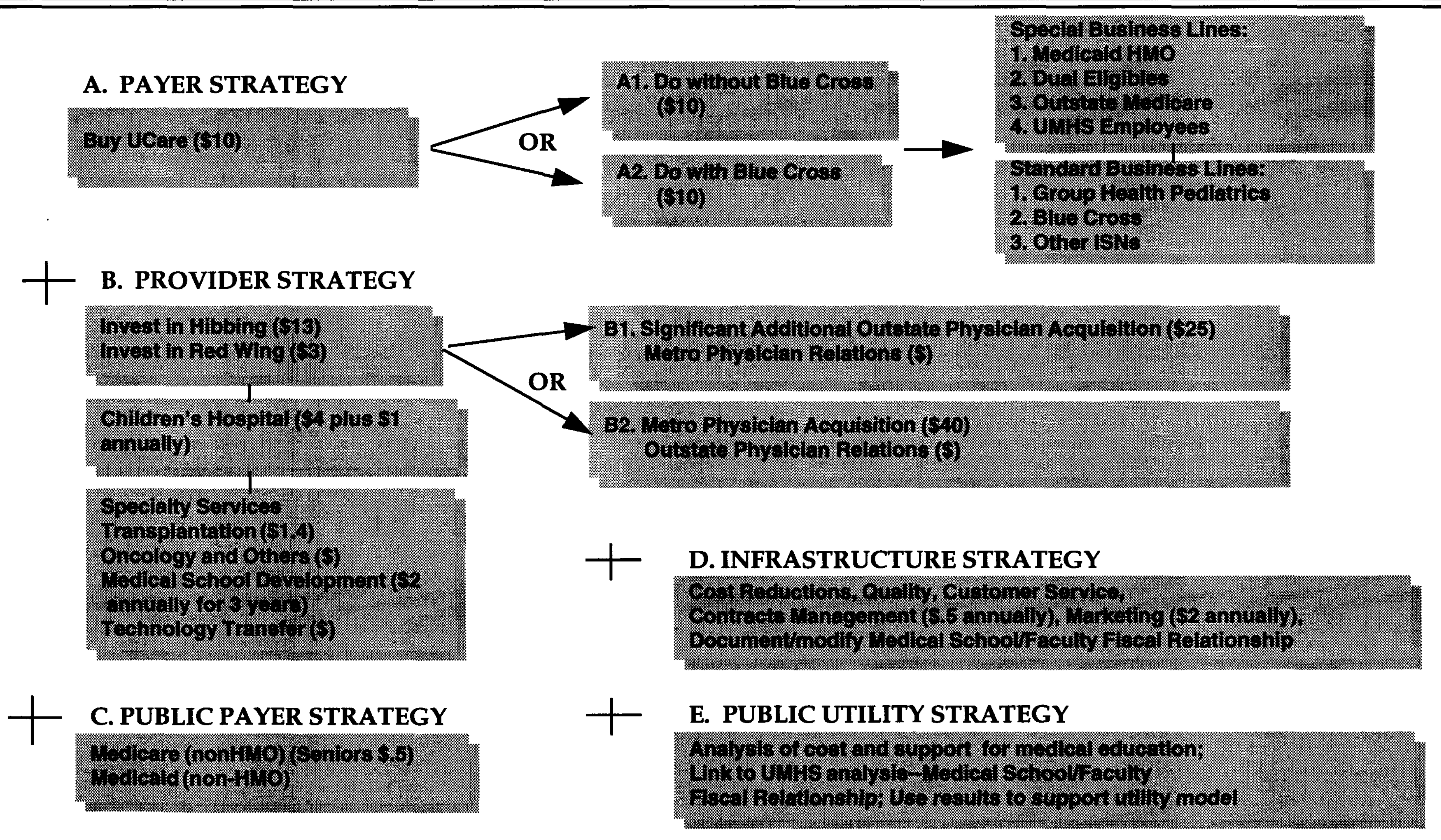
August 17, 1994

Based on work-to-date, five overall strategies have emerged to guide strategic action steps.

- Payer
- Provider
- Public Payer
- Infrastructure
- Public Utility

Strategic Action Steps

($65-80 million, plus $5 million annually)



A. Payer Strategic Actions Without or With Blue Cross

- Buy UCare
  - $10 million; 35,000 lives; Medicaid HMO license and management experience, payer relationship with other providers
  - A1. Without Blue Cross: Proceed alone with other payer strategic actions ($10 million)
  - A2. With Blue Cross: Joint venture on Medicaid HMO and the following special business lines; obtain a favorable long-term relationship in ISN including Health East/Fairview options and other Blue Cross contracts ($10 million)
- Use UCare to pursue special business lines
  - Compete for state dual eligibility demonstration project
  - Invest in outstate Medicare Project (tie to outstate provider strategy)
  - Incentivize UMHS employees to use UMHS
- Pursue standard business lines
  - Contract with Group Health for greater pediatric business
  - Seek Blue Cross and Blue Cross ISN business
  - Seek stronger relationships with other ISNs via discounting, strong contract management services, clinical services differentiation

A1. Payer Strategic Actions Without Blue Cross

- UCare Investment
  - Should provide a positive (10 percent) return plus the move of 1,000 discharges per year to UMHS
  - Will be vehicle to bid on state "Dual eligibles"project (90,000 projected---nationally, 1/6 of age 65+ population are poor)
  - Will be vehicle to develop outstate Medicare HMO project in conjunction with outstate physician acquisition program
  - Will be vehicle to attract UMHS employees
- Gain Group Health pediatric business via price freeze and Ramsey relationship
- Hold Blue Cross loss below current estimates (80% in Metro area, 30% in Outstate)
- Hold/grow non-Blue Cross business via discounts, higher profile for specialty care, clear standing as "neutral"

A2. Payer Strategic Actions With Blue Cross

- UCare Investment
  - Serves as leverage by becoming a joint venture with Blue Cross
  - Use joint venture to expand existing and develop new products described in A1
    - » Medicaid HMO
    - » Dual Eligibles
    - » Medicare HMO program
    - » University employees
  - Obtain special arrangement on Blue Cross business (ISN, other) to grow UMHS yield
    - » preferred standing
    - » long-term arrangement
    - » possible link to Southeast Quadrant development/Health One
- Gain Group Health pediatric business via price freeze and Ramsey relationship
- Approach other ISNs to hold (minimize loss) of business via discounts, higher profile for specialty care

B. Provider Strategic Actions

- Invest in Iron Range ($13 million)
  - Hibbing Mesaba Clinic physician practice acquisition ($8 million)
  - Mesabi Regional Medical Center and Radiation Therapy Center ($5 million)
- Invest in Red Wing practice development ($3 million)
- Invest in Children's Hospital ($1 million inpatient renovation, $3 million ambulatory care clinic; $1 million marketing per year)
- Invest in Specialty Services
  - Transplantation ($1.4 million, Bone Marrow)
  - Oncology and others
  - Medical School Development ($2 million annually for 3 years)
  - Technology Transfer (Translational Research)

B. Provider Strategic Actions (continued) (B1. Additional outstate OR B2. Metro physician acquisition)

- B1. Additional outstate physician acquisition ($25) and Metro physician relations ($)
  - Wadena I-94 ($3 million)
  - Other Iron Range, Virginia, Grand Rapids ($12 million)
  - I-35 or Other(s) ($10), OR
- B2. Metro physician acquisition ($40 million) and outstate physician relations ($)

C. Public Payer Strategic Actions

- Seek targeted ZIP code growth in Medicare in addition to outstate Medicare HMO through seniors program, higher visibility for specialty services
- Move UCare Medicaid discharges to UMHS; seek other Medicaid growth beyond UCare , explore potential services and areas

D. Infrastructure Strategic Actions

- Reduce cost (focus on length of stay, FTEs per admission, supplies and expense)
- Document outcomes
- Improve customer service
- Increase and focus marketing efforts ($1-2 million per year)
- Initiate seniors program ($500,000 per year)
- Hire and utilize contracts management staff ($500,000 per year)
- Document and modify as appropriate the Medical School and faculty fiscal relationship

E. Public Utility Strategic Actions

- Conduct analysis of cost and support for medical education in Minnesota
- Link to analysis of UMHS--Medical School/faculty fiscal relationships (see D. above)
- Utilize results to support public utility model

Next Steps

- Review/approve/modify overall strategic approach
- Ensure reasonableness of assumptions
- Test output via model
- Provide documents to Board members in advance of retreat

UNIVERSITY OF MINNESOTA HEALTH SYSTEM

BOARD OF GOVERNORS EXECUTIVE COMMITTEE MEETING

NOVEMBER 16, 1994 MINUTES

PRESENT: Mike Dougherty, Art Kydd, Peter Rapp, Stephen Hansen, Nellie Johnson, Tom Madison, Shelley Chou, MD, Roby Thompson, MD, Bill Brody, MD, Al Hanser, Greg Hart

STAFF: Vaman Pai

ABSENT: John Morrison

GUESTS: Cliff Fearing, Mark Koenig, Bob Erickson, Roger Paschke, Pat Board, Pete Mitsch, Joanne Jackson, Marvin Goldberg, MD,

---

Nellie Johnson, vice-chair, called the meeting to order at 2:40 pm..

Interstate Medical Center **-Information Item**

Mr. Greg Hart brought to the attention of the Executive Committee, a letter from IMC's attorneys detailing the position of the Internal Revenue Service on IMC's request for recognition as an organization exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Mr. Hart told members that the IRS had raised several significant concerns regarding the application and had been advised that the application in its present form would not be approved. Mr. Hart said that the IMC board has been appraised of the situation and several suggestions detailed in the letter from IMC's attorneys were being considered to address the IRS concerns.

CCSI - Letter of Intent **-Approval Item**

Mr. Greg Hart presented to the Executive Committee a request for approval to enter into a letter of intent to allow UMHC, a partner in the consortium that owns Life Link III, to explore the feasibility of merging LL III with Health Span Transportation Services, a division of Allina Health Systems. Mr. Hart said that this move was prompted by the reconfiguration of the Twin Cities health care system, particularly in the Allina Health System and that such a merger would allow for certain economies of scale and operational initiatives. Mr. Hart added that this letter of intent would allow the partners to enter into a due diligence process that would determine if such economies of scale and operational initiatives did exist, and if 501(c)(3) not for profit status could be maintained among other factors. A motion was made to approve the request, seconded and after a brief discussion, approved by the Executive Committee.

C.U.H.C.C. Community Board **-Information Item**

Mr. Peter Rapp presented to the Executive Committee a letter outlining the need for the formation of a community board for the Community University Health Care Center (CUHCC). Mr. Rapp explained that CUHCC had applied to qualify as a Federally Qualified Health Center, which would allow for an additional $400,000 in federal grants for the operation of this clinic. Among other issues that need to be addressed before the January 1995 deadline would be the reserve powers of the Board of Governors and the authority to hire and fire the executive director of the Center. This item was brought to the committee for information only and a final document will be presented to the full board for approval at its December meeting.

Credentials Committee Recommendations **-Approval Item**

Marvin Goldberg, M.D., Chief of Staff placed for approval the report and recommendations of the Credentials Committee. Dr. Goldberg also added that there was an additional request from the Hospital Counsel to consider the reappointment and extension of Dr. James Halikas for a period coinciding with the ongoing hearing process and its conclusion. A motion was made to accept the recommendations as presented, seconded and approved.

UMCA Common Billing Unit Financing **-Information Item**

Mr. Pat Board updated the members of the Executive Committee on the common billing implementation and the current status of its financial needs. Mr. Board informed members that UMCA had engaged Coopers and Lybrand to review UMCA's major financial assumptions and to explore financial options for capital and operating deficit requirements and to refine timing of its cash needs. Mr. Board added that UMCA legal opinion had recommended that, at this time, they pursue a loan option versus a creation of UMHS owned billing entity and that would be the thrust of the request UMCA would bring to the Board for approval at the December meeting.

Medical School Financial Support **-Information Item**

William Brody, M.D., Provost for the Academic Health Sciences, introduced a document that outlined the status of the medical school financial infrastructure and made a request for release of $2.7 million of UMHC reserves to fund deficits within the departments of Pediatrics and Medicine as these departments implement cost reduction plans. Dr. Brody emphasized the importance of these two departments to the medical school, but cautioned that funds would be released as and when departments demonstrated that cost reduction activity was in place. Dr. Brody then requested Ms. Joanne Jackson, Chief Financial Officer of the Academic Health Center to present the details outlined in the document.

Ms. Jackson detailed the six schedules outlined in the Provost's document and said that the medical school was in the process of reconciling its financial picture with the hospital and the University and would start making decisions only when the larger picture, which included obtaining information of both restricted and unrestricted funds from the University, was complete. Ms. Jackson added that the support for all Medical School departments would be a phased operation over a period of years. This item was presented for information and would come to the Board for approval of $2.7 million in December.

University Bond Rating/UMHS Strategic Plan -Information Item

Mr. Bob Erickson, Senior Vice President of Finance and Roger Paschke, Treasurer , University of Minnesota, presented at the invitation of the Board, a report on the University of Minnesota's bond rating profile and the effect UMHS strategic plan would have on the University's plan. Mr. Paschke informed the Executive Committee that the University presently has $330 million in outstanding debt and will incur an additional $120 million debt in the revamping of its steam plant and other outstanding construction projects next year. Mr. Paschke indicated that with a $450 million debt, there is limited flexibility for UMHC or the University to spend down its current reserves without jeopardizing the University's current AA bond rating. Staff will continue to explore this issue as part of the UMHS strategic planning process.

Strategic Plan/Board of Regents Strategy -Information Item

Mr. Mike Dougherty addressed the need of the Board of Governors to interact with the members of the Board of Regents. Mr. Dougherty also emphasized the necessity to make the Regents and the community understand how important the Hospital is not only in carrying out its tripartite mission of research, education and quality patient care, but that the Hospital and its reserves serves as an integral element of the University's financial standing. Mr. Dougherty asked that this perspective be considered as the University-wide debt capacity review proceeds.

Hibbing Report -Information Item

Mr. Greg Hart reported that discussions were going well in Hibbing, both on the Clinic and Hospital fronts and that the Board would probably see some kind of agreement with the Mesabi clinic in January. Mr. Hart also reported that UMHS was close to completing its first phase review of the Mesaba Regional Medical Center acquisition, and that a letter of intent would be ready in December. The approval process for such a letter and the eventual acquisition was also discussed. Mr. Hart added that the board would be continually updated and that it was essential for UMHS to continue working towards the Iron Range strategy to maintain its strategic position in the today's market. Mr. Hart also said that the three Hibbing components, the acquisition of the clinic and hospital and the construction of the radiation therapy unit should be considered as being linked together.

Iron Range Report- Continued

Mr. Hart also reported that bond issue referendum in Grand Rapids for the renovation of the hospital had failed in the November elections. The Virginia, MN, physician group has met with UMHS leadership and have asked to meet them for a second time in the near future.

Board Chair, Mr. Mike Dougherty requested that the Executive Committee be brought together via conference call on Tuesday, December 13, at 3:30 pm to revisit the long range policy once all the financial information has been gathered to enable members to make an informed report to the full Board at the December 14th meeting.

UMHC 1994-95 Capital Budget

Mr. Peter Rapp presented the 1994-95 capital budget to the Executive Committee for approval of a $7,800,000 recurring capital budget and for information, all major projects over $250,000. Due to lack of time, the discussion on this item was deferred to the December meeting of the board.

Board of Governors Nominations

Mr. Art Kydd announced that the Nomination Committee of the Board was ready to recommend four names to Board of Regents. Mr. Kydd reminded members that there were two vacancies on the board, and of those two, one vacancy existed for a nominee from Congressional District 6 which need to filled per the Regents mandate.

There being no other matters to discuss, the meeting was adjourned at 5:40 pm. The next board meeting is scheduled for December 14, 1994 at the Radisson Metrodome Hotel. The annual Board Christmas party will follow the regular meeting of the Board.

Submitted by

Vaman Pai
Staff

FREDRIKSON & BYRON, P.A.
Attorneys At Law

1100 International Centre
900 Second Avenue South
Minneapolis, MN 55402-3397
(612) 347-7000
FAX (612) 347-7077
Direct Dial No.
(612) 347-7047

November 8, 1994

PERSONAL AND CONFIDENTIAL **BY FACSIMILE**

Ellen Dunn
Administrator
Interstate Medical Center
Highway 61 West
2835 South Service Drive
Red Wing, MN 55066

Re: Application for Tax Exemption

Dear Ellen:

As you know, Interstate Medical Center ("IMC") has applied to the Internal Revenue Service for recognition as an organization exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The IRS is currently reviewing IMC's application. During a telephone conference call on October 21, 1994, Mr. Robert Kolbe of the IRS' Exempt Organizations Division expressed several concerns regarding IMC's governance structure and retention incentives.

The purpose of this letter is to summarize Mr. Kolbe's concerns and what changes IMC might make to address those concerns. I understand that IMC's Board of Directors will consider these issues at the next Board meeting on November 15, 1994, and I plan to be present at 8:30 a.m. to discuss this matter. I suggest that you enclose a copy of this letter with the mailing you are sending to Board members for that upcoming meeting. Please mark the envelope "confidential".

During our telephone conference call, Mr. Kolbe expressed the following concerns regarding IMC's application:

1. Physician Representation on Board of Directors. Mr. Kolbe stated that IMC should restructure the membership of its Board of Directors to meet the IRS' twenty percent "safe harbor" requirement. That "safe harbor" would limit the number of Board members who are physicians or current or former employees of IMC to twenty percent.

To meet the IRS' safe harbor, IMC's Board of Directors could be restructured as follows:

(a) IMC's Bylaws would provide for a Board of Directors of ten members, of which no more than twenty percent would be physicians or other current or former IMC employees.

(b) Two Board members would be selected by IMC physicians in the same manner as Physician Directors are currently selected ("Physician Directors").

(c) Five Board members would be selected by the University of Minnesota Health System ("UMHS") ("University Directors").

(d) Three Board members would be appointed by a selection committee, which is discussed further below ("Community Directors").

(e) Certain ex-officio, non-voting members may serve on the Board, as discussed further below.

Alternatively, IMC could propose a different allocation of the eight non-physician directors. For example, IMC could have more community representation, such as four University Directors and four Community Directors. The IRS is not particularly concerned with regard to the composition of the "non-physician component' of the Board, as long as the Board members represent prominent members of the community. Mr. Kolbe has accepted the classification of University Directors within the non-physician component of the Board. Since fifty percent of IMC's Board is presently appointed by UMHS, and in light of the fact that community involvement in IMC's Board will be a new experience for both UMHS and IMC, I thought the above allocation of five University Directors and three Community Directors made sense.

In addition to determining an appropriate allocation of non-physician directors, the Board will need to decide who would likely agree to serve as Community Directors. The first three Community Directors will likely be chosen through a somewhat informal process of considering who in the community would make a good Community Director and whether that person would serve if requested. Other tax exempt medical groups have included on their governing bodies local business leaders, educators, financial experts and allied health care professionals.

In the future, when Community Directors resign or finish their term of office, a more formal process will be required to appoint new Community Directors. For the reasons discussed below, I favor using a selection committee to appoint the successor to the Community Director who is resigning or completing his or her term. The selection committee would be smaller than the full Board, such as two University Directors, two Community Directors and one Physician Director. (If the IRS does not approve of the Physician Director serving on this committee, the IRS may permit the Physician Director to serve as a non-voting member.)

I favor the above selection committee for several reasons. First, the committee gives the constituencies represented by existing Board members a voice in the appointment of new Community Directors. Second, because 50% or fewer of the selection committee members are UMHS representatives, IMC can continue to use the argument that it is not a member of a "controlled group" with UMHS for employee benefit purposes. (IMC and UMHS would be members of the same controlled group if UMHS directly or indirectly controlled the appointment of eighty percent of the Board members. A controlled group would preclude IMC from covering physicians under its own qualified retirement plan, unless IMC met a narrow exception that it qualified as a "separate line of business" from UMHS.) Third, the selection committee should address the IRS' concerns regarding physician participation in the governance of tax exempt organizations but at the same time provide some assurance that appropriate persons will be named as Community Directors.

Another decision issue for the Board involves whether to include ex-officio, non-voting members for more physician input at Board meetings. The IRS has approved at least one tax exempt clinic that includes ex-officio, non-voting Board members who are physicians employed by the clinic (i.e., the medical director, the chair of the professional practice committee, and the chief executive officer. The clinic administrator should also be able to serve as a non-voting Board member.). In Interstate's case, since the Administrator has served as a voting Board member, it may make sense for that person to serve as an ex-officio, non-voting member. By so doing, the physicians still elect two voting Physician Directors.

2. <u>Conflict of Interest Policy</u>. Mr. Kolbe asked that IMC adopt a "conflict of interest" policy. The IRS has recently indicated in other rulings that physicians who serve as Board members should not vote on matters involving their compensation or on other matters in which they have a financial interest.

To address Mr. Kolbe's concern, IMC's Bylaws would be amended to include a conflict of interest provision. I do not regard this as a major issue, although the wording that we use will

need to be carefully considered so that IMC does not end up with a provision that precludes Physician Directors from voting on any matter that even remotely could affect their compensation.

3. Physicians' Committee. Mr. Kolbe firmly stated that the Physicians' Committee could not determine physician compensation. Instead, the Board would be responsible for determining physician compensation (with the Physician Directors not voting on the matter, pursuant to the conflict of interest policy). The Board could appoint a compensation committee to make recommendations in this regard, but no physicians may serve as committee members. In addition, Mr. Kolbe stated that the Physicians' Committee could not determine IMC's fee schedule, nor could the Committee determine which third party payor relationships IMC will participate in. Those decisions would be made by the Board.

To address Mr. Kolbe's concern, IMC's Bylaws would be amended to move the authority for determining compensation under Section 5.1(b) from the Physicians' Committee to the Board. In addition, Section 5.1(c) would be amended so that the Board has the authority for setting IMC's fee schedules and determining which third party payor relationships IMC will participate in. In addition, Section 5.1(c) would clarify that the Board will approve IMC's charity care policy.

4. Retention Payment. Mr. Kolbe raised a number of questions and concerns regarding IMC's payment of the retention incentives. Mr. Kolbe's primary concern is whether the payment of the incentives constitutes "private benefit" to IMC physicians (one of the grounds for denying tax exempt status). At this point, I do not believe any change to the retention incentive is necessary. However, because of the complex nature of this issue, I want to explain the IRS' concern in more detail at the Board meeting and how we intend to respond.

5. Charity Care. It would be helpful if Interstate could establish a dollar amount of "free care" that it intends to spend on patient care for its next fiscal year. We need to quantify in some manner the time and effort spent by IMC physicians in providing charity care. Mr. Kolbe was the least concerned with this issue. However, if we can estimate and track the amount of anticipated charity care, it would be beneficial to provide that information to Mr. Kolbe.

* * * *

In conclusion, the IRS has raised several significant concerns regarding IMC's application. Based on our telephone call and the IRS' position in other recent rulings involving tax exempt

integrated delivery systems, I do not believe that IMC's application will be approved in its present form. If, however, IMC revises its governance structure and we satisfactorily address Mr. Kolbe's concerns regarding the retention payments, Mr. Kolbe may be able to recommend approval of IMC's application.

There are two other courses of action that the Board could take with regard to IMC's application if these changes are not acceptable. First, the Board could decline to make any of the changes suggested by Mr. Kolbe. In that case, the next step in the review will be for IMC to be offered the opportunity for a conference at the IRS National Office, which I believe will be little more than a formality (a conference is required before issuance of an adverse letter). After the conference, I believe that the IRS would issue an adverse ruling on IMC's application. IMC could then challenge that ruling in court. For a variety of reasons which we can discuss at the Board meeting, I am not in favor of this course of action.

Second, the Board could withdraw IMC's application. In that case, IMC would not be a tax exempt entity and would be subject to state and federal income taxes since the inception of its business. I understand that Mike Larson is evaluating the income tax consequences if IMC did not become tax exempt.

At this point, I think it is premature to withdraw IMC's application. IMC may be able to restructure its governance to meet the IRS' concerns. We also may be able to address Mr. Kolbe's concerns regarding the retention incentives, although he felt strongly about the potential for private benefit regarding these payments. For these reasons, I prefer not to withdraw the application at this time.

If you or any Board members have any questions regarding this letter, please give me a call.

Very truly yours,

James B. Platt

JBP/349567

cc: Thomas J. Doyle, Esq.

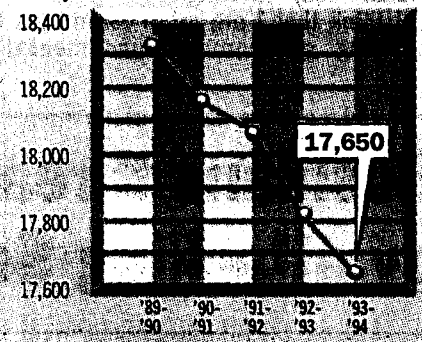
SAINT PAUL PIONEER PRESS
MONDAY, NOVEMBER 14, 1994

Economic Scalpel Cuts Deep At U

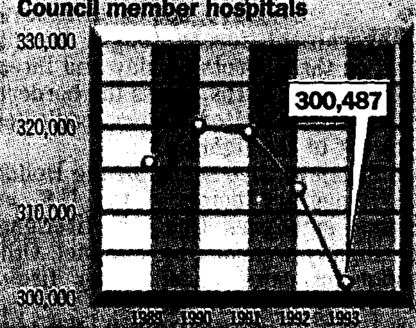
Hospital admissions dwindling

Patient admissions are declining at University Hospital and Clinic, as well as hospitals across the Twin Cities area. But the impact is magnified at the university because of its teaching mission. Fewer patients translate into fewer opportunities for doctor training.

University of Minnesota Hospital and Clinic admissions



Metropolitan Healthcare Council member hospitals



Source: University of Minnesota Hospital & Clinic; Metropolitan Healthcare Council.

PIONEER PRESS

Second of three parts

By Judith Yates Borger

Staff Writer

The University of Minnesota Hospital and Clinic, which trains 60 percent of the state's doctors and does the kind of research that has saved people whom other institutions could not help, now is fighting for its own life.

As health insurers keep an increasingly sharp eye on the bottom line, they're sending their enrollees to the hospitals with the lowest costs for the best results, period. No one wants to pick up the tab for teaching and research — costs that have always been built invisibly into the patient care bill at the university.

The problem has been compounded by the university's failure, until recently, to face the competitive conditions in which it now must function.

As the health care industry scrambles to sort itself out — with or without government reform — the university's hospital stands out as the one Twin Cities health care institution slow to adapt to the new era.

The situation is serious. For example, the number of babies delivered at the university dropped so low a couple of years ago that the medical school's obstetrical residency program was put on probation by the

HOSPITAL CONTINUED ON 5A ▶

HOSPITAL/ Mission at U under pressure

▼ CONTINUED FROM 1A

organization that accredits medical schools. Meanwhile, officials at other academic teaching hospitals around the country are gossiping that managed care in Minnesota is about to put one of the country's top teaching hospitals out of business.

That seems highly unlikely. Already there are indications that university hospital officials and the state's health plans are working together on areas of mutual benefit. There's talk of finding a way to pay for the teaching and research costs the university incurs that benefit the whole state.

But whatever happens, it's quite clear that the health care environment in which the university flourished as recently as 10 years ago is gone for good. The university hospital has changed already, and it's going to change more.

Academic teaching hospitals nationwide are facing serious challenges from managed health care. According to Minnesota Managed Care Review, the sting is particularly acute in the Twin Cities, where 43 percent of the people are enrolled in HMOs and many others in variants of managed care — among the highest proportions in the country.

The heart of the matter is this: The university's traditional mission of teaching, research and patient care is diametrically opposed to the needs of today's health care system.

VOICES

"I'm certain a lot of the research done in the future will be done in an organization like Allina. I hope the U will step up to the plate. We and the U should complement each other."

—Dr. James Ehlen
Allina Health president

over -

nomically, top-notch teaching and technological research that can improve care can help keep costs down. But health insurers cannot afford to pay for them without charging higher premiums.

"Everybody wants us to train primary care doctors, but nobody wants to send us primary care patients," lamented Greg Hart, president of the University of Minnesota Health System.

The fear is that if the university doesn't get enough patients with common ailments, eventually it will find itself providing more and more specialized treatments to fewer and fewer people, and before it dries up and blows away.

Although the University of Minnesota is a relatively small player in Minnesota's health care marketplace — only 6.4 percent of the patients treated in Minnesota's hospitals get their care there — it is a looming presence.

The majority of Minnesota's doctors are trained there. It has a long history of astounding medical firsts, such as organ transplants and open-heart surgery. And it has been the seedbed for many of the companies that make up Minnesota's medical device industry, which employs about 22,000 people (more than the 17,500 employed in Minnesota by Northwest Airlines).

Although Hart bristles at the characterization, the university hospital is a victim — of its own success, of its attitude in the past and of the brave new world of managed care.

Too much success

One of the university's goals is to develop highly sophisticated treatments and then perfect them until they can be transferred into community hospitals. For example, heart transplants, which were pioneered at the University of Minnesota, now are performed routinely at Abbott Northwestern Hospital in Minneapolis. Today, the university charges about $60,000 for a heart transplant, which is comparable to the price at Abbott, according to Hart. But in the developmental days, heart transplants at the university were a lot more expensive.

And there's the rub.

"There are only a few things that the U does today that can't be done just as well in community hospitals," said Dr. James Ehlen, president of Allina Health System, parent company to HMO Medica and hospital chain HealthSpan.

Ehlen added that the marketplace has made it clear it is not willing to pay a higher premium for access to the university.

"Again and again Medica offered subscribers a chance to have the university in the network if they wanted to pay more," Ehlen said. "They said 'no' because we already had Abbott Northwestern in our network."

VOICES

"Minnesota is not an easy state in which to recruit physicians. Doctors are paid more in other states. So it's important that we grow our own."

—George Halvorson
HealthPartners CEO

Attitudes of the past

The university didn't pay a lot of attention to the evolution of the marketplace toward managed care in the 1980s and early 1990s because it didn't have to, according to Robert Dickler, who was general director of the university hospital and clinic from 1987 to 1992. In those days, the university had all the patients it needed.

"The university had a long-standing role of being a referral institution," Dickler said.

In those days, the main customers of hospitals — especially the ones that did a lot of high-tech care — were the doctors who referred patients. Thinking its referrals were firmly in place, the university remained above the fray.

Meanwhile, the insurance companies and health maintenance organizations evolved — without the university. Discounted prices, mergers and consolidations meant that referrals to care for the sickest patients went to the hospitals that could do a good job of caring for those people and also were willing to negotiate discounted prices. The university refused to negotiate, according to Ehlen, and the number of patients treated there began to drop, from 18,500 five years ago to 17,600 last year.

It has taken a while for the doctors at the university to understand that the world of health care, driven by the marketplace, has changed, according to Don Wegmiller, a national health care consultant based in Minneapolis.

"They're very bright people, but they just don't get it," Wegmiller said. "They'd say, 'What do you mean patients won't come to me? I just gave a paper in Budapest.' "

Five years ago, Ehlen said, university officials would tell him that although they were unwilling to discount their prices, he needed to understand how valuable it would be to have the university in the HMO that Ehlen then headed.

In 1992, however, the university's attitudes began to change, Ehlen said.

"They came and said, 'Can you help us learn what managed care is?'" Ehlen said. "The U has covered some important ground in the last two or three years."

In July 1992, Medica signed a full-provider contract with the university. It included discounts for Medica patients.

Among the changes have been a $40 million reduction in the university's budget, a change in leadership and the formation of a unified system that can negotiate with the insurance companies. The university also has improved its relationship with referring physicians. It has even put a piano in the lobby, where three afternoons a week a pianist serenades passers-by as though they were in Dayton's.

Shifting gears

Given that the Twin Cities is considered the birthplace of managed care, it is ironic that the hospital where the majority of the state's doctors are trained is considered one of the most severely threatened by managed care. But it clearly will need to accommodate.

One possibility discussed at length by Minnesota's health care thinkers is moving more of the university's programs to community hospitals. The Birthplace, which opened at Fairview Riverside Medical Center in Minneapolis in mid-October, is a good example.

Because the number of births declined at the university — 400 in 1993 compared with 4,000 the same year at Fairview — and because Fairview lacked a neonatal intensive care unit, the two collaborated. The resulting program means the university's obstetrical residents will be trained at Fairview. University and private practice doctors will provide services for mothers and babies, from normal to high-risk pregnancies and deliveries.

The threatened loss of the university's certification for an obstetrical residency program was a big motivation for the Birthplace. For the university, it's an opportunity to save the OB program. For HealthPartners, the HMO whose doctors deliver at Fairview Riverside, it's a way to attract obstetricians.

"Minnesota is not an easy state in which to recruit physicians," said George Halvorson, HealthPartners' CEO. "Doctors are paid more in other states. So it's important that we grow our own. It would be a real disaster to Minnesota to lose that OB residency program."

While the program has benefited the Twin Cities by lowering the number of combined obstetrical beds from 201 to 146, it's not a concept that Hart would like to see replicated with all the university's programs.

"Taken to the extreme, you could have the university's whole cardiac program at Abbott Northwestern, OB at Fairview and so on," Hart said. "At some point you get to such a distributed state that you lose quality control."

Hart points out that before 1911, most medical education was done in community hospitals. That year, the University of Minnesota started to pull medical education into one school. A national report pointed to Minnesota as a model to improve the quality of medical education.

So, if the university isn't about to become a dandelion gone to seed, how can it fit into the brave new world?

Allina's Ehlen has some ideas.

The merger of Medica and HealthSpan into Allina has given that organization all the components necessary to do broad-based health care research accurately and at low cost, Ehlen said. The key is claims data on its 800,000 members and a system through which it can work with doctors on protocols being offered.

"I'm certain a lot of the research done in the future will be done in an organization like Allina," Ehlen said. "I hope the U will step up to the plate. We and the U should complement each other."

It's an idea that Hart welcomes.

"We would love to work with Allina that way," he said.

But beyond working together on research, Ehlen recognizes that the state must come up with a mechanism to keep the university teaching, researching and taking care of patients.

"Allina can do just fine without the U in the short term," Ehlen said. "Allina cannot do without the U in the long term."

Ehlen says it is conceivable the health plans will have to convince their customers of the need to pass along the university's costs for teaching and research so the university can maintain what it has.

"The alternative is to let the U deteriorate and disappear," he said. "Then we would have to rebuild what the U does now. Creating new structures doesn't appeal to me. I don't want to see the U hospital go away."

HealthPartners' Halvorson argues the answer is some kind of revenue-raising tax or surcharge. He predicts some such mechanism will happen, perhaps in four or five years, once the state is convinced it is necessary.

"It will be a 'just in time' surcharge," Halvorson said.

That's a change in attitude among the Twin Cities' health care heavy hitters from 18 months ago.

Then, Win Wallin, chairman of the board of Fridley-based Medtronic, was on loan to help the university medical school regain its friends. Wallin spent a fair amount of time shuttling like Henry Kissinger between meeting rooms at the Minneapolis Club as most of the key players in Twin Cities health care talked with most of the other key players. None of them, however, was talking seriously with the university.

The efforts apparently paid off. In January, Eagan-based Blue Cross Blue Shield of Minnesota announced it had agreed to form an integrated service network with the university. The network would be an important and large potential feeder into the university. In addition, Allina and HealthPartners have contracts with the university.

Toward a partnership

When push comes to shove, none of the major players wants to see the university hospital go away. But maintaining a 6 percent market share, as Hart argues the university must, does not pay research or teaching costs.

"There's going to have to be some kind of a private-public partnership to even the playing field for the university," said consultant Wegmiller. "They do have high costs, and it's not their fault. They provide a very valuable service. It ought to be treated like a public utility."

The now-defunct Clinton health care bill included a provision that 1.75 percent of premiums would go to universities to pay for research and training. A paper published this fall by the committee on research from Medical Alley, a Minnesota trade association, recommends that the state establish a research fund to replace resources that are available through patient-care funding.

Another option, according to Dickler, who is now vice president for clinical services at the Association of American Medical Colleges in Washington, D.C., would be to move more medical education and research into community hospitals.

"That would be neither good nor bad," Dickler said. "But to pursue that course will fundamentally change the nature of the University of Minnesota medical school. Community-based medical schools do not train academic leaders."

According to Ehlen, the university has to learn tough contracting, learn to cooperate with other tertiary-care providers, get into more population-based research and compete on a care delivery basis.

"If it does that, the U will get to be a very important player," he said.

What does the university hospital need most?

"A higher appreciation for our value," Hart said. "A better understanding of teaching and research."

Whatever happens, officials from other medical schools will be watching closely.

"The University of Minnesota is being looked to to carve out solutions in the context of health care reform today," Ehlen said.

UNIVERSITY OF MINNESOTA

Academic Health Center
Office of the Provost

Box 501
420 Delaware Street S.E.
Minneapolis, MN 55455-0374
612-624-5444
Offices located at:
4-185 Health Sciences Unit F
308 Harvard Street S.E.

November 15, 1994

DRAFT

MEMORANDUM

TO: Board of Governors Finance and Planning Committee

FROM: William Brody *William R. Brody*

RECOMMENDATION

The Academic Health Center requests approval by the Board of Governors of the Health System to fund $2.7 million of deficits in the Medical School with reserves accumulated within the hospital. These funds are for the use of the Provost of the Academic Health Center to fund carry forward deficits within the Departments of Pediatrics and Medicine as these departments implement cost reduction plans.

BACKGROUND

The Medical School has experienced a reduction in cash balances over the prior three years. Total reserves have dropped from $54.6 million to $37.0 million at the end of the 1994 fiscal year. Without the restructuring to be implemented during fiscal 1994/95 it is anticipated that the balance in **UNRESTRICTED FUNDS** would drop to $7.9 million (less than 5% of the operating budget). While these funds are unrestricted in use they are the funds used to handle unanticipated operating problems and fulfill agreements reached during hiring. Currently the Medical School has six open chairs requiring start up funding.

Since fiscal 1992 revenues have increased at only 2.2% while expenses grew at 11.8% depleting reserves rapidly. The slowed increases in private practice revenues, and unchanged state appropriations were significantly offset by mandated salary increases, and increased employment (schedule I and schedule IA). The performance to date is being monitored closely to assure achievement of the projection and discontinuance of this trend.

The school has identified three specific approaches that will reduce the current years deficit (schedule II). This schedule indicates a need for $3.0 million in funding from the UMHC. The specific request is reduced to an identified $2.7 million at this time to allow for implementation of cost reduction programs.

Beginning with the end of the first quarter of fiscal year '95 reports are being reviewed by the Provosts office with the Medical School which identify current financial performance (schedule III). The Medical School is reviewing all departments performance (schedule IIIA). Special attention is given to those departments that have identified cost reduction programs (pediatrics and medicine).

The Medical School is also now reviewing and identifying funds available from within the U of M Consolidated Endowment Fund that can be used either on an ongoing basis or as a one time solution to the current deficits (schedule IV).

A major portion of the deficit condition is created by the practice plans inability to fund prior commitments to the Medical School in the face of broadly decreasing/deflated revenues. As of the end of September ten of the Private Practice Funds are in a deficit position (schedule V). The first quarter reports from the plans are due in to the school as of November 4. These reports will be reviewed not only to assure compliance with Regents Policy but also to determine ability to pay outstanding balances.

The decision process concerning any program/department will bring together the information available from the Medical School, the Private Practice and the Hospital (example of hospital profitability report schedule VI). This process will result in a more comprehensive business based decision process.

The Medical School has additionally identified other action steps (in the areas of personnel, equipment purchases and expense control) to reduce cost on a broad basis and is in the process of reviewing these with all departments. Specific plans for significant departmental expense reductions in medicine and pediatrics have been submitted. These plans will be reviewed and monitored as implemented by the management of the department, practice plan, hospital and medical school for effectiveness as well as consistency with the overall objectives of the Academic Health Center.

The Academic Health Center has begun a specific three year financial planning exercise to determine total funding needs.

CONCLUSION

This commitment of the Academic Health Center to change the total operations and the methods of funding is the basis for the request to fund the June 30, 1994 deficit in Pediatrics of $1.5 million and the June 30, 1994 deficit in Medicine of $1.2 million (schedule V). The funding will be by authorizing the Provost to transfer funds from the Hospital to the Medical as cost reduction programs are implemented in these departments.

Your approval of this plan is requested.

CC: JoAnne G. Jackson
Shelly Chou
Greg Hart

Enclosures

JGJ/klc:BOGFin&Plngcom111594

Notes to Medical School Non-Sponsored Funds Summary

1) Increases in "Restricted-Not Spendable" cash balance at beginning of fiscal 1995 is due to scheduled additions to Cancer Center fund and Lions Research Building debt retirement fund.

2) Increase in "Restricted-Spendable" cash balance at beginning of fiscal 1995 is due to accumulated earnings in endowed chair and research endowment target accounts.

3) Fiscal year 1995 O & M appropriation includes the transfer of $1.6 million from the Hospital's O & M budget for Psychiatry and PM & R programs. Previously, the Hospital received the appropriations, then transferred the money to the Medical School. The entire annual O & M appropriation is received in the first quarter. Only one-fourth of this amount is reflected in the "Actual 6/30-9/30 1994" column.

4) Private Practice revenue - In fiscal years 1992 and 1993, deposits from the practice plans were recorded using a variety of revenue codes (e.g. gifts, external sales and practice plans). Thus, some of these deposits are buried in "other" revenue in those years. In fiscal 1994, deposits from practice plans were coded uniformly. The revenue projected for fiscal 1995 is based on budgets submitted by the plans.

5) "Other" Revenue includes state special appropriations, indirect cost recovery allocations, contracts with UMHC and other affiliated hospitals, clinical sales, gifts, endowment and other investment income, and sales to other university units.

   Actual "other" revenue for the first quarter of fiscal 1995 is disproportionally low due to "delinquent" payments on contracts from UMHC, billing lags on house staff contracts with affiliated hospitals, and a lag in endowment earnings distributions from the University's consolidated endowment fund.

6) Salaries and fringe benefits expense - salaries increased 8.8% in fiscal 1993 due to a University-mandated wage increase of approximately 5.5% and an increase in personnel employed. Fringe benefits in fiscal 1993 increased due to the increase in salaries and an increase in the University fringe rates. In fiscal 1994, the University adjusted the fringe rates down, which caused fringe benefits expense to decline. There was also a salary freeze in fiscal 1994 which contributed to the slight decrease in salary expense.

Notes (Cont.)

A 6.0% increase in salaries is expected for fiscal 1995, again due to a mandated University-wide salary adjustment which approximates 6 percent. Fringe benefits expense will increase by more than the 6% salary increase due to adjustments to the University fringe rates for civil service employees and graduate assistants. The fiscal 1995 salary projection is based on actual first quarter expenses, annualized. this results in a 7.8 % increase in salaries.

7) Transfers In <Out> - this represents the net transfer activity with University units outside the Medical School. " Net Transfers Out" are primarily the result of transfers to facilities management for building and renovation projects. This type of activity is projected to decline in fiscal 1995. The "Net Transfer In" in 1995, represents the Minnesota Care appropriation (2.2 million), support for Research Animal Resources (1.2 million) and Graduate School grants-in-aid (0.3 million).

8) Annual Deficit - The deficit reported for the quarter ended September 30, 1994 is disproportionally high compared to the projected deficit for the fiscal year ended June 30, 1995. "Other revenue" recorded in the quarter is approximately $6.5 million less than what has been earned. At September 30, 1994 the Medical School had earned but not yet received approximately $3.5 million from contracts with UMHC, $1.5 million from contracts with other affiliated hospitals and $1.5 million from endowments and other investments. The projection for fiscal year 1995 appears reasonable in light of this lag in revenues.

9) Transfers from Non-Operating Accounts - this represents transfers of quasi-restricted endowments into operating accounts to cover current expenses.

DRAFT

U of M Medical School
Non-Sponsored Funds Summary
(In Millions)

Operating Results	Actual 1991-92	Actual 1992-93	% change	Actual 1993-94	% Change	Actual 6/30-9/30 1994	Projected 1994-95	% Change
Revenue								
O & M Appropriation	$ 41.0	$ 41.3	0.7	$ 39.6	<4.1>	$ 10.4	$ 41.9 (3)	5.8
Private Practice	30.1	30.8	2.3	36.1 (4)	17.2	10.3	36.6	1.4
Other	74.8	78.7	5.2	70.1	<11.0>	10.2	70.7 (5)	0.9
	145.9	150.8	3.4	145.8	<3.3>	30.9	149.2	2.3
Expenditures								
Salaries	95.1	103.5	8.8	102.4	<1.1>	27.6	110.4 (6)	7.8
Fringe Benefits	17.7	21.8	23.2	18.8	<13.8>	5.3	20.7	10.1
Other	34.1	34.7	1.8	33.4	<3.7>	8.3	33.2	<0.6>
	146.9	160.0	8.9	154.6	<3.4>	41.2	164.3	6.3
Net Transfers In <Out>	<6.2>	4.5		<3.7>		0.7	3.7 (7)	
Annual Deficit	$ (7.2)	$ (4.7)		$ (12.5)		$ (9.6) (8)	$ (11.4)	

Statement of Changes in Cash	Actual 1991-92	Actual 1992-93	Actual 1993-94	Actual 6/30-9/30 1994	Projected 1994-95
Beginning Cash Balance	$ 54.6	$ 47.4	$	$	$
Unrestricted	n/a	n/a	25.2	16.3	16.3
Restricted-Spendable	n/a	n/a	8.9	10.1	10.1 (2)
Restricted-Not Spendable	n/a	n/a	8.6	10.6	10.6 (1)
			42.7	37.0	37.0
Annual Deficit	(7.2)	(4.7)	(12.5)	(9.6)	(11.4)
Transfers from Non-Operating Accounts	n/a	n/a	6.8	-	0.5 (9)
Interim Deficit Reduction Plan	n/a	n/a	n/a	-	5.0
Ending Cash Balance	$ 47.4	$ 42.7	$ 37.0	$ 27.4	$ 31.1

n/a = not available/not applicable

(#) notes on pages 2-3

DRAFT

Medical School
Payrolled Full-Time Equivalents

Classification	9/30/94	FY94	FY93	FY92
Faculty	602	592	573	548
Other Academic	292	286	266	239
Professional Students/Fellows	1333	1352	1362	1286
Civil Service	1278	1336	1332	1385
Total	3505	3566	3533	3458
Annual % Change-Faculty	1.7%	3.3%	4.6%	
Annual % Change-Non-Faculty	-2.4%	1.5%	1.7%	
Cummulative % Change-Faculty	9.8%	8.0%	4.6%	
Cummulative % Change-Non Faculty	-0.2%	2.2%	1.7%	

Interim Medical School Deficit Reduction Plan

(Millions)

	Fiscal Year 1994-95
New Funding from Dean	$0.5
Departmental Expense Reduction*	2.0
Interim UMHC Funding	3.0
Total Interim Deficit Reduction	$ 5.5

* An acceptable alternative to expense reduction is to provide clear evidence that increase in revenue will be achieved.

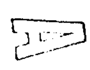
University of Minnesota Academic Health Center
Fund Balances on all Non-Sponsored accounts
Comparison between FY94 and FY95
(in thousands)
as of 9-30-95

Fund Class	Carry Forward from FY93	Carry Forward from FY94	% Inc (Dec)	FY94 Revenue & Transfers	FY95 Revenue & Transfers	% Inc (Dec)	FY94 Expense	FY95 Expense	% Inc (Dec)	FY94 Cash Balance	FY95 Cash Balance	% Inc (Dec)	Comments
Auxiliaries	51	224	336%	5	970	20333%	8	690	8202%	48	504	952%	b
Central Reserves	74	242	228%	764	273	-64%	146	424	191%	691	90	-87%	
Federal Appropriations	(9)	0	-100%	25	23	-7%	84	68	-19%	(68)	(45)	-34%	
Gen Oper. and Maint.	7,616	8,663	14%	91,437	92,912	2%	20,841	23,675	14%	78,212	77,899	0%	
Indirect Cost Recovery	6,007	4,194	-30%	6,534	6,857	5%	1,992	1,847	-7%	10,549	9,204	-13%	
Internal Service Org.	708	112	-84%	1,563	863	-45%	1,953	1,489	-24%	318	(514)	-262%	b
Non-Spon.-Bus.&Ind.	445	357	-20%	54	133	144%	138	106	-23%	362	385	6%	
Non-Spon.-Foundations	2,706	3,921	45%	2,269	2,358	4%	3,185	2,796	-12%	1,791	3,484	95%	
Non-Spon.-Federal	1	(34)	-4197%	0	49	100%	0	66	100%	1	(52)	-6247%	c
Non-Spon.-Other Govt	40	26	-35%	0	0	0%	1	0	-100%	40	27	-33%	
Non-Spon.-State of Mn	(50)	(39)	-22%	52	34	-33%	19	113	495%	(18)	(118)	565%	d
Non-Spon.-Other	39,433	35,069	-11%	10,399	15,367	48%	18,441	20,280	10%	31,391	30,156	-4%	
State Special Restricted	474	186	-61%	16,575	19,769	19%	1,676	1,892	13%	15,373	18,063	17%	
Unrestrict.-Not rep. elsewhere	30,394	31,716	4%	84,084	83,612	-1%	71,564	76,021	6%	42,913	39,307	-8%	
AHC Totals	87,890	84,637	-4%	213,760	223,220	4%	120,048	129,468	8%	181,603	178,389	-2%	a

Fund Balances by Units on all Non-Sponsored accounts

Unit	Carry Forward from FY93	Carry Forward from FY94	% Inc (Dec)	FY94 Revenue & Transfers	FY95 Revenue & Transfers	% Inc (Dec)	FY94 Expense	FY95 Expense	% Inc (Dec)	FY94 Cash Balance	FY95 Cash Balance	% Inc (Dec)	
UMD-Medicine, Duluth School	1,475	1,695	15%	4,673	5,644	21%	1,257	1,634	30%	4,891	5,704	17%	
Dentistry, School of	5,037	5,364	6%	12,663	13,195	4%	4,461	4,620	4%	13,240	13,940	5%	
Hosp & Clinic, The Univ of	25,253	26,714	6%	96,296	93,310	-3%	64,256	68,388	6%	57,293	51,636	-10%	e
Health Sciences	1,547	1,742	13%	7,611	6,167	-19%	1,434	1,517	6%	7,724	6,392	-17%	f
Medical School	42,446	37,232	-12%	60,129	70,527	17%	37,743	41,586	10%	64,833	66,173	2%	c,d
Nursing, School of	1,059	1,128	6%	3,873	4,060	5%	659	787	19%	4,273	4,400	3%	
Pharmacy, College of	2,136	2,927	37%	5,553	6,061	9%	1,636	2,135	30%	6,053	6,853	13%	
Public Health, School of	4,158	3,306	-20%	8,489	9,062	7%	3,288	3,511	7%	9,359	8,858	-5%	
Vet Medicine, College of	4,778	4,529	-5%	14,472	15,194	5%	5,314	5,290	0%	13,935	14,433	4%	b
AHC Totals	87,890	84,637	-4%	213,760	223,220	4%	120,048	129,468	8%	181,603	178,389	-2%	a

Source: XWJ012 report - any differences in the cash balances are due to rounding. Data as of 9/30/94.



Schedule III

DRAFT

UNIVERSITY OF MINNESOTA

Schedule IIIA

Twin Cities Campus

Office of the Dean
Medical School

Box 293
420 Delaware Street S.E.
Minneapolis, MN 55455
Office at 3-120 Owre Hall
612-626-4949
Fax: 612-626-4911

October 24, 1994

TO: Medical School Department Heads and
Divisions and Special Administrative Unit Directors

FROM: Shelley N. Chou, M.D., Ph.D., Interim Dean of the Medical School Shelley N. Chou

Over the past year we have devoted a considerable amount of time and energy working directly with you, your department administrators, University Central Administration, the UMHC Board of Governors, and the Provost's Office concerning financial problems that exist within the Medical School. To date, we have not cured those problems. In fact, the problem of current expenditures exceeding current revenue is continuing at a rapid pace. Experience of the July - September quarter of 1994-95 shows $8.9 million more expense than revenue during that time period. It is quite apparent that such a result is unacceptable. Consequently, I will be scheduling meetings with each of you to assess critical financial issues.

As you know, the problems we face are not evenly distributed. Also, in some instances they may be more apparent than real, e.g., an apparent deficit may be the result of delinquent, but collectible revenue. Nevertheless, we must examine these matters in a very critical way to determine the true magnitude of the problem and to find internal medical school solutions for the long term.

We will be sending to you available information on the status of your non-sponsored accounts. Please examine the data carefully and bring to the meeting attainable plans for correction of any existing deficits as well as plans for the future to prevent deficits from occurring. Be realistic. If you can not generate enough revenue to fund your spending plans, we will have no recourse but to cut expenditures.

SNC/tjp

cc: E. Wayne Drehmel, Ph.D.
Pete Mitsch
Department Administrators
JoAnne Jackson
Provost William R. Brody, M.D., Ph.D.

ENDOWMENT SUMMARY REPORT - UNIVERSITY INVESTMENTS

University of Minnesota Consolidated Endowment Fund

Schedule IV

	Market Value 6/30/94				
	Unrestricted Fund	Unrestricted Research Fund	Restricted Purposes		
	Quasi-Rest	Quasi-Rest	Quasi	True/Term	TOTAL
Dean's Office	$ 10,520,240	$ 2,673,595	$ 22,268,230	$ 34,037,251	$ 69,499,316
Biochemistry	-	-	-	-	-
Cell Biology	-	-	-	-	-
Microbiology	-	-	-	-	-
Pharmacology	-	-	1,443	10,624	12,067
Physiology	-	590,390	-	-	590,390
Institute of Human Genetics		-	-	-	-
Anesthesiology	-	-	-	-	-
Dermatology	-	-	-	-	-
Family Practice	-	-	-	-	-
Lab Medicine	-	-	488,449	419,513	907,962
Medicine	-	1,112,067	1,088,674	1,555,675	3,756,416
Neurology	-	125,937	26,031	89,865	241,833
Neurosurgery	-	-	-	-	-
OB/GYN	59,691	-	4,503	10,477	74,671
Opthalmology	1,913,452	570,007	157,760	3,851,492	6,492,711
Orthopaedic Surgery	316,687	-	312,423	163,701	792,811
Otolaryngology	-	-	-	812,297	812,297
Pediatrics	-	1,520,723	23,966	1,184,279	2,728,968
Physical Medicine & Rehabilitation	-	-	5,972	14,321	20,293
Psychiatry	-	-	-	3,237,901	3,237,901
Radiology	-	-	3,675	2,133,906	2,137,581
Surgery	10,760,440	6,748,979	1,459,783	1,560,687	20,529,889
Therapeutic Radiology	273,395	-	-	-	273,395
Urologic Surgery	-	-	-	-	-
Biomedical Engineering Center	-	-	524,893	2,165,008	2,689,901
Bone Marrow Transplant Program	-	-	-	-	-
Cancer Center	-	-	64,661	-	64,661
TOTAL	23,843,905	13,341,698	26,430,463	51,246,997	114,863,063
Annual Earnings	1,348,334	770,839	1,345,027	2,762,167	6,226,367

DRAFT

Schedule V

PRIVATE PRACTICE FUND SUMMARY

	Fund 1570 Balances		PMC Balances		PMC Adjusted Totals	
	6/30/94	9/30/94	6/30/94	9/30/94	6/30/94	9/30/94
Dean's Office	$ 1,624,278	$ 1,474,736	$ 128,997	$ 129,857	$ 1,495,281	$ 1,344,879
Physiology	2,942	1,892				
Anesthesiology	(16,772)	(150,108)				
Dermatology	91,679	(725)				
Family Practice	116,481	2,643,540				
Lab Medicine	68,628	(414,704)				
Medicine	(688,491)	(571,559)	523,275	581,763	* (1,211,766)	(1,153,322)
Neurology	(82,311)	(377,257)				
Neurosurgery	172,282	154,336				
OB/GYN	(543,577)	(581,857)				
Opthalmology	103,476	(39,737)				
Orthosurgery	305,903	435,062				
Otolaryngology	420,723	428,000				
Pediatrics	(998,892)	(1,600,700)	445,087	503,054	* (1,443,979)	(2,103,754)
Physical Medicine & Rehab	87,848	58,121				
Psychiatry	80,727	13,397				
Radiology	(4,456)	(1,268,063)				
Surgery	2,853,252	1,320,727	438,913	493,913	2,414,339	826,814
Therapeutic Radiology	4,653	(7,356)				
Urologic Surgery	(204,771)	(175,555)				
Cancer Center	53,710	114,032				
Area Class Total	3,437,314	1,458,222	1,536,272	1,708,587		
Deduct PMC Balances	(1,536,272)	(1,708,587)				
PMC Adjusted Total	$ 1,901,042	$ (252,365)				

* Balance to be funded

DRAFT

University of Minnesota Hospital and Clinic
Inpatient Medicine Service
Fiscal Year End June 30, 1994

DRAFT

Gross Charges	$70,559,000
Contractual Allowances	13,210,000
Total Revenue from Operations	57,349,000
Direct Expenses	$28,731,000
Indirect Expenses	24,146,000
Total Expenses	52,877,000
Revenue over Expense	$4,472,000

DRAFT

University of Minnesota Hospital and Clinic
Inpatient Pediatric Service
Fiscal Year End June 30, 1994

Gross Charges	$55,221,000
Contractual Allowances	12,417,000
Total Revenue from Operations	42,804,000
Direct Expenses	$22,825,000
Indirect Expenses	19,037,000
Total Expenses	41,862,000
Revenue over Expense	$942,000

UNIVERSITY OF MINNESOTA CLINICAL ASSOCIATES
COMMON BILLING IMPLEMENTATION
UPDATE

- Engaged Coopers & Lybrand - Objectives

  - Review UMCA major assumptions and resulting costs/cash flow deficit projections (estimates of required staff/equipment was previously developed and confirmed by consultant used for the common billing operations development)

  - Explore financing options for capital/operating deficit requirements

  - Refine timing of cash needs

- Current Status

  - Based on a review of the major assumptions provided by UMCA (for example 59MM in cash collections), the method used for calculating the cost/operating deficits is appropriate and the resulting numbers are reasonable.

  - C&L building model to describe sources of deficit

  - C&L recommends UMCA pursue lease options for capital

  - C&L recommends UMCA pursue loan/line of credit with UMHS for operating requirements

  - UMCA legal opinion that at this point UMCA pursue loan versus creation of UMHS owned billing entity

- Future Action

  - Develop specific lease options for UMCA Board review/action

  - Refine timing of operational cash needs

  - Explore loan options with UMHS - seek approval in December

coopers.lyb

AGENDA

BOARD OF GOVERNORS
EXECUTIVE COMMITTEE

November 16, 1994
2:30 P.M.
555 Diehl Hall

1. UMCA Common Billing Unit Financing
   (Information)

2. Medical School Financial Support
   (Information)

3. University Bond Rating/UMHS Strategic Plan
   (Information)

4. Hibbing/Iron Range Update
   (Information)

5. Strategic Plan/Board of Regents Strategy
   (Discussion)

6. UMHC 1994-95 Capital Budget
   (Information)

7. CUHCC Community Board
   (Information)

8. Board of Governors Nominations
   (Information

9. Credentials Committee Recommendations
   (Approval)

10. CCSI - Letter of Intent
    (Approval

11. Other

UNIVERSITY OF MINNESOTA

Office of the President
University of Minnesota Health System

Mailing Address:
Box 604
420 Delaware Street S.E.
Minneapolis, MN 55455-0381

Office at:
B390 Mayo Memorial Building
420 Delaware Street S.E.

612-626-5003
Fax: 612-624-7183

TO: Members, Board of Governors, Executive Committee

FROM: Gregory W. Hart

RE: Hibbing/Iron Range Update

DATE: November 9, 1994

We continue to make progress in solidifying our relationships in Hibbing and the Iron Range.

Negotiations around acquisition of the Mesaba Clinic continue to go well. Mr. Fearing will provide a detailed update on those negotiations at our meeting. We are still at our originally negotiated price ($7.89M over eight years); meetings over the past several weeks have centered around a long range plan for the clinic (including financial expectations), structure, and physician compensation. We hope to have a final recommendation for the Board in January.

Negotiations with the hospital in Hibbing, Mesabi Regional Medical Center, also are proceeding well. We have worked through most of the governance issues (see attached October 17 work group minutes). Other due diligence and planning activities are occurring in finance, information systems, risk management, benefit and pension review, marketing communications, legislative strategy, network development, and regional planning. Concurrence on a common long term plan with associated capital needs and financial outcomes is the most important piece of work remaining to be completed.

It is possible that we will be in a position of authorizing a letter of intent, with MRMC declaring a "record date" with vote 60 days thereafter, in December. If necessary as a result of timing, we may need to call a special meeting of the Executive Committee in December to authorize the signing of such a letter of intent.

In related developments, we continue planning through MRMC with the Duluth Clinic branch in Hibbing (Adams Clinic) about moving the clinic to the MRMC site. We are encouraged by those discussions. The Duluth Clinic leadership has, however, continued to express their concerns about our activity in northern Minnesota. Dr. Brody will want to report on a meeting he had in early November with the Duluth Clinic leaders.

We were invited to meet with the East Range Clinic in Virginia on November 8th.

This seemed to be a productive session; although the East Range Clinic is only in the early stages of evaluating its alignment options. Similarly, we are staying in touch with providers in Grand Rapids.

We will provide additional details and answer any questions at the meeting next week.

GWH/gs

MESABI/UMHS CORE WORK TEAM
October 17, 1994
11:00 - 1:00 p.m.

ATTENDANCE

Present: F. Gardeski, R. Dinter, J. Kritz, J. Bymark
Available by phone: G. Hart, K. Dunder, K. Halleland (flight cancelled due to poor weather conditions)
Absent: C. Fearing, T. Thompson

A. GOVERNANCE ISSUES AGREED TO
MESABI/UMHS BOARD OF DIRECTORS:

Membership
1) 12 Members
   4 UMHS appointed by UMHS Board ~~to include UMHS CEO~~
   6 Hibbing community representatives ~~to include MRMC CEO~~
   2 Presidents Mesaba and Duluth/Adams Clinic
2) MRMC Chief of Staff Ex-Officio

Succession
1) 3 year terms
2) 3 successive terms eligible
   Staggered 3, 2 and 1-year terms for the first board. The member with 1 year term would not count the 1 year as 1 term. Could still be eligible for 3, 3-year terms.
3) Establish a Regional Nominating Committee to nominate future board members. Eight members appointed by the board to make recommendation of more than 1 candidate to the board.

Committees
1) U of M member on each MRMC committee.

Reserved Powers
1) Final approval of MRMC's capital and operating budgets for any year.
2) Any modification or amendments of any capital or operating budget of MRMC in excess of 2% in the aggregate.
3) Final approval of strategic plans of MRMC (whether for MRMC or for any regional network), and of any material modifications to approved plans.
4) Incurrence of indebtedness (except short-term operating capital needs in excess of $50,000.
5) Any sale of all or substantially all of MRMC's assets, or any acquisition of, or merger consolidation with, or any change to a new location or expansion to additional locations (except to the extent any of the same are part of a strategic plan aproved by UMHS).
6) Any changes to MRMC's Articles of Incorporation or Bylaws.
7) A material transaction (such as a clinic acquisition) unless the same was part of a previously approved strategic plan.
8) Any action that might, in the reasonable judgment of UMHS, jeopardize the tax-exempt status of MRMC or UMHS.

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

General Director
Hospital Administration

Box 502
420 Delaware Street S.E.
Minneapolis, MN 55455
Office Location:
B313 Mayo Memorial Building
612-626-6933
Fax: 612-626-3028

November 11, 1994

TO: Members, Executive Committee

FROM: Peter F. Rapp, General Director

SUBJECT: FY 1995 Capital Budget Plan

I am submitting for information and approval an updated capital plan for FY 95. It contains for information, those major projects over $250,000, still in development, but likely to be presented to the Board within the next several months, as well as a request for approval of a $7,800,000 recurring capital budget. These are for items of a replacement nature that are less than $250,000.

The Executive staff has worked hard to focus our resources on the most critical items. I am pleased that our capital plan has been reduced to $21,050,000 from the $38,548,000 level presented in July. In addition, you will note a significant investment in Ambulatory Care is anticipated. As a major factor in our ability to attract and serve patients in this competitive market, our clinic operations must be efficient, personal and both patient and physician friendly. Work is underway now to offer specific space reprogramming and upgrade recommendations. We have estimated required expenditures in this area for your information.

This budget exceeds cash flows generated from operations and as such needs to be considered in the context of the current discussions of how to prioritize expenditures from Hospital reserves. We look forward to participating in those discussions as our major projects come forward for specific review during the year.

Finally, with your approval of the $7,800,000 recurring budget, it is my plan to release funds on a quarterly basis contingent upon achievement of Hospital financial objectives.

Thank you for your consideration.

PFR/sk

	FY 93 BUDGET	FY 94 BUDGET	PROPOSED 6/95 FY 95 BUDGET	PROPOSED 11/95 FY 95 BUDGET
MAJOR & SPECIAL PROJECTS	$23,820,500	$15,804,500	$22,783,000	$10,850,000
RECURRING EQUIPMENT	$6,425,000	$6,250,000	$7,600,000	$5,950,000
RECURRING REMODELING	$1,775,000	$1,750,000	$1,800,000	$1,850,000
RECURRING TOTAL	$8,200,000	$8,000,000	$9,400,000	$7,800,000
PHASE II RENOVATION	$8,568,355	$2,568,000	$6,365,000	$0 *
PSYCHIATRY RENOVATION	Incl. in Phase II Renovation	Incl. in Phase II Renovation	Incl. in Phase II Renovation	$1,500,000 **
FACULTY OFFICE COMMITMENT	Incl. in Phase II Renovation	Incl. in Phase II Renovation	Incl. in Phase II Renovation	$900,000
TOTAL	$40,588,855	$26,372,500	$38,548,000	$21,050,000

* Any remaining Phase II Renovation work has been incorporated in other budget categories

** Proposed Funding for inpatient Psychiatry renovation only. Funding contingent on current program review

	1995	1996	1997	1998	1999
APPROVED PROJECTS					
Heart Cath Room 1	$1,500,000	$0	$0	$0	$0
Inpatient Pediatric renovation	$1,250,000	$0	$0	$0	$0
SUBTOTAL	$2,750,000	$0	$0	$0	$0
FY 1995 MAJOR & SPECIAL PROJECTS					
Ambulatory Care Master Plan	$4,000,000				
oHeart Lung Clinic / Vascular Center					
oDerm/surg Clinic Reno					
oGeneral Clinic Desk Upgrade					
oClinic / Hospital Access		AMBULATORY CARE PROPOSAL TO BE SUBMITTED			
oPediatric Clinic		AT A LATER DATE			
oNeurosciences Renovation					
oUrgent Care Facility					
oColon/Rectal Clinic					
oUrology Clinic Relocation					
oPrimary Care Clinic					
oBMT Program Improvements					
oOncology Ambulatory Care					
PACU Renovation	$2,000,000	$0	$0	$0	$0
Building Infrastructure Upgrade	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Patient Meal Delivery System	$300,000	$0	$0	$0	$0
Service Improvements	$300,000	$300,000	$0	$0	$0
Misc. Computer Upgrade	$500,000	$4,100,000	$3,700,000	$4,500,000	$2,500,000
SUBTOTAL	$8,100,000	$5,400,000	$4,700,000	$5,500,000	$3,500,000
ANTICIPATED FUTURE PROJECTS					
Replace CT Simulator	$0	$1,300,000	$0	$0	$0
Replace Linear Accelerator	$0	$1,583,000	$1,600,000	$0	$0
Heart Cath Room 2	$0	$1,500,000	$0	$0	$0
Heart Cath Room 3	$0	$0	$0	$0	$2,000,000
CV Surgery Replace Room 7	$0	$1,500,000	$0	$0	$0
New Technology / Program Development	$0	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Off-site Office Building	$0	$2,000,000	$0	$0	$0
Relocate Inpt Rehab to Unit J	$0	$750,000	$0	$0	$0
SUBTOTAL	$0	$10,633,000	$3,600,000	$2,000,000	$4,000,000
GRAND TOTAL	$10,850,000	$16,033,000	$8,300,000	$7,500,000	$7,500,000

UNIVERSITY OF MINNESOTA

The Honorable Thomas R. Reagan, Vice Chair
Board of Regents

4743 Ponderosa Drive
Gilbert, MN 55741
218-865-4616

November 7, 1994

TO:

The Honorable Wendell R. Anderson
The Honorable Julie A. Bleyhl
The Honorable William E. Hogan II
The Honorable Jean B. Keffeler
The Honorable Hyon T. Kim
The Honorable H. Bryan Neel III
The Honorable Mary J. Page
The Honorable Lawrence Perlman
The Honorable William R. Peterson
The Honorable Darrin M. Rosha
The Honorable S. D. Sahlstrom
William Brody
Michael Dougherty
Al Hanser
Gregory Hart
Arthur Kydd
Roby Thompson

Dear Ladies and Gentlemen:

As chair of the Regents' Board of Governors Nominating Committee, I am writing to encourage you to offer nominations for two vacancies on the Health System Board of Governors (BOG). The committee will be bringing a slate of recommendations for review and action to the December 1994 Regents' meeting.

Please submit your nominations to the Regents' Office by close of business on Friday, November 18. The nomination should include a cover letter and a copy of the individual's resume or curriculum vitae.

The following information may be helpful to your consideration of potential BOG candidates:

- The Nominating Committee is recommending that three members of the BOG (whose present terms end in December) be reappointed for another three-year term. They are: Michael Dougherty, Arthur Kydd and Barbara Neubauer. The two members vacating are: Len Benias (due to health concerns) and Patricia McCullough (due to a personal conflict of interest).

- The current Board of Governors is composed of 21 members. With two vacancies, there are currently 15 men and 4 women. Two governors are persons of color. The breakdown of current congressional district (CD) representation is:

CD 1: 2	CD 3: 9	CD 5: 2	CD 7: 1
CD 2: 1	CD 4: 2	CD 6: 0	CD 8: 2

- According to a grid of "desired professional experience" to be represented on the BOG, all areas are satisfied except for a labor perspective (due to Len Benias resignation).

Thank you for your assistance in making governor recommendations. Again, please have them to the Regents' Office by November 18.

Sincerely,

Thomas R. Reagan

Thomas R. Reagan
Regent

cc: Steven Bosacker
Clifford Fearing
Carol Kraus
Vaman Pai

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic — *Office of the Chief of Staff*

Box 707
420 Delaware Street S.E.
Minneapolis, MN 55455-0392
612-626-1945

November 9, 1994

TO: Members of the Board of Governors

FROM: Marvin E. Goldberg, M.D., Chief of Staff
Chairman, Medical Staff-Hospital Council

SUBJECT: Credentials Committee/Medical Staff-Hospital Council Report and Recommendations.

The Medical Staff-Hospital Council on November 8, 1994 approved the attached Credentials Committee Report and Recommendations.

I am forwarding these recommendations to you for your review and approval. I will report the outcome of the Medical Staff-Hospital Council and the Quality Management Committee's actions at that time. If you should have any questions, please feel free to call on me.

MEG/dd
Attachment

mshc/cred.bog

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic — *Medical Staff Office*

Box 707
420 Delaware Street S.E.
Minneapolis, MN 55455-0392

612-626-1945
Fax: 612-624-7183

October 11, 1994

TO: Medical Staff-Hospital Council

FROM: Wesley Miller, M.D.
Chairman, Credentials Committee

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee after examining all pertinent information provided to them concerning the professional competence and other necessary qualifications, hereby recommends the approval of provisional status and clinical privileges to the following applicants to the Medical Staff of The University of Minnesota Hospital and Clinic.

Department of Family Practice	Category	Temporary Expires
Emily A. Lagace	Attending Staff	January 9, 1995

Department of Lab Med and Pathology	Category	Temporary Expires
Sarah J. Ilstrup	Attending Staff	November 8, 1994
Mark S. Wilke	Attending Staff	December 19, 1994

Department of Medicine	Category	Temporary Expires
Martin N. Burke	Attending Staff	November 1, 1994
Paul R. Coffeen	Attending Staff	November 1, 1994
Gladwin S. Das	Attending Staff	October 30, 1994
Mark S. Hamra	Clinical Staff	December 26, 1994
Susan Elizabeth Kline	Attending Staff	January 20, 1995
Mario Zarama	Attending Staff	November 27, 1994

Applications for Appointments cont.

Department of Neurology	Category	Temporary Expires
Souhel Najjar	Clinical Staff	December 8, 1994

Department of Orthopedic Surgery	Category	Temporary Expires
John M. Blair, Jr.	Attending Staff	December 4, 1994
John T. Braun	Attending Staff	December 16, 1994

Department of Physical Med and Rehab	Category	Temporary Expires
Bonnie L. Warhol	Attending Staff	December 26, 1994

Department of Psychiatry	Category	Temporary Expires
Faruk S. Abuzzahab	Clinical Staff	December 8, 1994
Galen W. Stahle	Clinical Staff	December 19, 1994

Department of Radiology	Category	Temporary Expires
David A. Lee	Attending Staff	November 1, 1994
Timothy V. Myers	Attending Staff	November 1, 1994

Department of Surgery	Category	Temporary Expires
Reinmar Hermann Belz	Clinical Staff	October 27, 1994
Craig S. Walvatne	Attending Staff	December 22, 1994

The following medical staff have submitted applications and supporting documentation requesting addition and/or deletion of clinical privileges. The Committee has reviewed and considered their requests and hereby recommends approval.

Department of Family Practice	Category
R. Craig Christianson	Attending Staff

Add: Neonatal Class A Privileges - UMHC and UMNICU at FRMC Campus: Newborn circumcision, venipuncture, removal of skin tags, bladder aspiration, incision and drainage of superficial abscesses and endotracheal tube placement.

Change in privileges continued:

Department of Family Practice	Category
James Van Vooren	Attending Staff

Add: Neonatal Class A Privileges - UMHC and UMNICU at FRMC Campus: Simple fracture and/or dislocation, laceration repair-simple, newborn circumcision,venipuncture, removal of skin tags, bladder aspiration, incision and drainage of superficial abscesses, umbilical artery catheterization, umbilical vein catheterization, percutaneous venous line placement, thoracentesis, and endotracheal tube placement.

Department of Medicine	Category
Michael J. Dugan	Attending Staff

Add: central line placement, arterial puncture, thoracentesis (aspiration only), abdominal paracentesis, managing patients in intensive care, lumbar puncture, manage blood transfusions, IV sedation for procedures, nasogastric intubation & lavage, foley catheterization of bladder, cancer chemotherapy by protocol, CNS chemotherapy, infusion pump filling, bone marrow transplantation, thoracentesis aspiration & chemotherapy.

Department of Neurology	Category
Lawrence Lockman	Attending Staff

Add: Neonatal Class A and Class B Privileges - UMHC and UMNICU at FRMC Campus: Lumbar puncture and subdural tap.

Department of Neurology	Category
Jean Horrobin	Clinical Staff

Add: Neonatal Class A Privileges - UMHC and UMNICU at FRMC Campus: Newborn circumcision, venipuncture, removal of skin tags and lumbar puncture.

Margaret Hostetter	Attending Staff

Add: Neonatal Class B Privileges - UMHC and UMNICU at FRMC Campus: Venipuncture, bladder aspiration, umbilical artery catheterization, umbilical vein catheterization and lumbar puncture.

Change in Clinical Privileges Continued:

Virginia Hustead | Clinical Staff

Add: Neonatal Class A, Class B and Class C Privileges - UMHC and UMNICU at FRMC Campus: Simple fracture and/or dislocation, peripheral arterial puncture, laceration repair-simple, newborn circumcision, venipuncture, removal of skin tags, exchange transfusion, bladder aspiration, blood transfusion, incision and drainage of superficial abscesses, umbilical artery catheterization, umbilical vein catheterization, lumbar puncture, percutaneous arterial line placement, percutaneous venous line placement, thoracentesis, chest tube placement, administration of vasoactive agents, amputation of extraneous digits, endotracheal tube placement, management of infants with mature tracheostomies on stable ventilator settings, pericardiocentesis, abdominal paracentesis and ECMO.

Department of Pediatrics | Category

Richard King | Attending Staff

Add: Neonatal Class A Privileges - UMHC and UMNICU at FRMC Campus.

Kimberly Krabill | Attending Staff

Add: Neonatal Class B Privileges - UMHC and UMNICU at FRMC Campus: Peripheral arterial puncture, peripheral venous cutdown, venipuncture, exchange transfusion, blood transfusion, umbilical artery catheterization, umbilical vein catheterization, lumbar puncture, percutaneous arterial line placement, percutaneous venous line placement, thoracentesis, administration of vasoactive agents, endotracheal tube placement, pericardiocentesis, fetal echocardiography, neonatal echocardiography, and ECG interpretation.

Nathaniel Payne | Clinical Staff

Add: Neonatal Class A, Class B and Class C Privileges - UMHC and UMNICU at FRMC Campus: Simple fracture and/or dislocation (not requiring casting, surgery of manipulation), peripheral arterial puncture, peripheral venous cutdown, laceration repair-simple, newborn circumcision, venipuncture, removal of skin tags, exchange transfusion, bladder aspiration, blood transfusion, incision and drainage of superficial abscesses, umbilical artery catheterization, umbilical vein catheterization, lumbar puncture, percutaneous arterial line placement, percutaneous venous line placement, thoracentesis, chest tube placement, administration of vasoactive agents, endotracheal tube placement, management of infants with mature tracheostomies on stable ventilator settings, ECMO management (no surgical placement of catheters), pericardiocentesis, and abdominal paracentesis.

Mary Ella Pierpont | Attending Staff

Add: Neonatal Class A and Class B Privileges - UMHC and UMNICU at FRMC Campus: Skin biopsy

Change in Clinical Privileges Continued:

Albert Rocchini Attending Staff
Add: Neonatal Class B Privileges - UMHC and UMNICU at FRMC Campus: Peripheral arterial puncture, peripheral venous cutdown, venipuncture, exchange transfusion blood transfusion, umbilical artery catheterization, umbilical vein catheterization, percutaneous arterial line placement, percutaneous venous line placement, thoracentesis, chest tube placement, administration of vasoactive agents, endotracheal tube placement, pericardiocentesis and peripheral arterial cutdown.

Leon Satran Attending Staff
Add: Neonatal Class A Privileges - UMHC and UMNICU at FRMC Campus: Veni-puncture, and percutaneous venous line placement.

Alan Sinaiko Attending Staff
Add: Neonatal Class B Privileges - UMHC and UMNICU at FRMC Campus: Percutaneous renal biopsy, peritoneal dialysis and abnormal paracentesis.

The following medical staff have submitted applications and supporting documentation requesting change in staff category. The Committee has reviewed and considered their requests and hereby recommends approval.

Department of Family Practice	Present Category	Requested Category
R. Craig Christianson	Clinical Staff	Attending Staff

The following medical staff are completing their provisional status and are eligible for regular appointments as members of the Medical Staff of The University of Minnesota Hospital and Clinic. The Committee has reviewed recommendations concerning their appointment and hereby recommends approval.

Department of Family Practice	Category	Date Eligible
David H. Wang	Clinical Staff	July 26, 1994

The Committee recommends acceptance of the resignations of Medical Staff appointments from the following physicians.

Department of Medicine	Category
Jamshid Niknam	Attending Staff
Department of Pediatrics	
Denise M. Goodman	Attending Staff
Thomas P. Green	Attending Staff

WM/vp
CRED\MSHC

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic *Office of the Hospital Counsel*

Box 708
Harvard Street at East River Parkway
Minneapolis, MN 55455

612-626-5429
Fax: 612-625-2626

November 10, 1994

MEMORANDUM

TO: Greg Hart

FROM: Keith Dunder

RE: Extension of Appointment for Dr. Halikas

As you know, Dr. Halikas' appointment on the medical staff was extended for 90 days from the end of August, and expires at the end of November. The hearing on the determination of the Credentials Committee has commenced, and should be finished on November 11, 1994, but there will necessarily be further proceedings, in the nature by review of the Medical Staff Hospital Council etc., and if he still disputes the findings, Dr. Halikas can make an appeal to the Board.

There is no reasonable basis to allow Dr. Halikas' appointment to expire at the end of November, and I would strongly recommend to the Board that his appointment be continued until the due process prescribed by the Bylaws is finished. This will likely require at least 60 days, given the difficulty of scheduling meetings and hearings, with the holidays coming etc.

I am aware that the Board is not meeting in November, and so this action will have to be taken by the Executive Committee. A motion should be made and approved at that time to extend Dr. Halikas' appointment for at least an additional 60 days. If you need me there, or need me to do anything further, please let me know.

KAD: ht
cc: Marvin Goldberg, M.D.

UNIVERSITY OF MINNESOTA

Office of the President
University of Minnesota Health System

Mailing Address:
Box 604
420 Delaware Street S.E.
Minneapolis, MN 55455-0381

Office at:
B390 Mayo Memorial Building
420 Delaware Street S.E.

612-626-5003
Fax: 612-624-7183

TO: Members, Board of Governors, Executive Committee

FROM: Gregory W. Hart

RE: Letter of Intent - Critical Care Services

DATE: September 14, 1994

In 1985, the University of Minnesota Hospital and Clinic entered into a partnership relationship with St. Paul Ramsay Medical Center and Abbott Northwestern Hospital to develop a not-for-profit (501C3) Critical Care Transportation service. This successful venture, Critical Care Services, Inc. (CCS), now provides critical care transportation service via fixed-wing aircraft, helicopter transport, and advanced life support ground transport. Other affiliated hospitals in this venture include St. Luke's Hospital in Duluth and Minneapolis Children's Hospital. The University of Minnesota Hospital and Clinic utilizes CCS almost exclusively. CCS has, for the last several years, operated with a small positive profit margin.

As a result of the reconfiguration of the Twin Cities health care system, particularly in the Allina Health System, the Board of Directors of Critical Care Services believes there are certain economies of scale and operational initiatives which may be gained through a merger of Critical Care Services and Health Span Transportation Services, a division of Allina Health Systems.

To this end, we are asking for your approval to enter into a Letter of Intent to allow the partners to enter into a due diligence process to determine if a merger would 1) enhance access to medical transportation services, 2) maintain and further reduce the cost of delivering medical transportation services, and 3) quantify and further improve the quality of prehospital care furnished through transportation services. This due diligence process would also include an independent evaluation of pertinent assets currently owned by Critical Care Services and Allina Health System. Pending the results of this review process, we may seek approval of a merger of CCS and the transportation division of Allina. Other factors being evaluated include IRS determination regarding our tax-exempt status, approvals required by law or regulation from the Minnesota Department of Health related to the merger or transfer of any license, and if required, receipt of clearance from the Federal Trade Commission and the Department of Justice relating to any Hart-Scott-Rodino notice, and any other required regulatory approvals.

GWH/gs

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

November 23, 1994

TO: Members, Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period
July 1, 1994 through October 31, 1994

The Hospital's operations for the month of October reflect inpatient census at less than budgeted levels, and outpatient encounters at greater than anticipated levels. The average length of stay was at budgeted levels, but because of the lower admissions, our patient days were 3.4% lower than expected.

INPATIENT CENSUS: For the month of October, inpatient admissions totaled 1,408 which were 12 less than the budgeted admissions of 1,420. Our overall average length of stay for the month was 7.5 days. Patient days for October totaled 10,330 and were 363 days below budget. Admissions were greater than budgeted levels this month in the areas of Gynecology, Medicine and Adult Psychology. These were offset by less than budgeted admissions in the areas of Pediatrics, Surgery, Family Practice and Neurosurgery.

OUTPATIENT CENSUS: Ambulatory care encounters (including CUHCC and Home Health) for the month of October totaled 34,707 which was 810, or 2.4%, above budgeted volumes of 33,897. Encounters were greater than budgeted levels in CUHCC, Emergency Room, Family Practice, Medicine and Surgery. Encounters were under budgeted levels in the areas of Dermatology, Dialysis and Psychiatry .

To recap our census:

Monthly Data						YTD Data				
93/94 Actual	94/95 Budget	94/95 Actual	Variance	% Var		93/94 Actual	94/95 Budget	94/95 Actual	Variance	% Var
1,446	1,420	1,408	(12)	(0.8)	Admissions	5,945	5,835	5,557	(278)(a)	(4.8)
10,608	10,693	10,330	(363)	(3.4)	Patient Days	43,338	42,656	41,073	(1,583)	(3.7)
6.9	7.5	7.5	(0.0)	(0.0)	Avg Length of Stay	7.2	7.3	7.3	0.0	0.0
342.2	344.9	333.2	(11.7)	(3.4)	Avg Daily Census	352.3	346.8	333.9	(12.9)	(3.7)
60.9	65.1	60.4	(4.7)	(7.2)	Percent Occupancy	62.7	63.3	60.7	(2.6)	(4.1)
32,569	33,897	34,707	810	2.4	Amb Care Encounters	133,657	131,260	135,537	4,277	3.3

(a)We should note that in the 1994-95 budget, we had planned to relocate our Obstetrics and Newborn services to Fairview Riverside around October 1st of this year. Instead, these services were relocated in early July. Because of this timing difference, of the 278 admissions that are below budget in October, 196 are attributed to Obstetrics and Newborn.

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows year to date revenues being greater than expenses by $5,392,000. This is a favorable variance of $597,000.

Patient care charges through October totaled $129,725,000, which was 2.7% less than budget. Ancillary revenue was $2,285,000 (2.4%) under budget and routine revenue was $1,256,000 (3.5%) below budget. Inpatient revenue averaged $17,336 per admission compared to the budgeted average of $17,105. Outpatient revenue averaged $246 per encounter compared to the budgeted average of $255.

Deductions from revenue totaled $35,024,000 which was $1,071,000 (3.0%) under budgeted deductions of $36,095,000. Deductions from revenue were less than anticipated through October primarily due to Minnesota Medicaid Program payments being greater than budgeted.

Operating expenditures through October totaled $101,636,000 and were $2,115,000 (2.0%) below budgeted levels of $103,751,000. The overall favorable variance is primarily due to less than anticipated spending in almost all expense categories. This is due in part to a lower than anticipated inpatient volumes. Insurance expense was greater than budget, due to the unanticipated reinstatement of insurance premiums to RUMINCO. In addition, in the month of October, we recognized a one-time expense of $260,000 for the disposal of assets associated with closing the University's internal laundry service. Effective October 1, 1994 the University changed to a lower cost outside vendor for laundry services.

ACCOUNTS RECEIVABLE: The balance in net patient accounts receivable as of October 31, 1994, totaled $50,319,000 and represents 68.1 days of net revenue outstanding.

CONCLUSION: Our operating position for the month of October and year-to-date is positive and above budgeted levels. We continue to monitor our activity levels closely and are making operating changes that are necessary and appropriate.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
SUMMARY STATEMENT OF OPERATIONS
FOR THE PERIOD JULY 1, 1994 TO OCTOBER 31, 1994

1993-94 October Actual	October Budgeted	October Actual	Variance Over/(Under) Budget	Variance %		1993-94 Actual	1994-95 Budgeted	1994-95 Actual	Variance Over/(Under) Budget	Variance %
$30,001,000	$33,370,000	$31,509,000	($1,861,000)	-5.6%	Gross Patient Revenue	$123,707,000	$133,267,000	$129,725,000	($3,542,000)	-2.7%
8,032,000	9,118,000	9,083,000	(35,000)	-0.4%	Deductions From Revenue	33,415,000	36,095,000	35,024,000	(1,071,000)	-3.0%
21,969,000	24,252,000	22,426,000	(1,826,000)	-7.5%	Net Patient Service Revenue	90,292,000	97,172,000	94,701,000	(2,471,000)	-2.5%
					Other Operating Revenue					
1,282,000	1,162,000	1,162,000	0	0.0%	Appropriation & Support	5,129,000	4,648,000	4,648,000	0	0.0%
1,121,000	1,246,000	1,368,000	122,000	9.8%	Other Revenue	4,594,000	5,163,000	5,568,000	405,000	7.8%
2,403,000	2,408,000	2,530,000	122,000	5.1%	Total Other Revenue	9,723,000	9,811,000	10,216,000	405,000	4.1%
24,372,000	26,660,000	24,956,000	(1,704,000)	-6.4%	Total Revenue From Operations	100,015,000	106,983,000	104,917,000	(2,066,000)	-1.9%
					Operating Expenses:					
9,762,000	10,361,000	10,317,000	(44,000)	-0.4%	Salaries	39,668,000	42,055,000	41,999,000	(56,000)	-0.1%
2,162,000	2,305,000	2,045,000	(260,000)	-11.3%	Fringe Benefits	8,789,000	9,341,000	8,542,000	(799,000)	-8.6%
1,710,000	1,676,000	1,713,000	37,000	2.2%	Contract Compensation	6,623,000	6,706,000	6,885,000	179,000	2.7%
5,002,000	6,185,000	5,076,000	(1,109,000)	-17.9%	Supplies And Services	21,563,000	24,569,000	22,876,000	(1,693,000)	-6.9%
1,032,000	1,026,000	894,000	(132,000)	-12.9%	Utilities And Maintenance	4,118,000	4,279,000	4,270,000	(9,000)	-0.2%
1,511,000	1,439,000	1,254,000	(185,000)	-12.9%	General Supplies & Expense	5,129,000	5,712,000	5,749,000	37,000	0.6%
14,000	14,000	139,000	125,000		Insurance	129,000	57,000	557,000	500,000	
1,547,000	1,636,000	1,797,000	161,000	9.8%	Depreciation & Amortization	6,194,000	6,402,000	6,374,000	(28,000)	-0.4%
617,000	590,000	607,000	17,000	2.9%	Interest	2,131,000	2,369,000	2,424,000	55,000	2.3%
326,000	318,000	280,000	(38,000)	-11.9%	Minnesota Care Tax	1,361,000	1,269,000	1,252,000	(17,000)	-1.3%
220,000	254,000	194,000	(60,000)	-23.6%	Provision For Uncollectibles	935,000	992,000	708,000	(284,000)	-28.6%
23,903,000	25,804,000	24,316,000	(1,488,000)	-5.8%	Total Operating Expenses	96,640,000	103,751,000	101,636,000	(2,115,000)	-2.0%
469,000	856,000	640,000	(216,000)		Net Revenue From Operations	3,375,000	3,232,000	3,281,000	49,000	
484,000	362,000	599,000	237,000	65.5%	Nonoperating Gains: Investment Income	1,969,000	1,563,000	2,111,000	548,000	35.1%
953,000	1,218,000	1,239,000	21,000		Revenue And Gains In Excess Of Expense Before Extraordinary Item	5,344,000	4,795,000	5,392,000	597,000	
0	0	0	0		Extraordinary Gain (Loss)	(442,000)	0	0	0	
953,000	1,218,000	1,239,000	21,000		Revenue And Gains In Excess Of Expense	4,902,000	4,795,000	5,392,000	597,000	

1993-94 October Actual	October Budgeted	October Actual	Variance Over/(Under) Budget	Variance %		1993-94 Actual	1994-95 Budgeted	1994-95 Actual	Variance Over/(Under) Budget	Variance %
1,446	1,420	1,408	(12)	-0.8%	Admissions	5,945	5,835	5,557	(278)	-4.8%
10,608	10,693	10,330	(363)	-3.4%	Patient Days	43,338	42,656	41,073	(1,583)	-3.7%
6.9	7.5	7.5	0.0	0.0%	Average Length Of Stay	7.2	7.3	7.3	0.0	0.0%
342.2	344.9	333.2	(11.7)	-3.4%	Average Daily Census	352.3	346.8	333.9	(12.9)	-3.7%
60.9	65.1	60.4	(4.7)	-7.2%	Percentage Occupancy	62.7	63.3	60.7	(2.6)	-4.1%
32,569	33,897	34,707	810	2.4%	Ambulatory Care Encounters	133,657	131,260	135,537	4,277	3.3%

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BALANCE SHEETS
OCTOBER 31, 1994 AND JUNE 30, 1994

ASSETS	10/31/94	6/30/94
General Funds		
Current assets:		
Cash and cash equivalents	$46,508,000	$46,458,000
Receivables:		
Patient services, net of allowances and uncollectible accounts of $30,228,000 at Oct '94 and $28,926,000 at June '94	50,319,000	48,723,000
State appropriations	1,824,000	1,769,000
Other	2,826,000	2,721,000
Inventories	5,494,000	5,547,000
Prepaid expenses and other	67,000	200,000
Total current assets	107,038,000	105,418,000
Assets whose use is limited:		
By board for property and equipment replacement and expansion	156,351,000	158,901,000
Under bond indenture agreement held by trustee	10,246,000	10,276,000
Total assets whose use is limited	166,597,000	169,177,000
Property and Equipment, net	154,062,000	150,278,000
Other Assets:		
Long-term portion - promissory note	5,088,000	4,806,000
Deferred third-party reimbursement	3,516,000	3,738,000
Deferred financing costs	816,000	850,000
Other	3,543,000	3,664,000
Total other assets	12,963,000	13,058,000
TOTAL ASSETS	$440,660,000	$437,931,000
Restricted Funds		
Investments	$9,370,000	$9,149,000

LIABILITIES AND FUND BALANCES	10/31/94	6/30/94
General Funds		
Current liabilities:		
Current maturities of long-term debt and capital lease obligations	$8,848,000	$8,520,000
Accounts payable	27,645,000	25,170,000
Due to third-party payors	6,691,000	6,873,000
Accrued liabilities:		
Salaries, wages and employee benefits	22,761,000	25,046,000
Interest	1,083,000	1,294,000
Deferred revenue	2,292,000	299,000
Total current liabilities	69,320,000	67,202,000
Long-term debt and capital lease obligations, less current maturities	143,306,000	148,207,000
Fund Balance	228,034,000	222,522,000
TOTAL LIABILITIES AND FUND BALANCE	$440,660,000	$437,931,000
Fund Balances:		
Endowment funds	$3,499,000	$3,438,000
Specific purpose funds	5,871,000	5,711,000
	$9,370,000	$9,149,000

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
STATEMENT OF CASH FLOWS OF GENERAL FUNDS
FOR THE PERIOD JULY 1, 1994 TO OCTOBER 31, 1994

OPERATING ACTIVITIES AND NONOPERATING REVENUES:	
Revenue and gains in excess of expenses and loss	$5,392,000
Adjustments to reconcile revenues and gains in excess of expenses and loss to net cash provided by operating activities and gains:	
Depreciation and amortization	6,597,000
Unreimbursed University general and administrative services	120,000
Provision for uncollectibles	708,000
(Increase) decrease in receivables	(2,455,000)
(Decrease) increase in accounts payable	2,476,000
(Decrease) increase in net amounts due to third-party payors	(182,000)
(Decrease) increase in accrued liabilities	(2,497,000)
(Decrease) increase in deferred revenue	1,993,000
(Increase) decrease in inventories	53,000
(Increase) decrease in prepaid expenses and other assets	80,000
Total adjustments	6,893,000
Net cash provided by operating activities and gain	$12,285,000
INVESTING ACTIVITIES:	
Acquisition of property, plant and equipment	($9,950,000)
Change in promissory notes	(293,000)
Increase in assets whose use is limited	2,580,000
Net cash used in investing activities	($7,663,000)
FINANCING ACTIVITIES:	
Repayment of notes payable	(4,572,000)
	($4,572,000)
Change in cash and equivalents	$50,000
Cash and cash equivalents at June 30, 1994	$46,458,000
Cash and equivalents at October 31, 1994	$46,508,000

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

General Director
Hospital Administration

Box 502
420 Delaware Street S.E.
Minneapolis, MN 55455

Office Location:
B313 Mayo Memorial Building

612-626-6933
Fax: 612-626-3028

October 23, 1995

TO: Members, Executive Committee
Board of Governors

FROM: Peter F. Rapp
General Director, UMHC

I have enclosed for your use key schedules and discussion points to be used in our meeting Wednesday night.

The material projects our financial model without consideration of strategic options; provides highlights of our recommended initiatives and a financial model which includes the estimated impact of those initiatives.

A more detailed discussion of the background analysis will be available Wednesday evening.

Thank you for your ongoing support.

PFR/sk

Enclosure

SUMMARY OF STRATEGIC PLAN

- Inpatient market decline offers significant threat if market share is not maintained or expanded
- Cost reductions must be achieved to maintain short term viability
  - Target for FY 1996-97 - $15 million
- Primary care sites should be developed in targeted suburban metro region immediately

SUMMARY OF STRATEGIC PLAN (continued)

- Partnerships with Family Practice or other existing primary care organizations should be explored with objective of developing competitive network in metro area for 50-100 primary care physicians
- Further exploration of opportunities to protect or develop market share in Iron Range and Red Wing markets should proceed

SUMMARY OF STRATEGIC PLAN - (continued)

- Partnerships with existing providers that benefit UMHS should be aggressively pursued
- Investments in key infrastructure must be made (i.e., Information Systems) to assure performance improvement

KEY ASSUMPTIONS
Reimbursement Trends

- Medicare rates increase by 0.5% for the DRG payment in years 1995-96 through 1999-00
- Senate version of Medicare legislation, the Indirect Medical Education (IME) factor will decrease from 7.7% in FY 1994-95 to:
  - 6.7% in FY 1995-96
  - 5.6% in FY 1996-97
  - 4.5% in FY 1997-98

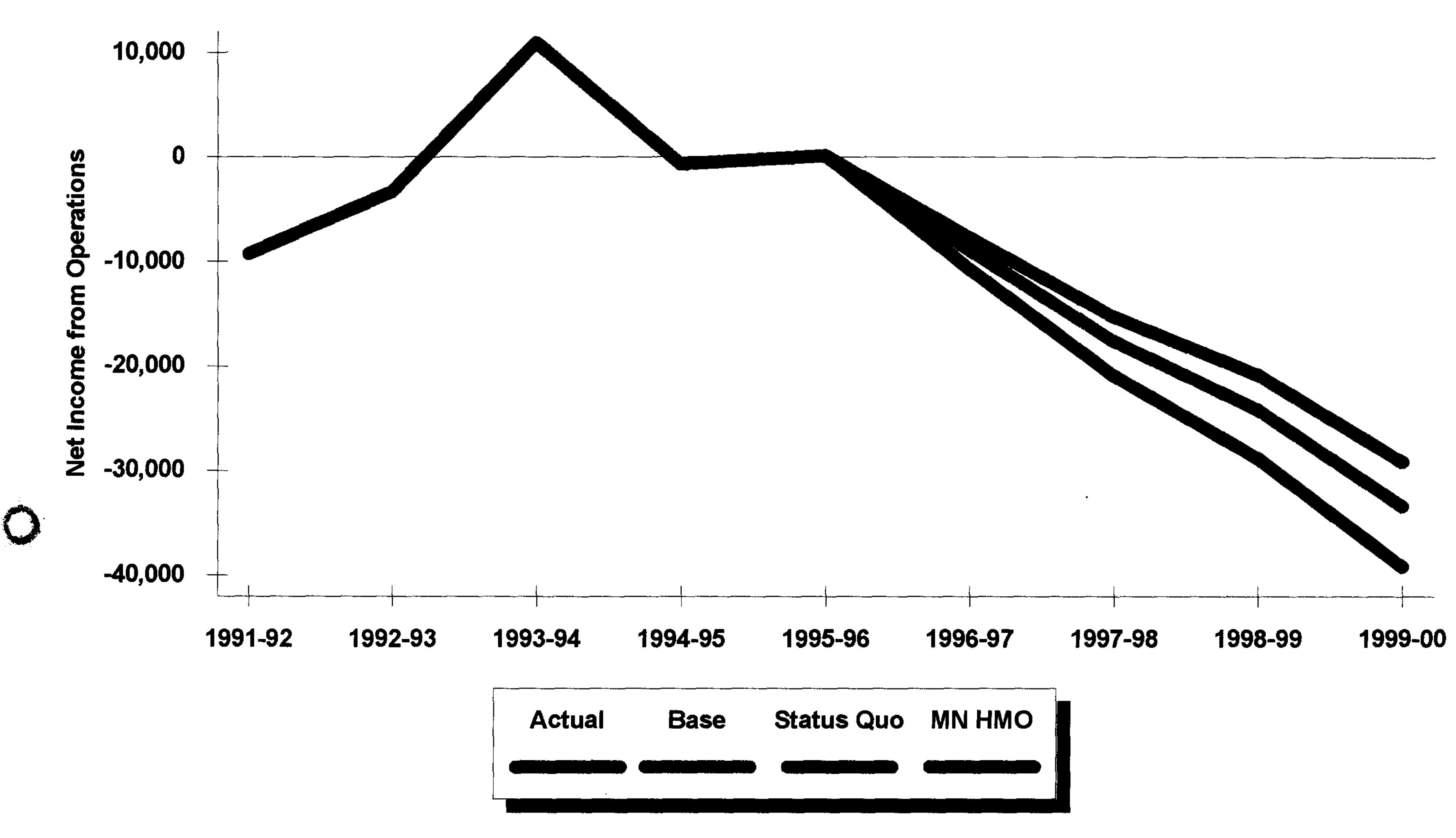
KEY ASSUMPTIONS
Reimbursement Trends (continued)

- Medical Assistance reimbursement rates decrease in 1995-96 by 3.5% and increase by 1.0% in future years
- Blue Cross rates remain flat in 1995-96 and increase by 1% in years 1996-97 through 1999-00
- HMO/PPO rates decrease in 1995-96 by 3.5% and increase by 2.0% in future years
- Commercial insurers' rates are assumed to increase at 3.5%

University of Minnesota Hospital and Clinic

Projected Baseline Profitability without Strategic Initiatives

1991-92 Actual through 1999-2000



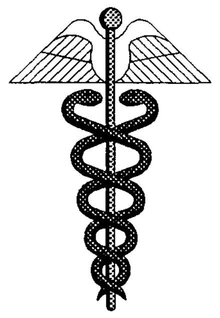
Base assumes a 1.5% decline in discharges per year and a 1.0% increase in outpatient encounters per year

Status Quo assumes discharges hold at 16,000 per year and a 1.0% increase in outpatient encounters per year

MN HMO assumes a 3.4% decline in discharges per year and a 1.0% increase in outpatient encounters per year

UNIVERSITY OF MINNESOTA HEALTH SYSTEM

Preliminary Strategic Direction
October, 1995
David Chin, M.D.
Coopers & Lybrand



MARKET ASSESSMENT

- **Market Share/Competition**
  - Rank among top 40 hospitals in several disease categories
  - Not a leader in any category among regional providers
  - Hospital consolidation is prevalent and powerful in market
  - System integration is key to success in managed care

MARKET ASSESSMENT CONT.

- **Projected Bed Demand**
  - Preliminary, conservative evaluation results in projection of 3700-4700 beds in market
  - Decrease of 1000 beds over next five years seems likely
  - Slope of decrease is likely to be constant, with the exception of timing of Federal or State reforms

MARKET ASSESSMENT CONT.

- **Physician Supply/Physician Demand**
  - Physician demand has been met in 11 county area
  - Population growth over next 5 years will add to population served

MARKET ASSESSMENT CONT.

- **Conclusion**
  - UMHS does not have a unique market position
  - UMHS needs to enlarge its local reputation in focused service areas
  - UMHS needs to build a primary care base and create alliances with key players in the market to build or maintain volume
  - UMHS faces a declining market, estimated 1000 beds over five years

FINANCIAL EVALUATION

- **Opportunities for Cost Reduction are Evident**
  - Improved utilization management
  - FTE/Occupied Bed Ratios
  - Nursing staff/Patient Day

UNIVERSITY OF MINNESOTA HEALTH SYSTEM (UMHS)
– TERTIARY ALOS COMPARISION –
UMHS Vs. MHC
BASED ON UMHS SERVICE LINE DEFINITIONS BY DRG
(Tertiary Cases = UMHS CMI >= 1.7000)

UMHS Service Definition	Average Length of Stay	
	UMHS	MHC
Cardiology	6.66	6.20
Digestive	13.78	10.39
Endicrine	18.47	8.02
Neurosciences	6.88	8.10
Oncology	24.18	8.85
Orthopedics	6.69	6.22
Pediatrics	14.03	15.58
Transplant	14.32	9.63
Vascular	10.01	7.45

Source : Metropolitan Healthcare Council (MHC) Standard Information Reports; Report 4A 1994.

FINANCIAL EVALUATION CONT.

- **Summary**
  - A competitive model is financially viable over the short term with cost reductions and a source of inpatient volume
  - The hospital can compete in the short term if costs are reduced
  - Long term, the tertiary market will decline for the hospital due to consolidation of provider groups, tertiary care as a commodity, and reputation.
  - Long term, maintenance of a competitive position will be difficult
  - Cannot comment more definitively on other options without more refined data

PRELIMINARY STRATEGIC DIRECTION

- **Overview**
  - Decrease costs
  - Build volume – target 80-100 hospital beds
    - Primary care in underserved local areas
    - Referrals from U-Care and Medicare
    - Specialty fee for service referrals
    - Primary care within ten minutes of the hospital
  - Build Volume through Primary Care Enhancement in local market area
    - Develop PCP capacity in area with 50 to 100 PCPs

PRELIMINARY STRATEGIC DIRECTION CONT.

- **Overview Cont.**
  - Focus on defined set of key research competencies only
  - Collaborate with School of Public Health
  - Pursue Legislative Financial Support

UMHS STRATEGIC RESPONSE

Maintaining and Increasing Volume

- Establish primary care sites in four suburban underserved areas. Estimated new admission volume impact of 3,800 admissions.
- Identify primary care partners to acquire or build primary care network of 50-75 additional providers in metro area.

UMHS STRATEGIC RESPONSE (continued)

- Support existing University Medical Center-Mesabi and Mesabi Clinic in Iron Range development plan through collaboration and non-capital intensive support.
- Monitor developments in Grand Rapids and Virginia to secure market share if opportunity arises and strong economic agreement is made.

UMHS STRATEGIC RESPONSE
(continued)

- Explore merger of River Region Health Services to expand Interstate Medical Center and increase market share within region. Do so if reduction in operating costs satisfy debt service requirements and existing River Region Health Services balance sheet can be maintained. Cost to UMHS $3 million cash, $7 million debt.

UMHS STRATEGIC RESPONSE
(continued)

Improving Performance

- Continue cost reduction efforts through labor reduction efforts. Target "top quartile" standard of peer institutions. Estimated reductions of $15 million next year.
- Achieve significant improvement in clinical utilization through Medical Staff.

UMHS STRATEGIC RESPONSE (continued)

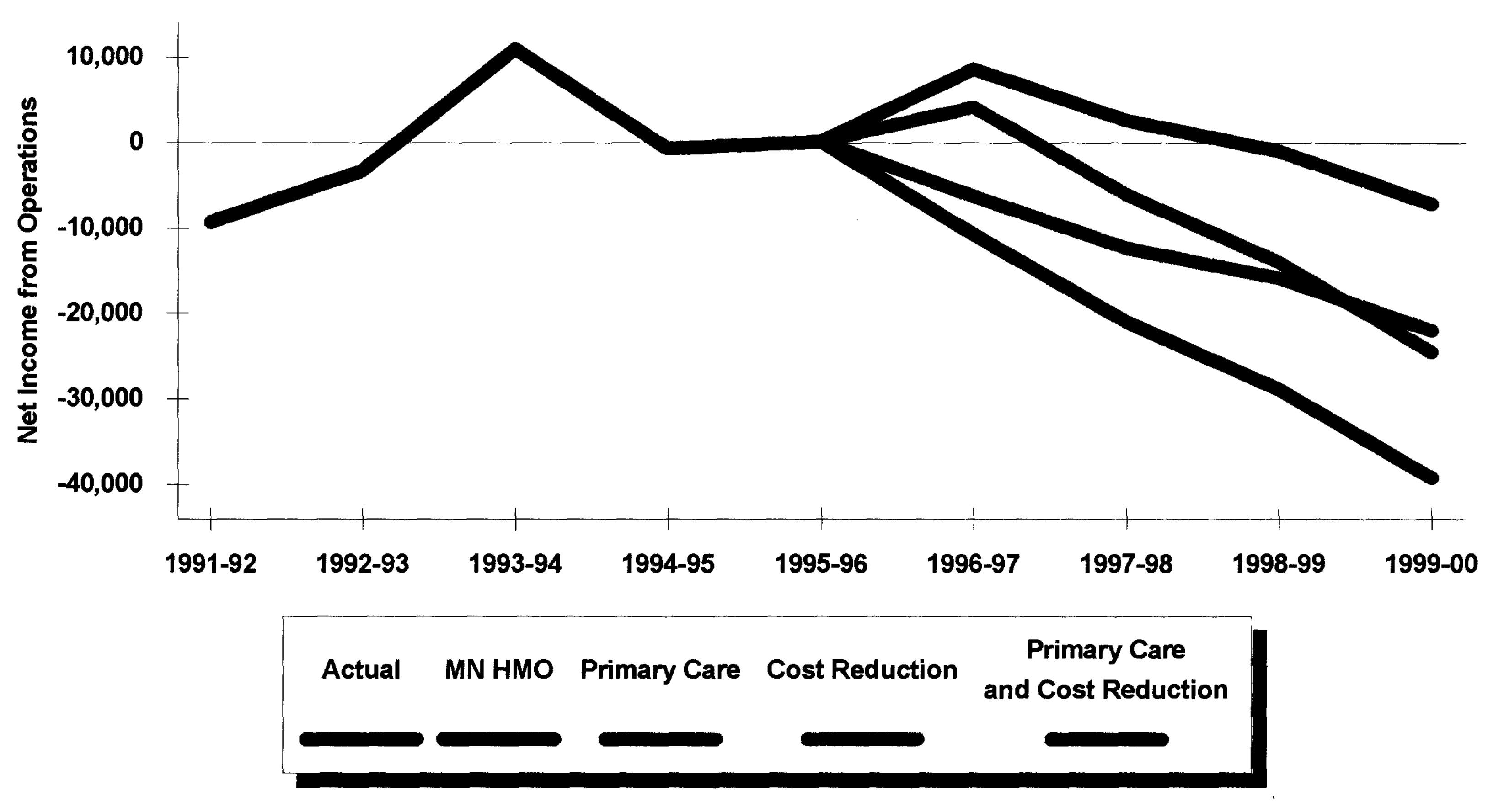
- Achieve more complete system capabilities with improved subacute programs and coordination of support system for primary care providers and referring physicians.
- Identify core programs, critical to institutional performance in market and provide essential business plan support, infrastructure investments in information systems and outpatient space. Support essential program development opportunities.

UMHS STRATEGIC RESPONSE (continued)

Partnerships

- Seek partners who add value to UMHS at program level and pursue long run risk sharing relationships.
- Explore within community interest in system wide relationships.

University of Minnesota Hospital and Clinic
Projected Profitability with Strategic Initiatives
1991-92 Actual through 1999-2000



MN HMO assumes a 3.4% decline in discharges per year and a 1.0% increase in outpatient encounters per year

Primary Care assumes a total of 5.1% increase in discharges by fiscal year 2000

Cost Reduction assumes a $15 million reduction in operating expenses in fiscal year 1997

Primary Care and Cost Reduction assumes both initiatives are implemented

CHAIRMAN'S MEETING
Monday, September 18, 1995
3:30 - 5:00 p.m. - B390 Mayo

AGENDA

1.	Interventional MR Project	Peter Rapp
2.	Aspen Update	Peter Rapp
3.	Partnership Discussions Update - Legacy - Fairview - Childrens	Bill Brody, M.D.
4.	Legislative Update	Bill Brody, M.D.
5.	Retreat Planning	Peter Rapp/Bill Brody, M.D.
6.	October Meeting - Medical Staff Appointments - Reorganization, Responsibilities Discussion	

UMHS BOARD OF GOVERNORS

Executive Committee

May 18, 1995

AGENDA

Revisiting the Strategic Plan : A time to Redirect the Focus	Discussion
BOG Nominations: Selection and Election Process of New Board Members	Discussion
UMHC May 24, 1995 Board Agenda	Information

The 1994 Strategic Plan Review Defined the Following Tactics for Achieving the Strategic Plan:

- Focus on Iron Range as the Highest Priority Greater Minnesota Community
- Gain Base of Enrolled Lives Through U-Care Acquisition
- Continue Efforts Around Blue Cross Networking
- Lay Groundwork for Public-Private State Resource Initiative

The Minnesota Plan Has Had the Following Key Elements:

- Reduce Cost Structure
- Create Integrated Delivery System (UMHS) and Physicians Group Practice (UMCA)
- Protect and Build Key Rural Referral Markets
- Building Primary Care Linkages Through Acquisitions and Affiliations
- Seek Non-Exclusive Network Relationship with Major Payor/Provider System

THE UNIVERSITY OF MINNESOTA HEALTH SYSTEM
BOARD OF GOVERNORS
May 24, 1995
2:30 P.M.
555 Diehl Hall

AGENDA

			Page
I.	Approval of the April 26, 1995 Minutes	Approval	1
II.	Chairman's Report	Information	
III.	Executive Report	Information	
IV.	Special Presentation: Quality Management Report		
V.	Consent Items		
	A. Finance, Planning and Development Committee		
	1. April 26, 1995 Minutes of the Finance, Planning and Development Committee	Information	
	B. Quality Management Committee		
	1. April 26, 1995 Minutes of the Quality Management Committee	Information	
	C. Human Resource Committee		
	1. April 26, 1995 Minutes of the Human Resource Committee	Information	
	D. Audit and Nominating Committee		
	1. April 26, 1995 Minutes of the Audit and Nominating Committee	Information	
	E. Executive Committee	Information	
	1. May 18, 1995 Minutes of the Executive Committee		
VI.	Committee Reports		
	A. Finance, Planning and Development Committee		
	1. Mesabi Budget	Information	
	2. Mesaba Clinic Budget	Information	
	3. UMHC 1995-96 Budget	Information	
	4. Capital Budget	Information	
	5. April 30, 1995 UMCA Financials	Information	
	6. April 30, 1995 UMHC Financials	Information	

B. Quality Management Committee

1. Medical Staff-Hospital Council Report Credentials Committee Recommendations — Approval
2. CUHCC Governance Bylaws — Approval

C. Human Resource Committee

No items requiring Board deliberation

D. Marketing Task Force Report

E. FORT Report — Information

VII. Resolution to conduct Non-Public Meeting of the Board of Governors to Discuss:

1. Specific Marketing and Contracting Matters

VIII. Other Business

IX. Adjournment