Board of Governors

University of Minnesota Hospitals & Clinics

May 18, 1983

Minutes

CALL TO ORDER: Mr. David Cost, Acting Chair, called the May 18th meeting of the Board of Governors to order at 1:40 p.m., in Room 555 Diehl Hall.

ATTENDANCE:

Present: David Cost, Acting Chair
Harry Atwood
Robert Goltz, M.D.
Robert Latz
Virgil Moline
Barbara O'Grady
Paul Quie, M.D.
C. Edward Schwartz
Lori Stieber
Timothy Vann
Neal Vanselow, M.D.

Absent: Fred Bohen
Al France
Tom Madison
J. E. Meilahn

MINUTES APPROVED: It was moved that the minutes of the meeting held April 20, 1983 be approved as submitted. The motion was seconded. Mr. Virgil Moline noted that he was present but not listed. The minutes were approved as corrected.

EXECUTIVE COMMITTEE REPORT: Mr. David Cost reported on the May 18th meeting of the Executive Committee established for the May meeting and comprised of Mr. Harry Atwood, Mr. Al France, Dr. Robert Goltz, Dr. Paul Quie, Mr. C. Edward Schwartz and himself. He indicated that the Executive Committee had addressed a number of issues related to Finance, Personnel and Purchasing, Liver Transplant Policy and Board Bylaws all of which were to be discussed by the full Board of Governors.

FINANCIAL STATEMENTS: July, 1982 - April, 1983: Mr. Cliff Fearing reported on the April Year-to-Date financial statements indicating that hospital operations continued to reflect a relatively stable level of activity. He reported that admissions were 3.1% above budget, patient days were 3.4% above budget at 165,902, and average daily census and percent occupancy were both 3.4% above budget. He added that the hospitals year-to-date operating position showed total revenue over expense of $8,874,015 representing a favorable variance of $8,521,793. Mr. Fearing further reported that patient care charges were 10.3% above budgeted levels while expenditures through April resulted in a

variance of 1.1% over budget. In response to a question, Mr. Fearing indicated that financial information discussed by the Finance Committee could be sent to the full Board in advance of their monthly meetings.

MEDICARE APPEAL:

Mr. Cliff Fearing reported on the 1979-80 Section 223 Medicare Appeal decision favoring University of Minnesota Hospitals and Clinics. It was reported that this decision could impact medicare reimbursement for the 1979-80 fiscal year through 1983-84, and that the impact on current year was estimated at $3.5 million.

RENEWAL PROJECT REFINANCING:

Mr. Fearing reported on the Regents authorization to proceed with an advance refunding of the Hospital Bond Issue of December, 1982. He reported that the Regents had acted at its May 13, 1983 meeting thereby providing the opportunity to pursue a net savings in per diem debt service. Mr. Fearing reported that Administration was monitoring interest rates in determining whether to proceed over the next two to three weeks.

PERSONNEL AND PURCHASING IMPLEMENTATION PLAN:

Mr. Ed Schwartz introduced the topic of Board of Governors Bylaws and Purchasing and Personnel Implementation brought about by the Regents resolution of December, 1982 relating to hospital governance. He added that two working groups had been established to recommend a decentralized approach to Personnel and Purchasing Administration for University Hospitals. He reported that the hospitals had been represented by Mr. Greg Hart on the Personnel working group and Mr. Ed Howell on the Purchasing working group and that recommendations from these groups had been submitted to Dr. Neal Vanselow for implementation.

Mr. Greg Hart summarized the Personnel and Purchasing Implementation plans for the Board of Governors. After discussion regarding the content of the implementation plans, it was moved that the Board of Governors endorse the concepts presented in the Personnel and Purchasing Implementation report. The motion was seconded. Discussion focused on the difficulty in addressing complex issues without prior opportunity for review by the Board of Governors. It was then moved that the motion be tabled in order to allow opportunity for Board of Governors review. The motion for tabling the items was passed unanimously.

LIVER TRANSPLANT CREDIT POLICY:

Mr. Ed Schwartz introduced the proposed administrative policy on potential liver transplant candidates indicating that this issue was being brought to the Board due to the high public visibility surrounding liver transplantation. He reported that the major elements of the policy included an "open door" policy for Minnesota residents, a minimum deposit requirement for all non-Minnesota residents, a $200,000 receivable limit for account balances in excess of minimum balance requirements, medical evaluation for all US citizens regardless of ability to pay, and a financial review mechanism. Minimum deposits for stay for

non-Minnesota US citizens and for non-citizens were reported at $112,000 and $175,000 respectively for pediatric cases and $132,000 and $175,000 respectively for adult cases.

Discussion focused on the definition of the term, resident. It was suggested that University Hospitals adopt the definition of Minnesota resident used by the University of Minnesota for purposes of in-state tuition. Further discussion focused on the use of collateral and the $200,000 limit of receivables. After further discussion, it was moved that the proposed policy on liver transplant credit be approved. The motion was seconded and passed unanimously.

CREDENTIALS COMMITTEE REPORT:

Dr. Paul Quie summarized the report of the Credentials Committee indicating that recommendations for clinical privileges had been reviewed and approved by the Executive Committee. Dr. Quie reported that those recommended for staff appointments included: Dr. Charles F. Moldow (Clinical), and Dr. George Sopko (Attending), Department of Medicine; Dr. Gregory Elliott (Attending), Department of Pediatrics; and Dr. Mark Moret (Attending), Department of Physical Medicine and Rehabilitation. It was moved that the Board of Governors approve the report of the Credentials Committee. The motion was seconded and passed unanimously.

NOMINATING COMMITTEE REPORT:

Mr. Harry Atwood presented the report of the Nominating Committee comprised of Mr. J. E. Meilahn, Ms. Timothy Vann, and himself. He reported that the Nominating Committee nominates Mr. David Cost for Chair and Ms. Timothy Vann for Vice Chair of the Board of Governors and moved that they be elected to serve during the remainder of the 1983 term. The motion was seconded and passed unanimously.

HOSPITAL DIRECTORS REPORT:

Mr. Ed Schwartz announced that Vice President Bohen and Dean Neal Gault had resigned their posts. He added that he had been asked to serve on the Medical School Dean Search Committee.

Mr. Schwartz also reported that a staff member would soon be assigned to planning University Hospital's response to DRG reimbursement and added that a report on this topic would be presented at the June meeting of the Board of Governors.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 3:40 p.m. by Mr. David Cost, Chair.

Respectfully submitted,

Ron Werft

Ron Werft
Secretary
Board of Governors

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

BOARD OF GOVERNORS

May 18, 1983

1:30 P.M.

555 Diehl Hall

University of Minnesota Campus

Agenda

I. Minutes - April 20, 1983 (Approval)

II. Chairman's Report (Information)
Mr. David Cost, Acting Chairman

III. Executive Committee Report (Information)
Mr. David Cost, Acting Chairman

IV. Nominating Committee Report (Approval)
Mr. Harry Atwood, Chairman, Nominating Committee

V. Hospital Director's Report (Information)
Mr. C. Edward Schwartz, Hospital Director

Board of Governors

Executive Committee

University of Minnesota Hospitals and Clinics

10:30 A.M.

626 Campus Club

Wednesday, May 18, 1983

Agenda

I. Financial Statement July 1, 1982 - April 30, 1983

II. Renewal Refinancing (See 223

III. Liver Transplant Policy

IV. Personnel/Purchasing Implementation

V. Nominating Committee Recommendations - COST - UAWU.

VI. Credentials Committee Report

VII. Bylaws Revisions Review

VIII. Other

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 11, 1983

TO: Board of Governors Executive Committee

FROM: C. Edward Schwartz

SUBJECT: Personnel/Purchasing Implementation

As you are aware, the recent change in Board structure and duties includes a greater degree of responsibility and authority for the Personnel and Purchasing functions within University Hospitals. In March, 1983, President Magrath, upon acceptance of the Regents/ Governors Task Force Report, asked Vice President Vanselow to convene working groups in these two areas. The working groups were charged with providing recommendations to Vice President Vanselow, Vice President Hasselmo, and Vice President Bohen in April, 1983.

The attached documents present the recommendations prepared by the working groups. Greg Hart played the lead role for the Hospitals in development of the Personnel recommendations, while Ed Howell played the lead role for Purchasing. These documents were reviewed and approved by the three Vice Presidents on April 19, 1983. At that time, Dave Preston was asked to develop an abbreviated version of the recommendations which will be presented to the Board of Regents at their June meeting.

These are critical new areas of Board of Governors responsibility, and we think it important that the Board be fully aware of and in concert with the recommendations that are made and the direction in which we are heading. While much more detailed work needs to be done, these documents represent an important departure point. We would thus appreciate any reactions or comments you may have, and plan on further discussion at the May 18 meeting of the Executive Committee.

/kj

attachments

Implementation Plan-Hospital Governance/Personnel

The following plan is written in response to the personnel-related recommendations in the Board of Regents Study Committee Report. It is based on these general premises. First, the need for change, based upon the Hospitals rapidly changing environment, has been accepted. Second, to the extent possible, that change should take the form of delegation of increased authority to the Hospitals Board of Governors, administrative staff, and the Vice President for Health Sciences. Third, there will continue to remain a need for centralized authority and/or coordination of some personnel relation functions.

As a general rule, the following principle is followed in distinguishing where decentralization is most appropriate, and where centralization is most appropriate: Where an understanding of the Hospitals operations, responsiveness, flexibility, and creativity in problem solving are most essential to one of the Personnel-related functions, decentralization is the most appropriate means of achieving those objectives. Where economics of scale and broad University-wide policy are the most important variables, "corporate" performance or monitoring of the related Personnel duties is the appropriate approach.

For purposes of this document, the personnel functions are divided as follows:

A. Compensation and Classification
B. Employee Benefits Administration
C. Labor Relations
D. Employment/Recruitment
E. Payroll Processing
F. Affirmative Action
G. Employee Relations
H. Organizational Development

In general, we view areas A, D, E, G, and H as needing, as a primary goal, to be responsive to operating needs, and thus recommend a decentralized model. Areas B, C, and F, for reasons of economy or corporate policy, should be generally maintained under the existing centralized model, with perhaps some modification. Specific proposals in each of the above eight areas follow.

A. Compensation and Classification

Recommendations

1. Responsibility for development of a position classification system, including compensation packages, should be delegated to the Hospitals Board of Governors.

2. Policies in such areas as vacation, holiday, on-call pay, overtime accrual, etc. should be developed on a decentralized basis.

3. The Hospitals should set, as a high priority objective, the establishment and implementation of incentive and merit based compensation plans for many of its employees, in order to best respond to upcoming and existing Federal regulations and health care economic conditions.

4. The above should apply, as recommended in the Regents report, to employee classifications which are unique to or primarily centered in the Hospitals. For purposes of initial establishment, "primarily centered in" shall be defined as any classification which is more than 50% hospital based.

5. Consistency with Regents policy should be assured through ongoing communication between the Hospitals and University Personnel Departments, as well as periodic reports to the Board of Regents.

Discussion

Compensation and position classification is central to the effective operation of the Personnel function. The existing process generally requires that the Hospitals salary and fringe benefit plans, as well as its position classification plan, be primarily in "lock-step" with that of the University, and, to a lesser extent, the State.

The Hospitals own environment and marketplace will continue to be the central variable determining its compensations and classification needs. Increasingly in the future, these marketplace variables will be different from those factors driving the general University plans. Medicare and Medicaid regulations, the health professional marketplace, and the Hospitals manpower resource needs will be the central variables dictating future Hospital compensation policy and practice. Given the relative uniqueness of these variables to the Hospitals, delegation to the Hospitals is appropriate.

The Regents Study Committee Report accurately identifies the need for consistency in compensation practice for those classifications which are spread throughout the University. We have used a 50% rule in determining which classifications should be "University governed" and which should be "Hospital governed". That is, if 50% or more of the employees in a given class are Hospital employees, that classification should be governed by Hospital compensation.

Union employee compensation and classification is addressed in section C.

We would recommend that authority in this area be delegated effective July 1, 1983. A major review of the Hospitals position classification system would be undertaken at that time, with changes recommended three to six months thereafter.

B. Employee Benefits Administration

Recommendations

1. As noted earlier, the Hospitals should study and, where appropriate, implement more incentive based or flexible benefit packages.

2. Where specific employee benefit plans are mandated by State law, central authority for and coordination of the employee benefits administration function should be maintained. Insurance and retirement plans fit into this category.

3. The Hospitals should develop an improved knowledge base and capability to respond to employee questions concerning employee benefits.

4. For purposes of payroll deductions for employee benefits, the Hospitals should pay an actual amount of expenses incurred, as opposed to the current across-the-board percentage deductions.

Discussion

Certain types of employee benefits (vacation, sick leave, etc.) are amenable to decentralization. Particularly where incentive based or flexible benefit packages can prove to be a substantial tool for employee motivation and reward, decentralization is most appropriate.

State law currently mandates certain benefit packages in the areas of insurance and retirement. The University, in fact, is part of larger Statewide contracts for insurance and retirement plans. The larger contracts allow for reduced premiums. It would thus be unwise for the Hospitals to break away from these larger contracts. In addition, the information flow for employee benefits administration as it is currently organized allows for economies of scale. It would be unwise for the Hospitals to duplicate these resources. The Hospitals should, however, develop greater expertise regarding the insurance and retirement plans in order to more effectively respond to employee questions.

July 1, 1983 should be the date for formal delegation of authority for these recommendations. A review of existing benefits in the sick leave, vacation, etc. area will be undertaken as part of the study noted in section 1, with recommendations again forthcoming in three to six months.

C. Labor Relations

Recommendations

1. Contract negotiations, given existing State law, need to continue to be conducted jointly under the direction of central University personnel.

2. The Unit 4 contract negotiations, given that it involves 80% Hospital employees, should be led by the Hospitals beginning in 1985 (the next negotiating period).

3. The potential for change in PELRA, to allow hospital specific units, should be investigated.

4. The responsibility for grievance administration should lie with the Hospitals, through arbitration when necessary.

Discussion

The Regents Study Committee Report identified labor relations as an area where integration and University-wide consistency will continue to be important. These recommendations are made with that consideration in mind.

The Unit 4 (Health Care Non-Professionals) bargaining unit, currently represented by AFSCME, is comprised of 80% Hospital employees. This contract is currently being re-negotiated; it would not be prudent to alter the bargaining process at this point. Beginning in 1985, however, it is envisioned that the Hospitals would take the lead in the contract negotiations for Unit 4. We presume the Regents would wish to maintain final approval authority for all union contracts.

Existing State law (PELRA) dictates that all unions be university-wide. Thus Hospitals employees can be "drafted" into a union that is primarily non-Hospital, and vice-versa. This situation could only be changed by amendment to PELRA to allow the establishment of Hospital-specific units in the future. We would recommend that the appropriate University officials give consideration to future legislation in this area.

Responsiblity for grievance administration (recommendation 4) should be immediately delegated to the Hospitals; the timeframe for the other recommendations, as noted above, should be 1985.

D. Employment/Recruitment

Recommendations

1. The current decentralized system works well for all concerned. Little change is recommended.

2. The potential for having the Hospitals manage the Hospital component of the student employment process should be explored with the Vice President for Student Affairs.

Discussion

The employment/recruitment function is already virtually completely decentralized. The exception here is the student employment function; we would recommend that student employment also be decentralized to the Hospitals. Preliminary discussions in this regard have occurred with the Student Employment Office, who are supportive of this recommendation.

E. Payroll Processing

Recommendations

1. The current decentralized approach to Payroll processing should be continued and expanded to include gross-to-net calculations and handling of deductions.

2. Should the University wish to maintain a central production point for check printing, for audit and control purposes, the Hospitals should continue to tie into this process. If however, central control of check production is not seen as being necessary, the Hospitals should print its own payroll checks.

Discussion

Here again, the payroll function is already largely decentralized, to the point where the Hospitals currently runs its own timecard/data collection systems, produces its own payroll reports, and runs on a pay period cycle different from the remainder of the rest of the University.

The remaining centralized payroll functions are the gross-to-net calculations and check production. These should also be decentralized, unless centralized control/audit is viewed as an overriding concern. If change is approved in this area, an October 1, 1983 target is recommended.

F. Affirmative Action

Recommendations

1. Due to the broad institutional policy nature of this area, centralized authority would continue to be necessary.

2. The current model of delegation of operational activity related to Affirmative Action should be continued.

Discussion

The recommendations in this section are made under the assumption that the Regents will continue to view Affirmative Action as an extraordinarily high priority, and wish to retain the existing central administration reporting relationship for this function. Operational activity for the Affirmative Action program has already been delegated to the Hospitals and operates effectively.

G. Employee Relations

Recommendations

1. The Hospitals should have the authority to develop and enforce its own personnel policies for compensation, sick leave, vacation,

overtime, layoffs and all other working conditions for non-union employees. Policy development and enforcement authority should be delegated to the Hospitals Board of Governors.

2. Consistency with University policy should be assured through periodic reports to the Board of Regents.

Discussion

Along with compensation and classification, the ability to manage working conditions through Personnel policy is most central to effective operation of the Personnel function under a decentralized system. We are thus recommending that the Hospitals have the authority to develop its own rules, regulations, and policies for its employees. The existing Civil Service Rules would thus be replaced with an analogous set of Hospital-wide personnel policies, to be approved and monitored by the Board of Governors.

A three month timeframe would be necessary for development and approval of these policies, with modifications, of course, to be made periodically.

H. Organizational Development

Recommendations

1. No changes are recommended. This area is currently fully decentralized.

Implementation Plan - Hospital Governance/Purchasing

In response to the purchasing-related recommendations contained in the Board of Regents Study Committee Report, the following plan outline has been developed. This plan is based upon two concepts incorporated in the aforementioned report. First, "the unique needs of the Hospitals and the need for rapid response to a changing health care environment warrant the need for change. Second, where feasible, this change should be accomplished through the delegation of increased authority to the Hospitals Board of Governors, the Vice President for Health Sciences and the Hospitals management staff. Finally, in certain functional areas, the need for centralized authority for some purchasing related activities will remain."

In developing this plan, decentralization is recommended where an understanding of the Hospitals operations and unique supply needs are most essential for effective management of the Purchasing & Stores functions. Centralization and/or "University" management or monitoring is recommended, where University-wide policy and/or significant economies of scale are of primary importance.

In examining this issue, the Purchasing and Stores functions have been divided into the following areas:

A). Requisition Processing and Bid Management

B). Purchase Order Issuance

C). Contract Administration

D). Storage and Distribution

E). Accounts Payable

F). Audits

Within the concepts identified above, areas A,B,C,D, and E are viewed as requiring knowledge of the unique supply needs of the Hospitals and being responsive to its ongoing operational requirements, thus a primarily decentralized mechanism is recommended. For reasons of corporate policy management and/or economies at scale, area F is recommended to remain under a centralized model with some modification.

Within each of the aforementioned six areas, the following specific proposals are presented:

I). REQUISITION PROCESSING AND BID MANAGEMENT

A. Responsibility for development of a system for processing requisitions and developing and issuing bids should be delegated to the Hospitals Board of Governors.

B. Policies relating to bid development, bid issuance, receiving and clocking of bids, bid openings and bid acceptance should be developed on a decentralized basis and endorsed by the Hospitals' Board of Governors and subsequently, the Board of Regents.

C. A listing of unacceptable vendors and criteria for determining said unacceptability should be developed on a decentralized basis.

D. Consistency with Regent's policy should be assured through the endorsement of the Hospitals Purchasing Policy & Procedure Manual; Quarterly reports to the Board of Regents and coordinated audit functions.

Discussion

The effective processing of requisitions and management of the Bidding activity is essential for the provision of responsive cost-conscious health care. The current mechanism requires that the Hospitals procurement of necessary supplies and equipment is essentially intertwined with the purchasing of supplies and equipment for all other units within the University.

The rapid advancements in medical care technology experienced during recent years is likely to continue in the foreseeable future. As a result of these rather rapid technological advances, there are frequent changes and modifications in the supplies and equipment used within University Hospital. In order for the Hospital to effectively purchase the items necessary for day to day operations, knowledge of these often unique supplies and equipment as well as their application is essential. Given the very high volume of these generally unique items, delegation of the requisition processing and bid management functions is appropriate.

Such a delegation should include the following elements:

- Usage of Hospital requisitions which are specifically distinguished from University requisitions.
- Hospital review of requisitions.
- Hospital based maintenance of requisition files.
- Hospital based bidding out of requisitions to include:
    - . Preparation of invitation for bids.
    - . Bid solicitation.
    - . Maintenance of vendor contacts.
    - . Maintenance of bid files.
    - . Tabulation of bids.
- Clocking of bids and conducting bid closings at the Hospital.
- Awarding of Contracts, under Hospital authority.

A set of procurement standards which guide the purchasing activity of the University have been endorsed by the Board of Regents. These standards should be used as the focus for the development of the Hospitals Purchasing Policies and Procedures which would be endorsed by the Hospitals Board of Governors and the Board of Regents. This would establish an appropriate relationship between

the University Purchasing activity and that of the Hospitals. Further to assure an appropriate relationship is maintained, representatives from University Purchasing and Hospital Purchasing should meet on a regular formalized basis to discuss any proposed changes in purchasing mechanisms or other issues of mutual concern.

We recommend that the authority to develop these functions be delegated to the Hospitals Board of Governors effective July 1, 1983. Full implementation of these changes would occur January 1, 1984.

II. PURCHASE ORDER ISSUANCE

A. The Hospitals should be delegated the authority to issue all Hospital Purchase Orders, with no further approval required.

B. Policy development and monitoring authority relating to the issuance of Purchase Orders should be delegated to the Hospitals Board of Governors.

C. Consistency with Regents policy should be assured through periodic reports to the Board of Regents in coordination with ongoing audit functions.

Discussion

As previously noted, timely acquisition of needed supplies and equipment is essential for the effective provision of Health Care in a changing competitive environment. Issuance of Purchase Orders is closely linked to the processing of Requisitions and Management of Bids which was discussed above. Thus, Purchase Order Issuance should also be managed decentrally. In addition, decentralization will facilitate efficient hospital accounting procedures.

Much of the activity associated with the issuance of Purchase Orders is currently handled on a decentralized basis. Delegation of final authorization to the Hospitals will complete the decentralization of this function, and is recommended. Further, this decentralization should include but not be limited to the following provisions:

- Developemnt of Purchase Orders which are unique and identifiable to the Hospitals

- Limitation of Hospital issuance of Purchase Orders to Hospital Accounts.

- Maintenance of Purchase Order files.

- Responsibility for credit returns and resolution of discrepancies with vendors.

The authority to develop the mechanisms for the Issuance of all Purchase Orders should be delegated to the Hospitals July 1, 1983. Following development of the mechanisms and endorsement of related Policies and Procedures by the Hospitals Board of Governors and the Board of Regents. Implementation is targeted for January 1, 1984.

III. CONTRACT ADMINISTRATION

A. The Hospitals Board of Governors should be delegated the authority to develop a mechanism for total Contract Administration. This mechanism would include provisions for Contract Negotiation, Group Purchasing Affiliations, Vendor Warehousing agreements, and other contemporary purchasing concepts.

B. Policies related to contract management should be developed on a decentralized basis. These policies should be endorsed by the Hospitals Board of Governors and the Board of Regents.

C. Compliance with University public disclosure requirements should be assured through ongoing reports to the Hospitals Board of Governors and Quarterly Reports to the Board of Regents.

Discussion

Historically, the Bidding system has been an effective mechanism for purchasing needed supplies and equipment. However, in recent years, increased competition within the hospital industry has created the need for hospitals to develop new and innovative mechanisms which include but are not limited to: the development of large multi-hospital purchasing groups, which allows hospitals to take advantage of high volume discounts; the development of Negotiated multi-item contracts, which allows hospitals to achieve significant savings by aggregating multiple, often diverse items, into large discounted contracts; the development of Vendor Warehousing agreements, which allows the hospitals to shift part of its inventory maintenance cost to the vendor.

While it is envisioned that the Bidding System would continue to be the primary means of purchasing supplies and equipment, the Hospital must be able to respond to the marketplace by possessing the ability to develop and access alternative purchasing mechanisms. Therefore, we would recommend that the Hospitals Board of Governors be delegated the authority to develop a mechanism for Contract Administration. The University set of procurement standards should be used as the focus for development of policies and procedures associated Contract Administration which would be included in the Hospital Purchasing Policies and Procedures Manual previously referenced.

Minnesota Statute requires the University of Minnesota to support the development of small and minority businesses through participation in the state "Set Aside Program". The Hospital would continue participation in such a program consistent with University practices. Thus it is recommended that the Hospitals participation in this

program will continue to be handled through the University Set Aside Coordinator. In order to effectively implement this relationship procedures should be jointly developed which are consistant with University Reporting requirements.

Authority to develop the mechanisms for Contract Administration should be delegated to the Hospitals Board of Governors, July 1, 1983. Implementation of Contract Administration should be targeted for January 1, 1984.

IV. STORAGE AND DISTRIBUTION

A. Unique Hospital Supply Items should continue to be stored and distributed under the current decentralized system. As related to external vendors, this system functions effectively and little change is envisioned.

B. The feasibility of delegating the responsibility to the Hospitals for the purchase and storage of items which are currently obtained from the General and Chemical Storehouse should be explored.

Discussion

Currently, the University General and Chemical Storehouse stock items which are not unique to the Hospital, but for which the Hospital is the primary user (50% or greater). Because the Hospital Warehouse is the center for distribution of supplies through-out the hospital, these items must also be stocked within the Hospital Warehouse. This results in double handling of these items and larger total inventories. In addition, the Hospital is charged a storage fee on those items obtained from the General and Chemical Warehouse. This fee when added to the overhead costs of storing these items in the Hospital Warehouse results in supply costs which are greater than those expreienced by other hospitals and therefore limits the Hospital's ability to function in a competitive marketplace.

The relationship between the Hospital Warehouse and other University warehouses is complex. This complexity includes financial interdependency, relationships with other University users and relationships with vendors and their contracts. Therefore, we recommend that the purchasing task force, or other group assigned by the Vice Presidents, continue to explore the feasibility of delegating to the Hospital the responsibility for the purchase and storage of items which the Hospital currently obtains from other University Storehouses. This exploration should focus upon the Hospital procurement of high volume, non-unique items directly from University contracts, for storage in the Hospital Warehouse and should be very cognizant of opportunities to take advantage of economies of scale and relationships with other units within the University. October 1, 1983, should be identified as the target date for making specific recommendations for modifying the storage and distribution function.

V. ACCOUNTS PAYABLE

A. The Hospital Board of Governors should be delegated the authority to conduct invoice auditing and determination of appropriateness for Vendor payments consistent with the decentralization of the purchasing function.

B. The current centralized approach to final issuance of payment to vendors should remain.

Discussion

In order for the Hospital to take full advantage of early payment discounts, maintain positive vendor relations, and accurately account transactions, a close working relationship between accounts payable and the purchasing function is required. Such a working relationship is required in order to maintain an appropriate knowledge base regarding bid prices, order quantities, freight charges, item description and invoicing patterns. Therefore, decentralization of the Accounts Payable function consistent with the decentralization of the purchasing function is recommended. Effective July 1, 1983, authority should be delegated to the Hospital Board of Governors to develop an Accounts Payable function with implementation targeted for January 1, 1984.

VI. AUDITS

A. The External Audit function should continue to be administered centrally. Centralization of this function is required for appropriate internal control within the University.

B. Communication of the findings of Legislative and other External Audits should be provided directly to the Vice President for Health Sciences, the Hospital Board of Governors and Hospitals Management as well as the Vice President for Finance and the Board of Regents.

Discussion

The recommendations in this section are made under the assumption that the Board of Regents will continue to view information regarding the financial status of the Hospital as having high priority and wish to retain central control for this important function. Further, it is assumed that consistent with the recommendation of the Study Committee on University Hospital Governance which call for reports from the Board of Governors to the Regents to be channeled through the Vice President for Health Sciences to the President, that audit results would also be disseminated to the Vice President for Health Science, the Board of Governors and Hospitals management in addition to the Vice President for Finance.

VII. CONCLUDING COMMENTS

The implementation of the aforementioned recommendations will likely impact other functions within the University. We have discussed in the development of these recommendations the areas of Accounting Records and Services and the Department of Audits. While there are no recommendations regarding these functions at this time, it should be noted that further examination at some future point in time may be desirable.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 5, 1983

TO: Medical Staff-Hospital Council
Board of Governors

FROM: Henry Buchwald, M.D.
Chairman, Credentials Committee

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee after examining all pertinent information provided to them concerning the applicant's professional competence and qualification, hereby recommend the approval of the following applicants requests for clinical privileges and Medical/Dental Staff appointment.

DEPARTMENT OF MEDICINE	CATEGORY
Charles F. Moldow	Clinical
George Sopko	Attending
DEPARTMENT OF PEDIATRICS	
Gregory R. Elliott	Attending
DEPARTMENT OF PHYSICAL MEDICINE & REHABILITATION	
Mark A. Moret	Attending

The following members of the medical staff have submitted applications requesting additional clinical privileges. The Credentials Committee have reviewed the requests and supporting information and hereby recommend the approval of their applications.

DEPARTMENT OF NEUROSURGERY	CATEGORY
Donald L. Erickson	Attending
Stephen J. Haines	Attending
Robert Maxwell	Attending
Edward L. Seljeskog	Attending
DEPARTMENT OF ORTHOPEDIC SURGERY	
Donald S. Bradford	Attending
James W. Ogilvie	Attending

APPLICANTS TO THE MEDICAL/DENTAL STAFF

MAY 1

NAME & DEPARTMENT	CATEGORY	FACULTY RANK	SPECIALITY	MEDICAL SCHOOL-COMPLETION DATE	INTERNSHIP, RESIDENCY & FELLOWSHIP-COMPLETION DATES	LAST POSITION
DEPARTMENT OF MEDICINE						
Charles F. Moldow	Clinical	Associate Professor	Hematology	State University of New York Brooklyn, N.Y 1964	Internship - Bellevue Hospital New York, NY 7/64-6/65 Residency - Bellevue Hospital New York, NY 7/65-6/66 Hematology Research Fellow New York University Medical Ctr. New York, NY 7/68-8/70	Director Hematology/Oncology Henn. Cty. Med.Ctr Mpls, MN 1/80-6/82 Chief, Medical Service VA Medical Center Mpls. MN 6/82-present
George Sopko	Attending	Assistant Professor	Cardiology	Case Western Reserve University Cleveland, Ohio 1973	Internship - D. C. General Hospital, Georgetown Service Washington, D.C. 7/73-6/74 Residency - D. C. General Hospital, Georgetown Service Washington, D.C. 7/74-6/76 Fellowship - University of Vermont, Cardiology Service Burlington, VT 7/76-6/78 NIH Fellow - Lab of Physiological Hygiene, Univ. of Minnesota 7/78-6/81	Asst. Prof. Med. Univ. of Minn. Lipid Research Clinic 7/81 - Present
DEPARTMENT OF PEDIATRICS						
Gregory R. Elliott	Attending	Instructor	Pediatric Pulmonary Infectious Diseases	University of Arkansas for Medical Sciences 1977 Little Rock, Arkansas	Pediatric Internship University of Arkansas Little Rock, AR 7/77-6/78 Pediatric Residency University of Arkansas Little Rock, Ark 7/78-6/80 Pediatric Fellowship University of Minnesota Hospitals & Clinics 7/80-12/82	Instructor Dept. of Peds. 1/83 - present

APPLICANTS TO THE M[illegible]CAL/DENTAL STAFF
MAY 1983

NAME & DEPARTMENT	CATEGORY	FACULTY RANK	SPECIALITY	MEDICAL SCHOOL-COMPLETION DATE	INTERNSHIP, RESIDENCY & FELLOWSHIP-COMPLETION DATES	LAST POSITION
DEPARTMENT OF PHYSICAL MEDICINE & REHABILITATION						
Mark A. Moret	Attending	Instructor	Pediatric Rehabilitation	George Washington University Washington, D.C. 1979	Pediatric Internship University of Minnesota Hospitals 7/79-6/80 PM&R Residency University of Minnesota Hospitals 7/80-12/82	Instructor, PM&R Univ. of Minn. 2/83-present

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 13, 1983

TO: MEMBERS, BOARD OF GOVERNORS

FROM: Ron Werft, Associate Director

SUBJECT: Board of Governors Bylaws

The attached set of bylaws have been prepared by Mr. Steve Dunham, University of Minnesota Attorney, in response to the recommendations of the Study Committee on Governance and Organization which were endorsed by the Board of Regents. This draft of Board bylaws is currently being reviewed by University Hospitals staff and will be discussed at the May 18 meeting of the Board of Governors. The bylaws will be initially reviewed by the Board of Regents at their June meeting for approval in July.

I hope you will be able to review this draft for discussion on May 18. Mr. Dunham will join us at the Board meeting to discuss this agenda item and will prepare a subsequent document for submission to the Board of Regents.

Thank you for your assistance in this effort. If you have any questions, please contact me at 373-8965.

RW/sds

Enclosure

DRAFT 5/3/83

Preamble

WHEREAS, the Board of Regents has determined that the operation of the University of Minnesota Hospitals and Clinics is essential to the academic, research and service missions of the University, and that the effective governance and management of the University of Minnesota Hospitals and Clinics is complicated by unique problems in the health care field which require diligent attention and special governance and management; and

WHEREAS, in 1974 the Board of Regents established a subordinate governing board to govern and manage the University of Minnesota Hospitals and Clinics and adopted Bylaws to describe the authority and responsibility of that board; and

WHEREAS, the Board of Regents has determined to revise the governance structure and the delegated authority and responsibility as provided in the Bylaws of the University of Minnesota Hospitals and Clinics.

THEREFORE, BE IT RESOLVED, that the Board of Regents hereby adopts the University of Minnesota Hospitals and Clinics Bylaws, 1983, and thus reconstitutes the Hospitals' Board of Governors and delegates to the Board of Governors certain powers as specified herein.

ARTICLE I. Scope and Name

Section 1. Scope of Services and Facilities. The hospital and clinical services provided by the University and staffed by health sciences faculty members, and the facilities in which these services are provided, shall constitute the services and facilities governed by these Bylaws. This does not include affiliated institutions controlled and operated by anyone other than the University, outreach service programs or activities, the student health services and facilities, or purely academic and research facilities and programs.

Section 2. Name. The facilities and services described in Section 1 shall be named the "University of Minnesota Hospitals and Clinics" (also referred to as the "University Hospital," the University Hospitals," the "Hospitals," or the "University Clinics").

ARTICLE II. Board of Governors

Section 1. Membership. The Hospitals governing board shall be known as the Board of Governors. The Board shall consist of thirteen (13) voting and two non-voting members. The Vice President for Health Sciences and the Vice President for Finance shall be ex officio non-voting members. The Chair of the Council of Clinical Chiefs, the Chief of Staff and the General Director shall be ex officio voting members. The remaining ten (10) mem-

bers shall be appointed by the Board of Regents. One of these ten (10) shall be a Health Sciences student. The others shall be selected for their proven or potential governance skills as evidenced by community leadership, occupation, previous governance experience or otherwise. In selecting members the Board of Regents also considers it desirable to have broad community representation, including geographic distribution and representation of women and minority groups.

The term of office of each member shall commence as of January 1 of the year of appointment and shall be for a period of three years, except for the Health Sciences student whose term shall be for one year. Persons appointed to fill vacancies shall serve the unexpired portion of the term of the office that was vacated. The student member shall continue to serve only so long as he or she continues to be a student in good standing enrolled at the University of Minnesota. No members except ex officio members shall serve longer than three successive terms, and persons who are appointed to fill the unexpired portions of vacated positions shall be considered to have served a term only if the vacated position has at least 18 months, or in the case of the student, six months remaining at the time of the appointment. Members shall continue to serve until their successors are selected and appointed.

The terms of all members are subject to action by the Board of Regents to change the size, structure or composition of the Board of Governors.

Section 2. Powers and Reservations.

(a) Delegated Powers

(1) The Board of Governors is hereby delegated the power and authority to manage the governance and operations of the Hospitals in accordance with and except as limited by law, these Bylaws, controlling University administrative policies, and actions by the Board of Regents. The Board of Regents expressly retains authority to appoint and replace the General Director, to approve the annual budget of the Hospitals, including capital expenditures, to determine the mission of the Hospitals, and to take such other actions as it may from time to time deem appropriate, including revoking any power and authority delegated by these Bylaws. The Board of Regents expressly retains the ultimate legal duty and responsibility for the University Hospitals.

(2) In accordance with the above general delegation of authority, and subject to subsequent change by the Board of Regents, the Board of Governors shall have the following specific powers:

(i.) to take appropriate action in all matters involving the quality of patient care and

the Medical and Dental Staff ("the Medical Staff") in the Hospitals; to appoint, determine clinical privileges, reappoint, discipline, suspend, remove, limit and otherwise deal with members of the Medical Staff; to establish, approve and amend the Medical Staff Bylaws, as well as rules and regulations of the Medical Staff; and to oversee all aspects of Medical Staff operations in order to insure compliance with applicable federal and state laws and regulations the requirements of the Joint Commission on Accreditation of Hospitals;

(ii.) to take all appropriate action relating to the Hospitals' personnel administration in accordance with the Implementation Plan--Hospital Governance/Personnel jointly developed by the Vice President for Health Sciences and the Vice President for Administration and approved by the Board of Regents simultaneously with approval of these Bylaws;

(iii.) to take all appropriate action relating to the Hospitals' purchasing needs in accor-

dance with the Implementation Plan--Hospital Governance/Purchasing jointly developed by the Vice President for Health Sciences and the Vice President for Finance and approved by the Board of Regents simultaneously with approval of these Bylaws;

(iv.) to review and make appropriate recommendations regarding actions concerning financial and strategic planning, program development and physical facility planning.

(3) The Board of Regents further delegates to the Vice Presidents for Health Sciences and Administration the authority to make changes in the Implementation Plans referred to in Article II, Sections 2(a)(2)(ii) and (iii) which are consistent with the general principles set forth in those Plans and to which they agree.

(b) Reporting. All reports and recommendations of the Board of Governors to the Board of Regents shall go though the Vice President for Health Sciences and the President of the University who shall forward the reports and recommendations to the Board of Regents in the ordinary course with their own comments and recommendations.

Section 3. Meetings and Notice.

(a) Regular Meetings. Regular meetings of the Board of Governors may be held each month but no less than once per quarter at a time and place which shall be set and publicly announced by the Chair of the Board of Governors. The Regular meeting held in the month of January shall be the Annual meeting of the Board of Governors.

(b) Special Meetings. Special meetings may be called by the Chair at his/her own discretion or shall be called at the request of five (5) members of the Board at such time and place as the Chair may determine.

(c) All meetings of the Board shall be public meetings except that the Board may vote to hold a non-public meeting in those circumstances in which the Board of Regents are permitted by their Bylaws to hold a non-public meeting.

(d) Notice of the time and place and purpose of a meeting shall be given to all Board members at least one (1) day prior to the meeting. Notice may be actual notice by telephone or written notice by regular mail.

Section 4. Quorum. At least one-half of the total number of voting members shall be necessary for a quorum except that

suspension, non-reappointment or revocation of privileges of any member of the Medical Staff shall only be taken at a meeting at which at least two-thirds of the number of members are present.

Section 5. Vacancies. Any vacancy on the Board of Governors occasioned by death, resignation, or removal shall be filled by the Board of Regents. The Vice President for Health Sciences shall give notice of any vacancy to the Board of Regents as soon as practicable.

Section 6. Suspension and Removal. Only the Board of Regents shall have the power to remove or suspend a member of the Hospital Board of Governors. The Hospital Board of Governors may, by a two-thirds vote of its voting membership, recommend, for cause, the removal or suspension of any of its members. The member shall be given at least ten (10) days written notice of such meeting and the basis for the proposed removal or suspension. The member so charged shall be entitled to be represented at the meeting at which the charges are to be heard by an attorney or other representative of the member's choice.

Section 7. Indemnification of Board Members.

(a) Protection Described; Persons Covered. The Regents of the University of Minnesota shall defend, save harmless and indemnify any person against any threatened, pending or completed action, suit or proceeding,

whether civil, criminal, administrative or investigative, whether groundless or otherwise, wherever brought, by reason of the fact that he or she is or was a member of Board of Governors of the University of Minnesota Hospitals and Clinics or an officer, employee or agent of the Board of Governors or of the Regents of the University of Minnesota and was acting within the scope of his or her official capacity, against expenses including attorneys' fees, judgments, fines and amounts paid in settlement actually and reasonably incurred.

(b) Eligibility Criteria; Certain Conduct Not Protected. This provision shall apply only in those cases where the person acted in good faith and in a manner s/he reasonably believed to be in or not opposed to the best interests of the the Regents of the University of Minnesota or The University of Minnesota Hospitals and Clinics, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful. This provision shall not apply in the event of malfeasance in office or willful or wanton neglect of duty or other actions. Furthermore, this provision shall only apply in those cases where the person seeking indemnification has given prompt notice of the action, suit or proceeding to the designated representative of the Regents of the University of Minnesota

Section 8. Compensation of Board Members and Committee Members. No Board member or any member of any committee of the Board shall receive any compensation for any services rendered in their capacity as a member. This shall not preclude any Board member or committee member from receiving compensation from the University for other services actually rendered or for actual expenses incurred as a member or in any other capacity.

ARTICLE III Officers

Section 1. Officers. The officers of the Board of Governors shall consist of a Chair, a Vice Chair, the General Director, and the Secretary. The Chair and the Vice Chair shall be elected by the Board of Governors at their Annual Meeting.

Section 2. Chair. The Chair shall appoint the Secretary and preside at all meetings of the Board of Governors. S/he shall make an annual report to the Board of Regents and such other reports as either the Board of Regents or the Board of Governors shall direct. S/he shall prepare the order of business for all meetings including any matters which may be ordered by the Board of Governors. S/he shall perform all of the acts usually attendant upon the office of Chair, shall appoint the members and chairs of all committees except the Executive Committee and the Chair of the Joint Conference and Accreditation Committee and shall be an ex officio member without vote of all standing and special committees.

Section 3. Vice Chair. During the absence or inability of the Chair to act, the Vice Chair of the Board of Governors shall perform the duties and exercise the powers of the Chair. Also, the Vice Chair shall serve as the Chair of the Joint Conference Committee.

Section 4. Secretary. The Secretary of the Board of Governors shall be appointed by the Chair of the Board from its members or from the administrative staff of the Hospitals. The Secretary shall provide the Chair with an agenda for each meeting, keep a faithful, correct and full record of the minutes of the meetings of the Board of Governors, furnish timely copies to each member of the Board and to the President of the University, and insure that copies of all minutes of the Board and its committees are sent promptly to the Secretary of the Board of Regents. S/he shall be the custodian of and shall faithfully keep all records of the various committees, including the books, records, documents, valuable papers and details covering the history and statistics of the Hospitals. S/he shall be responsible for the giving of all notices and attend to all correspondence which may be ordered by the Board of Governors. S/he shall perform such other duties as may be generally attributable to the office of the Secretary. S/he shall be authorized to designate Assistant Secretaries to help in keeping any of the foregoing minutes and records.

Section 5. General Director. The General Director shall be the chief executive officer of the Hospitals responsible for its operations. The General Director shall report for administrative purposes to the Vice President for Health Sciences. S/he shall report to the Board with respect to all matters delegated to the Board by these Bylaws and s/he shall report to the Vice President for Health Sciences with respect to all other matters. In accordance with and as limited by University policies and the authority delegated to the Board by these Bylaws (see in particular Article I, Section II (2)(a)(i), and 2(a)(2)(i)(ii)(iii) and (iv)), the specific authority and duties of the General Director shall be:

(a) To be accountable for carrying out all policies established by the Board of Governors.

(b) To work with the Medical Staff, the health science schools and colleges and with all those concerned with the rendering of professional health care services in the Hospitals to assure the achievement and maintenance of high standards of medical practice and patient care.

(c) To prepare an annual budget showing the expected receipts and expenditures as required by the Finance Committee. To select, employ, control, and discharge all employees. To develop and maintain personnel policies and practices for the Hospitals.

(d) To see that all physical properties are kept in good state of repair and operating condition.

(e) To supervise all business affairs and to ensure that all funds are collected and expended to the best possible advantage.

(f) To insure that all members of the Medical Staff comply with the Bylaws, rules and regulations and standards of practice of the Hospitals and the Medical Staff.

(g) To submit regularly to the Board of Governors or its authorized committees periodic reports concerning the professional service and financial activities of the Hospitals and to prepare and submit such special reports as may be required by the Board of Governors.

(h) To attend all meetings of committees of the Board of Governors or to designate an assistant to attend such meetings.

(i) To hire and replace assistants to aid in all his or her duties, to fix their titles, powers, duties and pay, and to delegate to them portions of his or her authority as s/he shall see fit.

(j) To perform any other duty that may be necessary to carry out the authority delegated to the General Director by these Bylaws.

Section 6. Compensation of Officers. Officers of the Board of Governors, with the exception of the General Director, Secretary or Assistant Secretaries, shall not receive any compensation for any services rendered in their capacity as an officer. This shall not preclude any officer from receiving compensation from the University for other services actually rendered or for actual expenses incurred for serving the Hospitals as an officer or in any other capacity.

ARTICLE IV Standing Committees

Part A: Executive Committee

Section 1. Composition. The Executive Committee shall consist of the Chair of the Board, the Vice Chair, the General Director, the Chair of the Council of Clinical Chiefs, the Chief of Staff and the Chairs of the standing committees of the Board. Any standing committee chair may, when absent, designate a member of the comittee to represent him or her, with vote, at any meeting of the Executive Committee. The Secretary or a designee shall attend all meetings of the Executive Committee and act as its secretary.

Section 2. Duties. The Executive Committee shall be responsible for the promulgation of policy for the guidance of the General Director to promote the efficiency of the work in the Hospitals, subject to all policies of the Board of Governors. The Executive

Committee shall have power to transact all regular business of the Board during the interim between the meetings of the Board of Governors.

Section 3. Meetings. The Executive Committee shall meet at the call of the Chair as often as necessary to accomplish its duties.

Part B: Planning and Development Committee

Section 1. The Planning and Development Committee shall consist of a Chair, at least two other members of the Board of Governors, two members of the Medical Staff and two members of the Hospitals management as designated by the General Director. The University Vice President for Finance, or a designee, and the University Vice President for Health Sciences, or a designee, shall be ex officio, non-voting members of the Committee.

Section 2. Duties. The Committee shall be responsible for reviewing and monitoring programmatic planning and capital development and the physical status of the Hospitals (including additions, alterations, repair and maintenance) and for formulating appropriate recommendations to the Board of Governors.

Section 3. Meetings. The Committee shall meet at the call of the Chair as often as necessary to accomplish its duties.

Part C: Finance Committee

Section 1. Composition. The Finance Committee shall consist of a Chair, at least two other members of the Board of Governors,

two members of the Medical Staff, and two members of the Hospitals management as designated by the General Director. The University Vice President for Finance, or a designee, and the Vice President for Health Sciences or a designee shall be ex officio non-voting members of the committee.

Section 2. Duties.

(a) The Committee shall be responsible for reviewing and monitoring the finances of the Hospitals, for examining the monthly financial reports from the General Director, and for formulating appropriate recommendations to the Board of Governors.

(b) The Committee shall be responsible for the preparation and submission to the Board of Governors at its last meeting before the end of the fiscal year of a budget showing the expected receipts, income and expenditures for the ensuing year for its review, recommendations, and transmittal to the Board of Regents. The Committee shall be further responsible for the examination of the monthly financial reports, preparation of a quarterly report for submission to the Executive Committee and such other financial reports as may be required.

Section 3. Meetings. The committee shall meet at the call of the Chair as often as necessary to accomplish its duties.

Part D. Joint Conference and Accreditation Committee

Section 1. Composition. The Joint Conference and Accreditation Committee shall be made up of equal numbers of lay Board and Medical Staff representatives and shall be composed as follows: the Vice Chair of the Board of Governors, who shall be Chair of this Committee, the General Director, the Chief of Staff, at least two other members of the Board of Governors, and at least two other members of the Medical Staff with equal numbers selected by the Medical Staff Hospital Council and the Council of Clinical Chiefs.

Section 2. Duties. The Joint Conference and Accreditation Committee shall be a forum for the discussion of matters of the Hospitals' medical policy and practice, relating to efficient and effective patient care. All recommendations of any committee of the Medical Staff to the Board shall first be sent to the Joint Conference and Accreditation Committee for its consideration and recommendation before being acted upon by the Board. The Committee shall perform such other duties as shall be given it by the Board of Governors and shall also have the following specific duties:

(a) To acquire and maintain J.C.A.H. accreditation for which purpose it shall form a committee that includes key Hospitals' personnel who are involved in implementing the accreditation program. From time to time,

it shall require that the Joint Commission's survey forms be used as a review method to estimate the accreditation status of the Hospitals and it shall supervise a trial survey during the interim year between regular Joint Commission on Accreditation of Hospital surveys for purposes of constructive self-criticism. It shall identify areas of suspected non-compliance with Joint Commission on Accreditation of Hospital standards and shall make recommendations to the Executive Committee of the Board of Governors and to the Medical Staff for appropriate action;

(b) To develop and maintain methods for the protection and care of patients and others in the event of disaster. Specifically, it shall adopt and periodically review a written plan to safeguard patients at the time of an internal disaster, particularly fire, and shall assure that the plan is rehearsed at least four times a year. It shall adopt and periodically review a written plan for the care, reception and evaluation of mass casualties. It shall assure that such plan is coordinated with the inpatient and outpatient services of the Hospitals, that it adequately reflects developments in the hospital community and the anticipated role of the Hospitals in the event of disasters in nearby communities, and that the plan is rehearsed by key personnel at least twice a year;

(c) To make recommendations to the Board of Governors on all applications for appointment or reappointment to the Medical Staff of the Hospitals and on all other matters dealing with suspension or revocation of privileges of members of the Medical Staff;

(d) To recommend to the Board of Governors the professional privileges permitted each member of the Medical Staff;

(e) To recommend to the Board of Governors all Bylaws, rules and regulations for the control of the Medical Staff, or amendments thereto, that it may consider necessary to assure proper patient care;

(f) To make recommendations to the Board of Governors regarding any communications, requests or recommendations presented by the Medical Staff through its duly authorized representatives;

(g) To receive and consider all reports on the work of the Medical Staff and make such recommendations to the Board of Governors as the Committee considers to be in the best interest of the Hospitals;

(h) To receive and consider issues that may arise in the planning and operation of the Hospitals that affect the relationship of the Board, Hospitals' management and Medical Staff.

Section 3. Meetings. The Joint Conference and Accreditation Committee shall meet at least nine times a year.

Part E. Other Committees

The Executive Committee may create such additional committees as it deems necessary including, for example, a committee to review these Bylaws periodically and make recommendations for amendments.

Section 3. Meetings. The Joint Conference and Accreditation Committee shall meet at least nine times a year.

Part E. Other Committees

The Executive Committee may create such additional committees as it deems necessary including, for example, a committee to review these Bylaws periodically and make recommendations for amendments.

ARTICLE V Medical Staff

Section 1. Organization of the Medical Staff. The Board of Governors shall authorize the organization of the Medical Staff to discharge those duties and responsibilities delegated to the Medical Staff by the Board of Governors and specifically to accomplish the following purposes:

(a) To monitor the quality of medical care in the Hospitals and make recommendations thereon to the Board so that

all patients admitted to or treated at any of the facilities, departments or services of the Hospitals shall receive the best possible care;

(b) To recommend to the Board concerning the appointment or reappointment of an applicant to the Medical Staff of the Hospitals, the clinical privileges such applicant shall enjoy in the Hospitals and appropriate action that may be necessary in connection with any member of the Medical Staff, to the end that at all times there shall be a high level of professional performance of all persons authorized to practice in the Hospitals;

(c) To adequately represent the physicians and dentists of the Hospitals to provide a means for discussing issues concerning the Medical Staff and the Hospitals within the Medical Staff organization and with the Board of Governors and the General Director;

(d) To establish specific rules and regulations to govern actions of members of the Medical Staff.

Section 2. Bylaws of the Medical Staff. The Bylaws, rules and regulations setting forth Medical Staff organization and government in such a manner to accomplish the purposes set forth in Section 1 of this Article shall be recommended by the Medical Staff, and Bylaws, rules and regulations as are adopted by the

Board of Governors shall then become effective and shall then become part of the Bylaws, rules and regulations of the Hospitals.

Section 3. Appointment to the Medical Staff and Assignment of Clinical Privileges. The Board of Governors shall appoint graduates of recognized medical and dental schools meeting the minimum personal and professional qualifications prescribed in the Medical Staff Bylaws to membership on the Medical Staff of the Hospitals and shall assign clinical privileges to them. Physicians so appointed shall have full responsibility for the treatment of the individual patient subject only to such limitations as the Board of Governors and its designees may impose, and to the Bylaws, rules and regulations of the Medical Staff as adopted by the Board of Governors. Initial appointments shall be provisional staff appointments. During provisional appointments the physicians shall serve in their designated service under the observation of designated members of the attending staff as to their clinical competence and other qualifications under the Medical Staff Bylaws. The provisional appointment requirement may be waived by the Board of Governors in the case of certain physicians whose experience or proposed role at the Hospitals warrants such a waiver, as determined in the sole discretion of the Board. A physician shall be eligible for regular appointment to membership on the attending staff after serving a provisional appointment of at least six months. Regular appointments to the attending staff shall be for one year only, renewable each year

in accordance with the reappointment procedures and promotion procedures set forth in the Medical Staff Bylaws. Reappointments to the Medical Staff shall be made at the regular June meeting of the Board of Governors. Materials provided by an applicant for medical staff membership and privileges and other information which is gathered in the credentialling process shall be available for review by the applicant, the Board, the Hospitals administrative staff, medical staff officers, members and committees, and their representatives, for use in conducting their official duties, but shall not be released to any other person unless required or authorized by law or by the authorization of the medical staff member or applicant.

Section 4. Procedures for Board Actions Pertaining to Medical Staff Members or Applicants for Membership.

(a) At its next regular meeting after receipt of a recommendation from the Joint Conference Committee concerning an applicant for Medical Staff membership or concerning a member of the Medical Staff the Board of Governors shall consider the recommendation. The Board's decisions on Medical Staff membership are final and conclusive.

(b) At any time in its consideration of such recommendations, the Board may in its absolute discretion defer

final determination by referring the matter to a committee of its choice for further consideration. Any such referral shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendations, the Board shall consider the matter further.

(c) Whenever the Board of Governors determines on its own motion and without prior Joint Conference Committee action to decrease the clinical privileges of a member of the Medical Staff or revoke his or her staff membership, the Board shall refer such determination to the Joint Conference Committee for its consideration and recommendation. Whenever the Board of Governors determines to reject a recommendation of the the Joint Conference Committee favorable to an applicant for staff membership, either with respect to membership or to clinical privileges, or determines to reject a recommendation of the Joint Conference Committee favorable to a Medical Staff member with respect to reappointment, promotion in staff category or increase in clinical privileges, before taking final action the Board shall notify the applicant or Medical Staff

member in writing, sent by certified mail or registered mail, return receipt requested, of this decision of the Board. Such applicant or staff member shall have 10 days following the date of receipt of such notice within which to request a hearing by a Hearing Committee to be appointed by the Board. Request for a hearing shall be by notice to the General Director in writing, sent by certified or registered mail, return receipt requested. In the event the applicant or Medical Staff member does not request a hearing within the time and in the manner required, s/he shall be deemed to have accepted the action involved and it shall become effective immediately. If a hearing is requested it shall be conducted under the procedures set forth in Article VII of the Medical Staff Bylaws, with the following exceptions: (a) the members of the Hearing Committee shall be appointed by the Board of Governors and, (b) at the conclusion of the hearing, the committee's decision and report shall be sent directly to the Board for action. Thereafter, the applicant or staff member or the Credentials Committee of the Medical Staff shall have the right to an appeal to the Board of Governors which shall be conducted under the procedures set forth in Article VII, Part D, of the Medical Staff Bylaws.

(d) When the Board finally acts in the matter it shall send notice of such decision through the General Director by certified or registered mail, return receipt requested, to the applicant or staff member involved as well as to the Chief of Staff of the Hospitals and the Credentials Committee of the Medical Staff and the clinical service concerned. The procedure provided for above and in the Medical Staff Bylaws, Article VII, shall be the exclusive procedure for review and appeal, and the applicant or staff member shall not have recourse to a review of the matter by any other body or review tribunal.

(e) If an application is finally denied by the Board of Governors, the applicant after the expiration of one year from the date of such denial may reapply for membership on the Medical Staff unless the Board of Governors provides otherwise in the formal written denial.

(f) After the Board of Governors agrees to the appointment or reappointment of an applicant to membership on the Medical Staff, the General Director shall make available to that applicant a copy of the Bylaws and rules and regulations of the Hospitals and of the Medical Staff in force at that time. The applicant shall sign a statement furnished him or her by the

General Director that states that s/he has read and understood these Bylaws, rules and regulations and that s/he specifically agrees to the following undertakings:

(1) An obligation as a member of the Medical Staff to provide continuous care and supervision to all patients within the Hospitals for whom s/he has responsibility.

(2) An agreement to abide by all such Bylaws, policies and directives of the Hospitals, including all such Bylaws, rules and regulations as shall be given to him or her by the Board of Governors and the Medical Staff.

No appointment or reappointment shall take effect until such a statement has been signed by the individual concerned.

(g) Any member of the Medical Staff whose engagement in an administrative role in the Hospitals requires membership in the Medical Staff shall not have his or her Medical Staff membership or privileges terminated or limited without being afforded full access to the procedural rights provided in the Medical Staff Bylaws, Article VII.

Section 5. Medical Staff Clinical Services.

(a) The Board may delegate to clinical services, through approval of the Medical Staff Bylaws or by appropriate Board resolution, certain responsibility in monitoring the quality of medical care in the Hospitals and the authority and responsibility to make recommendations to the Board concerning an applicant's appointment, reappointment and privileges to the Medical Staff of the Hospitals.

(b) After consultation with the Joint Conference Committee, at its June meeting each year, the Board of Governors shall appoint the chief of each clinical service of the Medical Staff to serve at the discretion of the Board for an intial term of three years, except in the case of a chief of a clinical service who is an individual other than the Head of the corresponding medical or dental school clinical department, in which case the initial appointment shall be for one year. Vacancies in the office of the chief of a clinical service may be filled at any time by the Board. In the event that a chief of a clinical service is appointed at some time other than the June meeting, and if the appointment is made no later than December, for purposes of determining the time of reappointment the appointment shall be deemed to have commenced the preceding June. In the event that the appointment is made after December, for

purposes of determining the time or reappointment the computation of time shall be deemed to commence at the next succeeding June.

(c) All clinical services shall be directly responsible to the General Director for all matters of administration.

Section 6. Medical Staff Committees.

(a) The Board may delegate, through approval of the Medical Staff Bylaws or by appropriate Board resolution, to certain committees of the Medical Staff responsibility for monitoring the quality of medical care in the Hospitals and the authority to make recommendations to the Board concerning an applicant's appointment, reappointment and clinical privileges to the Medical Staff of the Hospitals.

(b) At its June meeting each year, the Board of Governors shall appoint committee chairs of all Medical Staff committees except the Medical Staff Hospital Council, the Council of Chiefs of Clinical Services and the Nominating Committee to serve at the discretion of the Board for an initial term of two years. These appointments shall be made after receiving recommendations from the Medical Staff Hospital Council through the Joint Conference Committee. Thereafter, committee

chairs may be reappointed by the Board from year to year. Members of each Medical Staff committee with the exception of the Medical Staff Hospital Council and the Council of Chiefs of Clinical Services shall be appointed yearly by the Chief of Staff with no limitation in the number of terms they may serve.

ARTICLE VI Hospital Auxiliaries

Section 1. Composition. The Board of Governors shall be authorized to designate volunteer activities for the Hospitals and shall provide for their coordination as an integral part of the Hospitals' operations. These activities may be performed by but not limited to the University Hospitals Volunteer Association, the Masonic Memorial Auxiliary, the Women of Variety Tent #12, the Faculty Women's Club - Hospital Auxiliary, and such other support volunteers as the Board may from time to time recognize.

Section 2. Duties. Volunteer activities may include but are not limited to performing patient-related services within or outside the Hospitals, conducting fundraising activities and community service projects, entering into contracts as approved by the General Director or a designee, and carrying on other such activities necessary to accomplish their purposes as approved by and coordinated through the Office of Volunteer Services.

ARTICLE VII Amendments

Section 1. These Bylaws may be amended or replaced in whole or in part at any regular meeting of the Board of Regents by majority vote of the members present at the meeting.

Board of Governors

University of Minnesota Hospitals and Clinics

April 20, 1983

Minutes

CALL TO ORDER: The April 20, 1983 meeting of the Board of Governors was called to order at 1:35 p.m.

ATTENDANCE:

Present:
David Cost, Acting Chair
Harry Atwood
Al France
Robert Goltz, M.D.
Robert Latz
Tom Madison
J. E. Meilahn
Barbara O'Grady
C. Edward Schwartz
Lori Steiber
Timothy Vann
Neal Vanselow, M.D.

Absent:
Fred Bohen
Paul Quie, M.D.

Guests:
Sally Pillsbury
Jo-Anne Barr
Leonard Bienias
Dionisa Coates
Debbie Gruye
Al Hanser
Fannie Kakela
Mary Lebedoff
Paul Winchell, M.D.
George Winn

MINUTES APPROVED: It was moved that the minutes of the meeting held March 16, 1983 be approved as submitted. The motion was seconded and passed unanimously.

INTRODUCTIONS: Ms. Sally Pillsbury introduced members of the Board of Governors whose terms were ending and those newly appointed. Following a brief report on the activities of the West Metro Trustee Council, she passed the gavel to Dr. Neal Vanselow, Vice President for Health Sciences, who presided until the election of an acting chair.

ELECTION OF ACTING CHAIR:

Mr. David Cost was nominated for Acting Chair of the Board of Governors. The nomination was seconded. There being no further nominations, it was moved that Mr. Cost serve as Acting Chair until such time that the Board of Governors elect officers for the remainder of 1983. The motion was seconded and passed unanimously. Vice President Vanselow passed the gavel to Mr. Cost who chaired the remainder of the meeting.

FINANCE/ PLANNING & DEVELOPMENT COMMITTEE REPORT:

Mr. Al France introduced the report of the joint meeting of the Finance Committee and the Planning and Development Committee held April 20, 1983. Mr. Cliff Fearing presented the 1983-84 operating budget indicating that University Hospitals was confronted with two major changes in planning for the next fiscal year: TEFRA regulations (Tax Equity and Fiscal Responsibility Act) and the 1982 series bond requirements along with feasibility study guidelines. He then presented budget objectives for 1983-84 as follows:

1. To provide the capital and operating resources that are necessary and essential to fulfill the Hospitals' mission.

2. To reinforce the need for cost containment among the management and medical staff at the Hospitals, by communicating through the limitations imposed by the approved budget, the need for fiscal restraint and budgetary accountability.

3. To restrict the price increases necessary from the effects of cost-shifting to the levels identified in the financial feasibility study. More specifically, to operate the Hospitals within the financial limitations imposed by TEFRA, including the Section 223 and target rate increase limitations.

4. To provide the cash flow necessary to fund the financial obligations resulting from the Renewal Project bonding, consistent with the targets established in the financial feasibility study and the legal obligations contained within the Bond Indenture.

Mr. Fearing then reported on the price increases required to finance expected increasing costs, revenue deductions, and renewal project cash flow needs for 1983-84 indicating that at 9.70% increase in prices and a 9.85% increase in total patient charges would meet these requirements. He reported that this would increase total patient charges to $188,871,500 for fiscal year 1983-84 and added that this compares to a 10.38% increase in total patient charges forecast in the 1982 Touche Ross Feasibility Study. Mr. Fearing then presented detailed schedules included in the budget letter to the Board of Governors Finance Committee from C. Edward Schwartz.

1983-84 BUDGET APPROVED:

It was moved that the 1983-84 Operating Budget be approved as submitted to the Board of Governors. The motion was seconded and passed unanimously.

BAD DEBT REPORT:

Mr. Al France presented the Bad Debt Report for the Third Quarter of the 1982-83 fiscal year. He recommended that $924,828.52 be written off as bad debt for the third quarter. In response to a question Mr. Fearing indicated that this represented 1.9% of gross charges compared to a budget of 2.5%. The motion was seconded and passed unanimously.

CAPITAL BUDGET APPROVED:

Mr. Harry Atwood introduced Capital Budget for 1983-84 indicating that the budget had received careful analysis by the Planning and Development Committee and the Finance Committee. Mr. Greg Hart presented a detailed report of the components of the capital budget (attached). Mr. Atwood moved that the board approve a capital budget for 1983-84 of $4.9 million. The motion was seconded and passed unanimously.

3/31/83 FINANCIAL STATEMENTS:

Mr. Greg Hart presented the third quarter financial report indicating that admissions were 3.3% over budget, patient days were also 3.3% above budget, and outpatient clinic visits were 4.0% above projected visits through the third quarter. He reported that the operations position was quite favorable as of March 31, 1983, and that the accounts receivable were down to 70 days, the lowest accounts receivable in University Hospitals records. Mr. Hart further reported that revenue over expense for the period of July 1, 1982 through March 31, 1983 amounted to $7,476,371 - 7.5% of budgeted total patient charges.

JOINT CONFERENCE COMMITTEE REPORT:

Mr. David Cost presented the report of the Joint Conference Committee of April 19, 1983. He reported that the Medical Staff Hospital Council had approved in concept the development of a nutrition support team presented by Dr. Frank Cerra. He added that the committee also reviewed the functions of the Joint Conference Committee and suggested that quality assurance and accreditation were the most important functions of this group. He further reported that the committee had received a report on the Joint Commission on Accreditation of Hospitals reconsideration of medical staff organization. He indicated that this issue focuses on potential limitation of membership on hospital medical staffs and the anti-trust implications thereof. It was added that the outcome of the JCAH deliberations on this subject would not be known until August, 1983.

HOSPITAL DIRECTOR'S REPORT:

Mr. C. Edward Schwartz reported that progress had been made on the implementation of the decentralization of personnel and purchasing functions. He reported that task forces had been appointed and that the hospital representatives for personnel and purchasing were Mr. Greg Hart and Mr. Ed Howell respectively. He further reported that Vice President Neal Vanselow had appointed

a committee to explore multi-institutional arrangements for University Hospitals and Mt. Sinai Medical Center. He added that the report of this working group would be completed during the summer.

Mr. Schwartz then reported on the Liver Transplant Policy indicating that the draft policy had been discussed with the Departments of Medicine, Surgery, and Pediatrics. He added that the policy would be brought back to the Board of Governors when it reached its final form.

In regard to staff considerations, Mr. Schwartz reported that the list of candidates for Hospital Attorney had been narrowed to 12 and that 6 had been interviewed at this time. He added that Mr. John Diehl had proposed an alternative mechanism to meet the hospitals' legal requirements. He further reported that 75 individuals had applied for the Director of Planning and Marketing position and that applications were now closed.

Finally, Mr. Schwartz reported that the University Hospitals Dental Clinic had opened on the 7th floor of the Phillips Wangensteen Building.

REPORT OF THE CHAIR: Mr. David Cost appointed an Executive Committee to function in lieu of Board of Governors committees until officers were elected and such committees were formed. He appointed Mr. Harry Atwood, Mr. Al France, Dr. Robert Goltz, Dr. Paul Quie, Mr. Ed Schwartz and himself to serve as an executive committee of the Board of Governors.

Mr. Cost then appointed a Nominating Committee to recommend a slate of candidates for officers of the Board of Governors. To this committee he appointed Mr. Harry Atwood as Chairman, Ms. Timothy Vann, and Mr. J. E. Meilahn. Mr. Cost asked that the Nominating Committee present its recommendations at the May 18th meeting of the Board of Governors.

It was then indicated that Board Members would be asked their preference for committee assignment. Mr. Ron Werft will distribute a survey along with the Board of Governors Bylaws to members to determine their interest in committee membership. In response to a question regarding the bylaws, Vice President Vanselow indicated that the revised bylaws of the Board of Governors would come before the Board prior to their submission to the Board of Regents for final approval.

ADJOURNMENT: There being no further business, Mr. Cost adjourned the meeting at 3:50 p.m.

Respectfully submitted,

Ron Werft

Ron Werft
Executive Secretary
to the Board of Governors

PROPOSED CAPITAL EQUIPMENT & REMODELING RENOVATION BUDGET FOR FISCAL YEAR 1983-84

The Capital Equipment and Remodeling/Renovation budget for fiscal year 1983-84 includes the following components:

Equipment		$ 4,173,827
Remodeling/Renovation		769,875
	TOTAL	$ 4,943,702

The attached pages contain analyses of the following components:

Page 1 - Equipment Budget by Department
Page 2 - Equipment Items of $50,000 or more
Page 3 - Remodeling/Renovation Budget by Department
Page 4 - Certificate of Need Items

EQUIPMENT BUDGET BY DEPARTMENT

DEPARTMENT	EQUIPMENT BUDGETED AMOUNT
AMBULATORY SURGERY	$ 59,200
ANESTHESIOLOGY	30,900
BIOMEDICAL ENGINEERING	9,500
COMMUNICATIONS CENTER	850
ENVIRONMENTAL SERVICES	15,754
HOSPITAL PERSONNEL	925
INFECTION CONTROL	3,640
LABS	701,578
MAINTENANCE & OPERATIONS	2,000
MATERIALS MANAGEMENT	164,225
MEDICAL RECORDS	11,166
NURSING	116,650
NUTRITION	14,200
OPERATING ROOM	222,753
OUTPATIENT	80,583
PATIENT ACCOUNTING	10,000
PATIENT MONITORING	391,000
PHARMACY	8,900
PROTECTION SERVICES	1,500
RADIOLOGY	1,286,000
REHABILITATION	19,145
RESPIRATORY THERAPY	208,700
THERAPEUTIC RADIOLOGY	229,873
COMPUTER SERVICES	584,785
TOTAL	$4,173,827

EQUIPMENT ITEMS OF $50,000 OR MORE

DEPARTMENT	ITEM	COST
LABS	Centrifugal Analysis (2 @ $58,000)	$ 116,000
PATIENT MONITORING	Monitoring System CCU/201	145,000
RADIOLOGY	Tomographic Unit	70,000
	GI R/F Unit	325,000
	GI R/F Unit	325,000
	CT Scanner	400,000
THERAPEUTIC RADIOLOGY	VAX Treatment Planning Computer	194,175
COMPUTER SERVICES	Data Communication Equipment	241,853
	B7850 Software	200,697
	FRS	50,000
	TOTAL	$ 2,067,725

NOTE Individual Capital Equipment items subject to re-prioritization pending further review.

REMODELING/RENOVATION BUDGET BY DEPARTMENT

DEPARTMENT	REMODELING BUDGET AMOUNT
AMBULATORY SURGERY	$ 3,500
HOSPITAL PERSONNEL	1,000
INFECTION CONTROL	30,600
LABS	50,415
MAINTENANCE & OPERATIONS	59,000
MATERIALS MANAGEMENT	28,500
MEDICAL RECORDS	2,440
NURSING	101,305
NUTRITION	1,160
OPERATING ROOM	13,900
OUTPATIENT	19,600
PATIENT ACCOUNTING	2,900
PHARMACY	56,500
RADIOLOGY	150,000
REHABILITATION	10,250
SOCIAL SERVICE	600
THERAPEUTIC RADIOLOGY	1,365
VOLUNTEERS	690
COMPUTER SERVICES	236,150
TOTAL	$ 769,875

RE-OCCURRING CAPITAL EQUIPMENT/REMODELING ITEMS REQUIRING CERTIFICATE OF NEED

CT Scanner	$ 500,000

Minutes

Joint Conference Committee

April 19, 1983

ATTENDANCE:

Present: David Cost, Chairman
Edward Ciriacy, M.D.
John Delaney, M.D.
Debbie Gruye
Fannie Kakela
Arthur Klassen, M.D.
Robert Maxwell, M.D.
Timothy Vann

Absent: Richard Kronenberg, M.D.
William Krivit, M.D.
Mary Lebedoff
Paul Quie, M.D.
Jack Quistgard
C. Edward Schwartz

Staff: John Diehl
Greg Hart

Guests: Nancy Janda
Ron Werft

APPROVAL OF MINUTES:

The minutes of the March 15, 1983 meeting of the Joint Conference Committee were approved as submitted.

MEDICAL STAFF HOSPITAL COUNCIL REPORT:

Dr. Maxwell reported on behalf of the Medical Staff Hospital Council. He indicated that the primary agenda item at the April meeting of the Council was a proposal for the establishment of a nutritional support service team. This proposal, made by the Pharmacy and Therapeutics Committee and Dr. Frank Cerra, includes the creation of the role of medical director for nutritional support services, as well as the creation of a subcommittee of the Pharmacy and Therapeutics Committee. The intent of these organizational changes is to assure, through a centralized educational and consultative group, the most appropriate use of nutritional therapy. The Medical Staff Hospital Council approved the organizational elements of this proposal.

JCAH STANDARDS REVISIONS: Mr. Hart indicated that another item for discussion at the Medical Staff Hospital Council meeting, as well as a recent Clinical Chiefs meeting, was a revision being proposed in the Medical and Dental Staff Standards of the JCAH. This revision involves redefining the potential membership on the organized medical staff. As it currently exists, only physicians and dentists are allowed full membership on the medical staff, according to JCAH guidelines. Under the new concept, each hospital, at its discretion, may add other professional groups to what will now be termed the "organized staff". Mr. Hart indicated that the JCAH is scheduled to discuss this matter at its April board meeting.

There was discussion of this change both from the point of view of hospitals generally and University Hospitals specifically. Mr. Hart indicated that no bylaws changes are mandated at this point.

OTHER: The Committee discussed its past activities and role. Conclusions included the preference for more indepth review of the credentialing process by the Joint Conference Committee, continuation of committee and clinical program presentations as an informational base, more periodic review of Quality Assurance work plan status, and the need for all Board members to serve as members of the Joint Conference Committee during their tenure as Board members.

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

Respectfully submitted,

Greg Hart/e

Greg Hart

UNIVERSITY OF MINNESOTA
Office of the Vice President for Finance and Treasurer
301 Morrill Hall
100 Church Street S.E.
Minneapolis, Minnesota 55455
(612) 373-5940

May 3, 1983

The Honorable Charles H. Casey
The Honorable William B. Dosland
The Honorable Willis K. Drake
The Honorable Erwin L. Goldfine
The Honorable Lauris Krenik
The Honorable David M. Lebedoff
The Honorable Verne Long
The Honorable Charles F. McGuiggan
The Honorable Wenda W. Moore
The Honorable David K. Roe
The Honorable Mary T. Schertler
The Honorable Michael W. Unger

Dear Ladies and Gentlemen:

I am writing today to follow-up my earlier letter of March 9th, 1983 (attached) concerning the possible desirability of an advance refunding of the Hospital Bond Issue of December, 1982.

With interest rates in the tax-exempt market trending gradually, but steadily downward over the last 75 days, and with a favorable outlook for continuation of this trend for at least the remainder of this fiscal year, I believe the University in its own economic interest should re-enter the capital markets between now and June 30th, 1983 and proceed with an advance refunding of the Hospital Bond Issue. For reasons detailed below, I will seek authorization from the Board at the meeting of the Committee of the Whole on May 13th to accomplish this financing proposal.

As I indicated in my earlier letter, an advance bond refunding or defeasance is basically a substitution of a new bond issue (the "Refunding Bonds") for an existing bond issue (the "Outstanding Bonds"). When refunding bonds are issued in advance of the payment date of the Outstanding Bonds, both issues will be outstanding until the date selected for the payment of the Outstanding Bonds (normally the earliest optional redemption dates). To avoid a doubling of the University's debt as issuer, the proceeds received from the sale of the Refunding Bonds, after all issuance costs are paid, are deposited in an escrow account with a bank or trust company and applied to the payment of the Outstanding Bonds. In our context, the net effect of a refunding would utilize the proceeds from the new bond issue to pay off the original debt; only the new debt would be paid from revenues of the Hospital.

In the wake of my letter to the Board of March 9th, we have proceeded to prepare necessary legal and financial documents that will be required for a refunding action. These efforts have included a review of the Indenture and the Official Statement, including a review by our outside auditors -- Touche Ross -- of Hospital operations and financial performance for the nine month period (July 1, 1982 -- March 31st, 1983) since the last complete outside audit.

Based on the Hospital's interim operating and financial statements, it appears that both activity levels and net revenues are running substantially ahead of the projections of the Touche Ross feasibility study of November, 1982. Admissions now appear up by 300 for the current fiscal year over the Touche Ross November projections; for the current year, patient days now seem likely to come in at 199,000, 6,000 higher than the November projection of 193,000 for the same period.

As the result of this auspicious operating and financial performance, we expect to be able to hold the very strong ratings achieved last December. As you will remember, the University is currently rated AA - by Standard and Poor's and A-1 by Moody's. Moreover, after informal, preliminary contacts with the rating agencies, our underwriters and financial advisor have informed me that we will not need a new feasibility study because of the short period of time that has elapsed since the November study, and the absence of any major adverse development in the economic/financial environment.

Although we have experienced a strong year in Hospital operations and related finance, all longer-term financial analysis and planning continues to be based on the conservative planning parameter of 175,000 patient days per year strongly counselled by consultant Robert A. Derzon of Lewin Associates, and adopted by President Magrath in April, 1982.

In sum, preparatory technical, financial and legal work is rapidly nearing completion, and the trend of interest rates is favorable. As you will remember, we finalized the debt service per patient day at $83.70 in the December Bond Issue. As of the date of this writing, we project additional bottom-line savings of $6.62 per patient day -- or about $1,150,000 per year for 30 years -- from an advanced refunding. If interest rates continue to trend downward over the weeks ahead, as we and others anticipate, we believe total net savings could be at least 10% below the original issue, and savings of this magnitude would leave us with debt service per patient day of $75-77.00.

The case for proceeding to an advance refunding before June 30th, 1983 -- probably at least two weeks prior to June 30th -- is based on two factors:

- If refunding is not accomplished before June 30th, the end of the fiscal year, we face a delay of about 60 - 75

days while the year-end audit of Hospital financial records proceeds and provides the required financial accounting of Hospital operations that prospective investors would expect;

- While there is very broad consensus on the favorable trend in interest rates over the next 30 to 90 days, the agreement erodes and dissipates for the period beyond. Many informed and expert analysts believe the combination of an improving private economy and still-large federal deficits spells interest rate trouble in the fall of 1983 and into 1984.

Accordingly, with support from President Magrath, Vice President Vanselow and the Hospital staff, and agreement by General Counsel Dunham that the University's interests have been safeguarded in the legal and financial documents now in the final stages of preparation for an advance refunding, I recommend that the Board of Regents authorize re-entry into the financial markets during the period May 13th -- June 30th, 1983 for the purpose of securing an advance refunding of the Hospital Bond Issue concluded in December, 1982 subject to the following guidance:

- That entry be timed to achieve the largest possible net savings, and only be undertaken if total net savings of $7.00 per patient day (about 8%) are indicated;

- That long bonds not be sold at rates of interest greater than 9.6%. The existing issue provides long bonds at 11.0%.

- That the total debt service be minimized and not exceed $525 million. Total debt service for the currently outstanding issue is $560,500,000. To accomplish this debt service goal, the principal amount borrowed may be somewhat larger than the $156,340,000 that was borrowed in December.

- That authority to act on a timely basis in the financial markets on the Board's behalf be clearly delegated, subject to the policy guidance outlined above, to the Vice President for Finance and Treasurer, with the concurrence of the President of the University and the Secretary of the Board of Regents.

I will be discussing this request further at the meeting of the Committee of the Whole on May 13th with Vice President Vanselow, Mr. Dunham, Mr. Schwartz and Mr. Fearing and will in the meantime be pleased to answer any questions you may have.

Sincerely,

Fred Bohm

Frederick M. Bohen
Vice President for Finance
and Treasurer

cc: President C. Peter Magrath, University Vice Presidents, Mr. Duane A. Wilson, Mr. Stephen S. Dunham, Mr. C. Edward Schwartz

UNIVERSITY OF MINNESOTA

Office of the Vice President for Finance and Treasurer
301 Morrill Hall
100 Church Street S.E.
Minneapolis, Minnesota 55455
(612) 373-5940

March 9, 1983

The Honorable Charles H. Casey
The Honorable William B. Dosland
The Honorable Willis K. Drake
The Honorable Erwin L. Goldfine
The Honorable Lauris Krenik
The Honorable David M. Lebedoff
The Honorable Verne E. Long
The Honorable Charles F. McGuiggan
The Honorable Wenda W. Moore
The Honorable David K. Roe
The Honorable Mary T. Schertler
The Honorable Michael W. Unger

Dear Ladies and Gentlemen:

I am writing today to inform you of trends in the capital markets that may suggest the need and desirability for an advance refunding of the recently concluded Hospital Bond Issue.

As you know, the University issued $156,340,000 in tax-exempt bonds for the financing of the Hospital Renewal Project in December of 1982. These bonds were issued at a time when the tax-exempt bond market had temporarily stabilized due to an uncertain economic environment and the unclear impact of new laws requiring registration of tax-exempt bonds.

Since December when the Renewal Project Bonds were issued, the long, deep national and regional recession has apparently bottomed out, and signs of economic recovery have generated continued improvement in the stock market and bond markets.

As of the first week of March 1983, the rates on tax-exempt bonds were approximately 10% below the rates at which the December 1982 Renewal Project Bonds were sold. The December 1982 bonds sold with an average coupon rate of 10.6%; current rates would be approximately 9.6% to 9.7%.

Due to this continued improvement in the tax-exempt bond markets and because the December Renewal Project Bonds cannot be redeemed (prepaid) under the optional redemption provision of the December issue until 1992, we have been evaluating another option for taking advantage of the improved interest rates. This alternative is known as an advance bond refunding or a defeasance. (The University of Minnesota is only one of many organizations facing this same issue. As of March 4, 1983, $5.7 billion of bond refundings have been announced and scheduled to be issued in the near future.)

The purpose of an advance refunding is to reduce the debt service over the remaining life of the original issue; typically, this is undertaken

when interest rates fall to a point where the debt service on the new bonds, including all new issuance costs, are demonstrably less than those of the original issue.

A refunding is basically a substitution of a new bond issue (the "Refunding Bonds") for an existing bond issue (the "Outstanding Bonds"). When Refunding bonds are issued in advance of the payment date to the Outstanding Bonds, both issues will be outstanding until the date selected for the payment of the Outstanding Bonds (normally the earliest optional redemption dates). To avoid a doubling of the issuer's debt, the proceeds received from the sale of the Refunding Bonds, after paying all issuance costs, are deposited in an escrow account with a bank or trust company and applied to the payment of the Outstanding Bonds.

The escrowed funds are invested in United States Treasury Obligations. The earnings on the United States Treasury Obligations are used to pay the debt service on the Outstanding Bonds prior to the date selected for final payment of the Outstanding Bonds. On the date selected for final payment, the maturing principal of the United States Treasury Obligations is used to pay in full the remaining principal of the Outstanding Bonds. In our contexts, the net effect of a refunding would utilize the proceeds from the new bond issue to pay off the original debt; only the new debt would be paid from revenues of the Hospital.

An assessment of the economic benefit of an advanced refunding of our existing Bond Issue as of March 4th by Merrill Lynch/White Weld, Lehman Brothers Kuhn Loeb, and Dougherty, Dawkins, Strand & Yost, Inc., indicatesthat debt service per patient day could then have been reduced by approximately $7.50 per patient day using current market interest rates, about 10% below the $83.70 per patient day costs of the current issue. (Since this is a reduction in debt service, there will be no negative impact on the Standard and Poor or Moody's bond rating because of the refunding.)

We have also received a preliminary opinion from the University's Bond Counsel, Dorsey, Windhorst, Hannaford, Whitney & Halladay, that the advanced refunding is permissible under the December Bond Indenture and also under IRS arbitrage regulations. I have also asked the University's General Counsel, Steve Dunham, to review these matters and address and resolve any internal University concerns.

The costs of preparing and issuing the Refunding Bonds will be less than with the original issue. We are advised that the underwriting syndicate is willing to issue the Refunding Bonds without a new feasibility study. However, underwriters discount costs, lawyer's fees, printing fees, travel expenses and various accounting fees will be incurred. Due to a recent decision by the Treasury Department these expenses can be included to determine the overall interest expense of the refunding issue. The

effect of this decision increases the interest rate at which the IRS will permit the proceeds of the refunding issue to be reinvested. This effectively allows the new issue costs to be paid by the increased interest earnings allowed by the Treasury Department over the life of the refunding issue (see recent Treasury Department announcement attached).

In response to those developments, I am authorizing the preliminary preparation of financial and legal information and documents that will facilitate a timely reentry by the University into the Capital markets for a new, refunding issue. I see no need to seek authority now from the Regents to accomplish this in the weeks immediately ahead. The current trend of the market is favorable, however, and if it continues as I anticipate, I expect to recommend a refunding that would occur within the next 60 - 120 days.

Vice President Vanselow, Mr. Fearing and I will be happy to answer any questions you may have.

Sincerely,

Fred Bohen

Frederick M. Bohen
Vice President for Finance
and Treasurer

FMB:pl

cc: President C. Peter Magrath
University Vice Presidents
Mr. Duane A. Wilson, Secretary
to the Board
Mr. Stephen S. Dunham
Mr. C. Edward Schwartz

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

RENEWAL PROJECT BOND MATURITY SCHEDULE

1982 SERIES BONDS

Due	Amount	Coupon Rate
1987	$ 930,000	8.000%
1988	1,005,000	8.500
1989	1,090,000	8.750
1990	1,185,000	9.000
1991	1,295,000	9.250
1992	1,410,000	9.500
1993	1,550,000	9.750
1994	1,695,000	10.000
1995	1,870,000	10.200
1996	2,060,000	10.300
1997	2,270,000	10.400
1998	-	-
2002	7,700,000	10.625
2012	41,500,000 *	10.375
2014	61,180,000	11.000
2016	29,600,000	6.750 **
	$156,340,000	

1983 SERIES BONDS

Due	Amount	Coupon Rate
1987	$ 1,365,000	6.500%
1988	1,450,000	6.750
1989	1,550,000	7.000
1990	1,660,000	7.250
1991	1,780.000	7.500
1992	1,910,000	7.750
1993	2,060,000	8.000
1994	2,225,000	8.200
1995	2,405,000	8.400
1996	2,610,000	8.500
1997	4,055,000	8.600
1998	5,345,000	8.750
2002	20,015,000	9.000
2012	57,255,000	9.250
2014	34,180,000 *	8.875
2016	27,825,000	6.500 **
	$167,690,000	

* American Municipal Bond Assurance Corporation insured bonds.

** Original Issue Discount Bonds priced to yield 10.75% and 8.75% for the Series 1982 and Series 1983 Bonds respectively.

UNIVERSITY OF MINNESOTA
TWIN CITIES

Office of the University Attorney
330 Morrill Hall
100 Church Street S.E.
Minneapolis, Minnesota 55455
(612) 373-3446

May 12, 1983

TO: Fred Bohen
Mike Dougherty
Cliff Fearing
Jerry Mahoney
Peter Seed
Duane Wilson

FROM: Steve Dunham SSD

RE: Proposed Resolution - Series 1983 Refunding Bonds

This is the form of the resolution we intend to present to the Board of Regents' Committee of the Whole meeting on Friday morning. If you have any suggested changes, please call me before Friday morning.

Thanks.

SSD:ph
Attachment

PROPOSED Resolution Authorizing the Issuance of University Hospitals and Clinics Series 1983 Refunding Bonds

WHEREAS the Regents of the University of Minnesota (the "University") have issued its $156,340,000 University Hospitals and Clinics Bonds, Series 1982 (the "Series 1982 Bonds") pursuant to an Indenture of Trust dated as of December 1, 1982;

WHEREAS the proceeds of the Series 1982 Bonds have been and will be used to construct and equip a new 432-bed replacement hospital to be known as Unit J, as was fully described in the Official Statement dated December 24, 1982;

WHEREAS interest rates have declined since the issuance of the Series 1982 Bonds and it now appears that the University may be able to lower significantly the financing costs of the Hospitals Project by issuing new Series 1983 Bonds (the "Refunding Bonds") to refund all or a portion of the Series 1982 Bonds;

WHEREAS Refunding Bonds can be issued by a First Supplemental Indenture to the Indenture of Trust dated as of December 1, 1982;

NOW, THEREFORE, be it resolved by the Regents of the University of Minnesota as follows:

1. The Vice President for Finance is authorized to approve the mailing of a Preliminary Official Statement describing the proposed Refunding Bonds.

2. The President and the Secretary are authorized to execute a Purchase Contract for the Refunding Bonds with certain investment bankers and banks for whom Merrill Lynch, Pierce, Fenner & Smith Incorporated is acting as representative (the "Bond Purchaser"). The Purchase Contract shall be in a form substantially similar to the Purchase Contract dated December 10, 1982 for the Series 1982 Bonds and shall be approved by the Vice President for Finance and the General Counsel prior to execution. The total debt service on the bonds sold under the Purchase Contract shall not exceed $525,000,000, and the interest rate on the long bonds shall not exceed 9.6%.

3. The President and the Secretary are further authorized to execute a Supplemental Indenture of Trust to the Indenture of Trust dated as of December 1, 1982. The Supplemental Indenture shall be approved by the Vice President for Finance and the General Counsel prior to execution. The Supplemental Indenture shall provide for the issuance of the Refunding Bonds to refund all or a portion of the Series 1982 Bonds. It shall also provide for the establishment of an escrow account to hold the proceeds of

the sale of the Refunding Bonds to be used to pay the principal and interest debt service on the Series 1982 Bonds thereby refunded.

4. The Vice President for Finance is authorized to approve an Official Statement for the Series 1983 Refunding Bonds in substantially the same form as the Official Statement for the Series 1982 Bonds with whatever changes are necessary to update the contents and to conform the Official Statement to the Supplemental Indenture.

5. If the President and Secretary exercise the authority delegated to them under paragraph 2 and 3 of this Resolution, and if the Vice President for Finance approves an Official Statement as authorized by paragraph 4, then they and other University officers are authorized to execute all other documents and certificates necessary for completion of the sale of the Refunding Bonds. Copies of all the documents necessary for the refunding transaction shall be delivered, filed and recorded as provided in the Supplemental Indenture and Purchase Contract.

6. The President and Secretary are authorized and directed to prepare and execute the Refunding Bonds as may be prescribed in the Supplemental Indenture and to deliver them to the Trustee for authentication and delivery to the Bond Purchaser.

7. The Secretary and other officers of the University are authorized and directed to prepare and furnish to the Bond Purchaser certified copies of all proceedings and records of the University relating to the Refunding Bonds, and such other affidavits and certificates as may be required to show the facts relating to the legality of the Refunding Bonds as such facts appear from the books and records in the officers' custody and control or as otherwise known to them; and all such certified copies, certificates and affidavits, including any heretofore furnished, shall constitute representations of the University as to the truth of all statements contained therein.

8. The execution of any instrument by the appropriate officer or officers of the University herein authorized shall be conclusive evidence of the approval of such documents in accordance with the terms hereof. In the absence of the President or Secretary, the Supplemental Indenture and the Purchase Contract may be executed by the Chair or Vice Chair, and the Treasurer, respectively.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 18, 1983

TO: Board of Governors Executive Committee

FROM: Clifford Fearing
Gregory Hart
Barbara Tebbitt

SUBJECT: Report of Operations for the period July 1, 1982 through April 30, 1983.

The operations of the Hospital for April continue to reflect a relatively stable level of activity with little change in the overall mix and intensity of services experienced through March. To highlight our position:

Inpatient Census: During the month of April, admissions totaled 1,744 and our average length of stay was 9.2 days. The total inpatient census for the month was 16,601 days. The average daily census for the month of 553 patients represents an overall occupancy rate of 75.1%.

The favorable patient day variance continues to occur primarily within the Intensive Care, Pediatric and Rehabilitation areas.

To recap our year-to-date census:

	1981-82 Actual	Budget	Actual	Variance	% Variance
Admissions	16,905	16,891	17,414	523	3.1
Avg. Length of Stay	9.6	9.5	9.5	-	-
Patient Days	162,567	160,400	165,902	5,502	3.4
Avg. Daily Census	534.6	527.6	545.7	18.1	3.4
Percent Occupancy	72.8	71.7	74.1	2.4	3.4

Outpatient Census: April clinic visits totaled 17,847 compared to a projected total of 18,919 visits. Our year-to-date clinic census totals 172,936, or 1,108 (0.6%) over projected visits of 171,828. Clinic visits through April, 1983 are 3.0%, or 5,070 visits ahead of the April, 1982 total of 167,866.

Financial Operations: The Hospitals year-to-date operating position through April shows total revenues over expense of $8,894,015 and represents a favorable variance of $8,521,793.

Patient care charges totaled $144,596,357 and are 10.3% above budgeted levels. The favorable variance in patient charges continues to be the result of higher than anticipated census levels as well as changes in the mix and intensity of patient services.

Expenditures through April total $124,561,571 and result in a variance of $1,303,015 (1.1%) over budget. Medical supplies, drugs and blood continue to be the primary reason for this variance and correlates with the increased census levels and ancillary utilization.

Accounts Receivable: The balance in patient accounts receivable as of April 30, 1983 was $37,175,624 and is an increase of $2,926,871 from June 30, 1982. The April balance represents 73.6 days of revenue outstanding.

Conclusion: The Hospitals' financial position through ten months of the 1982-83 fiscal year is positive and above budgeted levels. We remain optimistic that our projected year end financial objectives will be achieved.

/jem

REPORT # CM470-2

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS
INPATIENT CENSUS BY MAJOR CATEGORY - SUMMARY
04/30/83 YTD

RUN DATE: 04/30/83 PAGE 1

	AVERAGE BEDS	INPATIENT DAYS BUDGET	INPATIENT DAYS ACTUAL	ADMISSIONS BUDGET	ADMISSIONS ACTUAL	OCCUPANCY RATE BUDGET	OCCUPANCY RATE ACTUAL	AVERAGE STAY PRIOR YR	AVERAGE STAY CURRENT YR
MEDICAL/SURGICAL	411.8	89,293	90,302	11,065	11,435	71.1	72.1	8.1	7.8
PEDIATRICS	83.0	18,471	19,608	1,976	2,087	73.2	77.7	9.5	9.4
PSYCHIATRY	60.0	15,071	15,306	490	492	82.6	83.9	32.3	31.0
REHABILITATION	40.0	6,957	7,936	253	265	57.2	65.3	28.7	28.4
OBSTETRICS	24.0	4,219	4,055	929	931	57.8	55.6	4.5	4.4
NEWBORN	20.0	3,127	3,667	743	712	51.4	60.3	4.2	5.3
INTENSIVE CARE-ADULT	63.8	13,912	15,272	861	917	73.8	78.7	16.8	16.7
INTENSIVE CARE-PEDS	34.0	9,350	9,756	574	575	90.5	94.4	16.6	16.9
TOTAL HOSPITAL	736.6	160,400	165,902	16,891	17,414	71.7	74.1	9.6	9.5
TOTAL - EXCLUDING									
PSYCH & REHAB	636.6	138,372	142,660	16,148	16,657	71.6	73.7	8.6	8.5

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS
STATEMENT OF OPERATIONS
FOR PERIOD JULY 1, 1982 TO APRIL 30, 1983

	Budgeted	Actual	Variance Over/(Under) Budget	Variance %
Gross Patient Charges	$131,050,503	$144,596,357	$ 13,545,854	10.3
Deductions from Charges	21,147,165	27,189,267	6,042,102	28.6
Other Operating Revenue	2,494,229	2,498,302	4,073	0.2
TOTAL REVENUE FROM OPERATIONS	$112,397,567	$119,905,392	$ 7,507,825	6.7
Expenditures				
Salaries	$ 61,124,494	$ 60,474,928	$ (649,566)	(1.1)
Fringe Benefits	11,043,026	10,379,763	(663,263)	(6.0)
Contract Compensation	6,527,114	7,161,014	633,900	9.7
Medical Supplies, Drugs, Blood	17,860,201	19,779,089	1,918,888	10.7
Campus Administration Expense	4,352,613	4,352,613	-	-
Depreciation	4,532,368	4,651,978	119,610	2.6
General Supplies & Expense	17,818,740	17,762,186	(56,554)	(0.3)
Total Expenditures	$123,258,556	$124,561,571	$ 1,303,015	1.1
Net Revenue from Operations	$(10,860,989)	$ (4,656,179)	$ 6,204,810	
Non-Operating Revenue				
Appropriations/Univ. Support	$ 9,977,221	$ 9,778,326	$ (198,895)	(2.0)
Accured Interest Income	923,658	3,505,816	2,582,158	-
Shared Service	332,332	266,052	(66,280)	(19.9)
Total Non-Operating Revenue	$ 11,233,211	$ 13,550,194	$ 2,316,983	20.6
Revenue Over/(Under) Expenses	$ 372,222	$ 8,894,015	$ 8,521,793 (1)	

(1) Variance equals 7.6% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS
OPERATING CASH FLOW

FOR PERIOD JULY 1, 1982 TO APRIL 30, 1983

Source of Funds		
Beginning Cash Balance		$ 4,574
Loss from Operations	$ 4,656,179	
Non-Operating Revenue	13,550,194	
Excess of Revenue over Expense		$ 8,894,015
Items not Requiring the Outlay of Cash:		
Depreciation		$ 4,651,978
University Support: G & A		4,352,614
K/E Utilities		98,860
Increase in 3rd Party Payable		8,986,226
Decrease in Prepaid Expenses		30,979
Reserve Cash Paid on Operating Liability		1,420,708
Other Adjustments		(208,981)
Total Funds Provided from Operations		$28,230,973
Funds Applied		
Transfers to Plant:		
Capital Expenditures	$ 4,101,929	
Increase in Capital Encumbrances	180,051	
Total Transfers to Plant		$ 4,281,980
Increase in Accounts Receivable		$ 2,718,072
Increase in Accrued Revenue		3,574,445
Increase in Inventories		364,408
Transfers to Renewal Project		2,916,667
Transfer to Reserves - 3rd Party Payable		8,986,226
Increase in Deferred 3rd Party Reimbursement		180,378
Decrease in Accrued Expenses		1,592,239
Total Funds Applied		$24,614,415
Total Operating Cash Available		$ 3,616,558 (1)

(1) Total operating cash available of $3,616,558 plus transfers to plant of $4,281,980 and transfers to Renewal Project of $2,916,667 equals cash generated from operations of $10,815,205.

Minutes

Joint Meeting of the
Finance Committee and
Planning and Development Committee

University of Minnesota Hospitals & Clinics

April 20, 1983

Members Present:	Harry Atwood Jo-Ann Barr Leonard Bienias David Brown, M.D. Dionisa Coates Clifford Fearing Al France Seymour Levitt, M.D. Jack Mason Virgil Moline Cheri Perlmutter David Preston C. Edward Schwartz Paul Winchell, M.D. George Winn, D.D.S.
Members Absent:	Joseph Buckley, M.D. Don Erickson, M.D. Jeanne Givens Stephen Gerberding Al Hanser Clint Hewitt John Quistgard Margaret Sandberg Lawrence Weaver
Staff:	Nels Larson Jane Morris
Guests:	David Cost Gregory Hart Nancy Janda Mark Koenig Sally Pillsbury Barbara Tebbitt Don Van Hulzen
Call to Order:	The joint meeting of the Finance Committee and the Planning and Development Committee was chaired by Mr. Al France and was called to order at 9:45 a.m. in room 626 of the Campus Club.
Minutes Approved:	The minutes of the March 16, 1983 meeting of the Finance Committee and the minutes of the March 16, 1983 meeting of the Planning and Development meeting were approved.

Proposed Operating Budget for 1983-84:

Mr. Fearing gave highlights of the Budget Letter for fiscal year 1983-84 noting that this budget incorporates elements that have not had to be dealt with in the past. Among these elements are the changes in federal regulations, i.e., the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and Blue Cross/Blue Shield's AWARE program. The impact of both TEFRA and AWARE is that they will change the amount of reimbursements to UMH&C and increase contractual adjustments and allowances for bad debts. Adjustments for these factors have been made consistent with those projected and developed by Touche Ross in the November 1982 Feasibility Study.

Mr. Fearing stated that the other major factor influencing this budget is the requirements of the Bond Indenture for UMH&C to contribute $4 million in equity to the Renewal Project, to provide cash to amortize $2.8 million of abandoned planning cost and to generate cash to cover $9.25 million in capital needs.

Mr. Fearing stated that demand has been projected using fiscal year 1982-83 as a base and adjusted for the decline that Touche Ross and others have forecast. In addition, new programs have only been included if they do not increase costs to patients or are offset by other operating cost reductions.

Mr. Fearing explained that the primary basis for the 1983-84 budget is the current year 1982-83 experience, adjusted to reflect changes projected in the Touche Ross Feasibility Study, requirements of the Indenture, and new federal reimbursement regulations. The total impact of these and other changes will be to increase costs by a projected 7.1%, requiring a price increase of 9.7%. Total cash flow is projected to be $16,366,000 for fiscal year 1983-84 (compared to $16.5 million for FYE 1982-83) and is consistent with the Touche Ross Feasibility Study and Bond Indenture requirements.

Mr. Hart outlined schedules I - VII showing demand analysis, FTE analysis, expenditures and Bond Indenture requirements. He explained that the single largest expenditure item is salaries with a 6.7% increase in total salaries (assuming a 5% increase for all personnel and a 9% increase for nursing salaries). Mr. Fearing continued with summaries of schedules VIII - XI showing projections for deductions from revenue, non-operating revenue analysis, statement of operations, and cash flow and cash from operations. In response to a concern raised by Mr. France regarding the increased amount of bad debt, Mr. Schwartz explained how the amount of bad debt attributable to the AWARE program was arrived at.

A motion was made and approved by the committee to accept the Hospital operating budget for fiscal year 1983-84 as presented and recommend it to the full Board of Governors.

Proposed Capital Budget for 1983-84:

Mr. Atwood stated that the total budget for capital equipment and remodeling and renovation for fiscal year 1983-84 is $4,943,702. Mr. Koenig reviewed schedules breaking down the capital budget by department and by cost. He highlighted departments and items with the greatest costs, noting that a certificate of need is required for rental of a CT scanner.

A motion was made and approved by the committee to accept the proposed capital equipment and remodeling/renovation budget for fiscal year 1983-84, subject to future approval of individual high cost items, and to recommend it to the full Board of Governors.

Bad Debt Report:

Mr. Fearing reported that bad debts for the third quarter amounted to $956,701.07 (represented by 2,611 accounts) and $2,277.08 of Home Health Services accounts. He stated that the year-to-date total for bad debts is $2,481,718.39 which is 1.9% of gross charges (compared to the budgeted level of 2.5%). Mr. Fearing stated that the increase in bad debt amount is largely due to economic conditions and changes in Welfare programs.

Mr. France asked that a review of collection procedures be prepared for next month's meeting of the Finance Committee. Mr. Cost requested that a patient origin study also be prepared to identify the percentage of out-of-state bad debts.

A motion was made and approved by the committee to accept the report and recommend it to the full Board of Governors.

March YTD Financial Statements:

Mr. Fearing gave a brief review of the financial statements for the period July 1, 1982 through March 31, 1983. He stated that the trends seen throughout this fiscal year have continued to the present. The inpatient and outpatient census levels are both above budget. The Hospitals' year-to-date operating position through March shows a favorable variance of total revenues over expense of $7,551,165. Patient care charges were above budget by 10.3% at $129,934,644, and expenditures were slightly over budget by 0.8% at $922,968. The balance for accounts receivable for the period through March is $34,951,498 and represents 70.5 days of revenue outstanding (down from 78 days last month). Mr. Fearing stated that the overall financial position of the Hospital is very positive.

Renewal Project Update:

Mr. Schwartz reported that construction for Radiation Therapy is progressing very well with a target completion date of January 1984. Steel and concrete bids have been completed for Unit J. Mr. Schwartz stated that the project is approximately 25% under contract and about 15% under budget for the contracts awarded. A user review process of the 95% completed drawings is now underway and it is hoped that by fall the entire project will be under contract.

Mr. Schwartz indicated that authorization will be requested from the Regents in May for possible refinancing of the bond issue, and that the financial situation is being carefully monitored to find the appropriate time to maximize savings. In the meantime, all preliminary steps towards the refinancing are being taken.

Adjournment: There being no further business, the joint meeting of the Finance Committee and the Planning and Development Committee was adjourned at 11:50 a.m.

Respectfully submitted:

Jane E. Morris
Recording Secretary

March 23, 1983
Star/Trib.

Blue Cross to start preferred-provider group

Blue Cross and Blue Shield of Minnesota announced a plan Tuesday that could concentrate most of its Twin Cities area subscribers in 15 of 27 metropolitan area hospitals.

It will be the state's first preferred-provider organization (PPO). The organization will offer discounts averaging about 14 percent on premiums for hospital coverage and about 7 percent on total health-care packages to members of group plans. Since employers pay most of the premiums for group plans, they're expected to benefit most.

The 15 hospitals are promising that they won't charge more than a given amount for members of the plans. In return, they'll be able to fill more of their empty beds, said Andrew Czajkowski, president of Blue Cross-Blue Shield.

Some of Blue Cross-Blue Shield's competitors also are seeking special rates from Twin Cities hospitals in return for more patients. For example, Group Health Plan, Inc., the state's oldest and largest health-maintenance organization, is offering to guarantee a minimum number of patients per year to hospitals agreeing to special rates.

Blue Cross-Blue Shield groups will be offered a choice of continuing with conventional coverage or switching to the new plan. Anyone in the new plan who goes to a nonparticipating hospital for nonemergency care will risk having to pay part of the hospital bill in addition to any deductibles and co-payments, Czajkowski said.

He said the hospital part of the PPO is only the first step; physicians' services will be added later in the year and the entire program may be expanded to include other services and other areas of the state.

Hospitals participating in the plan are: Eitel, Metropolitan Medical Center and Mount Sinai, all in Minneapolis; Mercy Medical Center, Coon Rapids; Methodist Hospital, St. Louis Park; North Memorial Medical Center, Robbinsdale; Unity Medical Center, Fridley; Divine Redeemer, South St. Paul; and Bethesda Lutheran, St. Paul Children's, Midway, Mounds Park, St. John's, Samaritan and United, all in St. Paul. Some nonparticipating hospitals, such as Abbott Northwestern and Fairview, are developing PPOs in collaboration with physicians.

Sabo responds on VA

I found your March 10 editorial on funding for the Veterans Administration replacement hospital at Fort Snelling confusing, and I feel I must set the record straight.

Your editorial states that I am trying to include the Minneapolis VA hospital in the jobs bill currently moving in Congress. That is incorrect. I and the other members of the House Appropriations Committee never worked to put the funding for the facility in the jobs package, because I worked out an agreement with the Senate Appropriations Committee last fall for the hospital to be funded in the first regular supplemental appropriations bill to be passed this spring. I also did not want the VA hospital to take away funding from other worthy programs in the jobs bill.

I am troubled by your apparent lack of concern about the urgency of preventing further delays in this project. You say that "gaining two months or six weeks at Fort Snelling does not meet any reasonable criterion." I fail to understand how anyone who has lived through a Minnesota winter can make such a statement.

The VA will be ready to go to bid July 15. It is questionable whether the VA can legally begin this process if an appropriation is not in place at that time. There is roughly a 45-day process for soliciting bids, so the bids would be opened on or about Sept. 1. Then there is an approximately 30-day review process for the VA to select a contractor. Contracts would be awarded on or about Oct. 1.

If the VA adheres to this timetable it can begin construction before the ground freezes. If it is delayed, the contractor will either have to excavate in frozen ground, a more costly operation, or lose a major portion of the construction season. Estimates show such a delay would increase the cost of the hospital by up to $10 million.

My efforts to ensure that a replacement medical center is built are based on need, not on "public relations." Instead of being "embarrassed," as you suggest, I will continue to work to make sure that funds are appropriated and the timetable is adhered to. — **Rep. Martin Olav Sabo, Washington, D.C.**

Star/Trib. 3/22/83

... painted woodwork, so we ... such as one p

NY Times
4/7/83

Physicians Criticize Rules on Newborns

By GLENN COLLINS

NEW Federal regulations affecting the treatment of severely handicapped newborn babies came under sharp criticism yesterday at a conference of doctors, philosophers, lawyers and historians debating the ethics of caring for seriously ill infants.

"The approach of the regulations is grotesquely oversimplified, and inadequate for sensible decision making," said Alan J. Weisbard, a professor at the Benjamin N. Cardozo School of Law at Yeshiva University, where the conference took place.

Under the Federal rules, which took effect March 22, the Department of Health and Human Services is operating a toll-free 24-hour telephone number, which must be posted in hospital maternity wards and nurseries. Government investigators have been taking reports of infants being denied food or care in hospitals receiving Federal funds.

'None of us wants to withdraw care.'

Surgeon General C. Everett Koop has argued for the Reagan Administration position, saying that the regulations are designed to insure that handicapped infants are not permitted to die from lack of medical treatment. The rules have been backed by the National Right to Life Committee, an antiabortion group.

"None of us in neonatology wants to withdraw care from these infants," said Dr. Alan R. Fleischman at the conference, which was sponsored by Montefiore Medical Center; the Hastings Center Institute of Society, Ethics and the Life Sciences, and the New York Council for the Humanities.

"Unfortunately, some of these babies have no chance to survive, and prolonging their life is inhumane," said Dr. Fleischman, who is director of the division of neonatology, or newborn care, at Montefiore. "Sometimes we are prolonging dying, and not prolonging living." He cited cases of babies born without brains, or with other profound abnormalities.

The new Federal regulations have been challenged by the American Academy of Pediatrics, which represents 24,000 pediatricians, and its efforts have been supported by 12 other groups, including the American Medical Association and the American Hospital Association.

The professional medical associations maintain that Federal and state investigators, responding to anonymous complaints, might interfere in decisions that should be made by doctors and parents. In addition, the groups said that the department had not permitted 60 days of public comment before imposing the rules, which were published in the Federal Register March 7.

Tomorrow, Federal District Judge Gerhard Gesell in the District of Columbia will hear arguments on the regulations. On March 22, he denied a plea from medical associations requesting that he issue a temporary restraining order against the regulations.

The rules were issued after the death of a severely handicapped baby in Bloomington, Ind., whose parents won a court suit to deny the infant food, water and medical aid.

The anonymous infant, known in court papers as "Baby Doe," died last April in Bloomington Hospital. The child was born with Down's syndrome and was unable to eat normally because the esophagus was not connected to the child's stomach.

"The main focus of criticism of the Reagan Administration regulations has been procedural, involving who shall do the deciding in these cases," said Dr. John D. Arras at the conference. He is philosopher in residence at Montefiore Medical Center, and advises doctors there and elsewhere on ethical dilemmas in medicine.

."But there are serious underlying questions of substance here," he said, "involving the quality of life and the issue of when it is morally appropriate to withhold care."

Such issues were debated before an audience of 250, whose members questioned the scholars closely about topics as diverse as genetic screening technology and the disagreements between right-to-life advocates and their opponents involving infanticide and euthanasia.

Among the speakers was the critic Leslie A. Fiedler, professor of English at the State University of New York at Buffalo. "We have primordial responses toward those born with congenital malformations," he said, "and they color the rational, philosophical, and religious attitudes we've been addressing here today."

Annually, 250,000 of the 3.5 million babies born in the United States need special hospital treatment, varying in time from a few hours to many months. There are 7,500 intensive-care beds available for the treatment of newborns and the cost of that care is estimated at $1.5 billion to $3 billion a year.

'U' herpes drug may be the best yet

Dr. Robert Vince

By Gordon Slovut
Staff Writer

A drug developed in Minnesota appears more effective against herpes infections than anything now available, researchers say. And it might even cure the stubborn venereal disease.

The drug, Cyclaradine, has been tested in laboratory dishes, test tubes, guinea pigs and mice. Human trials apparently await the approval of the Schering Corp., a drug company that holds the rights to it for the next three years. There is no way to predict when it might be available to the public.

An estimated 300,000 Minnesotans and 15 to 20 million Americans have genital herpes; each year another 500,000 Americans catch the disease. Initial infections disappear after about two weeks, only to return months or years later. The recurrent infections generally are not as severe, but can be lethal to an infant who comes in contact with them during birth.

Dr. Robert Vince, a medicinal chemist in the University of Minnesota's College of Pharmacy, headed the research team. He said tests in animals indicate that the drug is more effective as an ointment against genital herpes than acyclovir, which has been on the market for about a year under the brand name Zovirax.

Perhaps even more significant, Dr. William Shannon, a virologist at the Southern Research Institute in Birmingham, Ala., said he has shown that when injected, Cyclaradine "crosses the blood-brain barrier" in laboratory animals. That means, he said, that it may be the first drug with the potential for eliminating "latent" herpes viruses from the ganglia, the nerves around the brain and spine, thus effecting a cure.

Herpes has been considered incurable because those latent viruses, out of reach of existing drugs known to attack the genital herpes virus, periodically climb down the nerves and cause sometimes painful eruptions.

Vince is to announce his findings today at the national meeting of the American Chemical Society in Seattle. In an interview before he left, Vince said Cyclaradine was effective against all human types of genital herpes infections in guinea pigs, including some that acyclovir is unable to combat. He said he first infected the vaginas of the animals with herpes, then spread Cyclaradine ointment on the infected areas of about half the animals to see if herpes sores would develop.

"The infections occurred in about 100 percent of the untreated guinea pigs," he said. "In the treated animals no lesions developed."

More tests will determine whether the drug will help against recurrent infections.

The new drug does not have one of acyclovir's shortcomings, a short period of effectiveness, Vince said. In experiments with guinea pigs, acyclovir must be applied to genital tissue within two hours of exposure to a herpes virus or it won't shorten the duration of infection, Vince said. He said Cyclaradine can be applied successfully up to 12 hours after exposure.

He said he developed the drug with Shannon and Dr. Susan Daluge, an organic chemist who has left the University of Minnesota to join Burroughs Wellcome Co., the manufacturer of acyclovir.

Vince was involved in the development of acyclovir as a graduate student at the State University of New York in Buffalo, where he studied under Dr. Howard Scheaffer, an organic chemist who subsequently became a vice-president of Burroughs Wellcome.

Vince said his group started developing Cyclaradine about three years ago, using federal grants and money from the Schering Corp. The patent is held by the University of Minnesota, he said. The drug is the result of manipulation of the molecules that make up Vira-A (vidarabine), a Parke, Davis & Co. drug that was the first of the effective anti-herpes agents, Vince said.

The trouble with Vira-A (also is known as Ara-A) is that it isn't effective against genital herpes or cold sores, two prime candidates for treatment by an antiviral ointment, Vince said. However, it is effective against herpes keratitis, an eye infection that can lead to blindness if untreated.

Vince said he and his co-workers designed Cyclaradine so it would not have the two main weaknesses of Vira-A — an inability to penetrate cells and no resistance to an enzyme, adenosine deaminase, found in cells throughout the body.

Shannon said one of the real tests of Cyclaradine's potential was against herpes encephalitis in mice. He said the germ was injected into the brains of the mice, "one of the most severe tests for a drug because herpes encephalitis is very lethal, and most drugs of this kind just don't get to the brain. If you don't treat them they are dead within four to seven days. The Cyclaradine reduced the mortality to zero to 10 percent."

Shannon said more toxicity studies must be done before trials in humans could be done but that early results are promising.

Mayo developing vaccine that may protect against two cancers, mono

By Lewis Cope
Staff Writer

San Diego, Calif.
A vaccine being developed at the Mayo Clinic may protect against the "kissing disease" in the United States — and against two types of cancer common in Africa and China.

Dr. Gary Pearson of the Rochester, Minn., clinic said Tuesday that he hopes to start human trials of the vaccine against infectious mononucleosis in two to five years. While the ultimate aim is to combat the two types of cancer, he said that mononucleosis is enough of a problem that the "vaccine would be useful in this country."

Mononucleosis is common among teen-agers and young adults, particularly those of college age. The virus apparently can be transmitted in saliva. While not normally dangerous, mononucleosis causes weakness that often lasts several weeks. Occasionally there are serious complications.

The virus known to cause the "kissing disease" also is found in the two types of overseas cancer, both of which start in the head. It's the Epstein-Barr Virus (EBV), a member of the troublesome herpes family. Other herpes viruses cause problems ranging from chicken pox to genital herpes.

Viruses long have been known to cause cancer in animals, but proof of any human cancer virus has been lacking. However, the evidence against EBV is widely considered by researchers to be the strongest, based on the consistency and the way that the virus is found in the cancer patients. Extensive lab tests support the theory.

Now there is "the realistic possibility that it might be possible to prevent certain types of cancer with an antiviral vaccine," Pearson said at the American Cancer Society's seminar for medical reporters.

The cancers are Burkitt's lymphoma, the leading form of cancer among children in much of equatorial Africa, and nasopharyngeal carcinoma, the third-leading cause of cancer in Chinese adults; it strikes in the nose and throat. EBV also has been likened to one type of cancer of the lymph nodes in the United States, but many more questions remain on that score.

Pearson said he suspects that EBV is not the only factor in any cancer. But in the African and Asian cases, at least, "it seems to be a necessary factor."

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1989, MEDICARE WILL USE UP FUND, 2 U.S. REPORTS SAY

LOAN IS CITED AS A FACTOR

But Rises in Hospital Fees and in Population Over 65 Are Noted as Big Problems

By ROBERT PEAR
Special to The New York Times

WASHINGTON, Feb. 20 — Medicare, the health insurance program for 26 million elderly Americans, is facing huge financial problems that have been exacerbated by the withdrawal of $12.4 billion from the Medicare trust fund to rescue the old-age benefits trust fund of the Social Security system.

A new study by the Congressional Budget Office contains projections indicating that the Medicare trust fund will be depleted in 1987 or 1988.

The annual report of the Medicare trust fund, to be issued in April, shows that it will be depleted in 1989 or sooner if the Social Security System fails to pay interest on the money it has borrowed. Social Security has already missed one interest payment, according to the report sent to key members of Congress.

'Big Surprise' in Medicare

Senator Bob Dole of Kansas, chairman of the Finance Committee, which has authority over both the retirement and health insurance programs, said: "If you think we face serious deficit problems with the Social Security cash program, you're in for a big surprise when you look down the road at Medicare's future. Using the current optimistic assumptions, Medicare could literally go broke sometime toward the end of the decade, perhaps as early as 1987 or 1988."

The study by the Congressional Budget Office, carried out at the request of Senator John Heinz, said that Medicare's basic financial problems arose because hospital costs were growing much faster than the earnings taxed to generate revenue for the Medicare trust fund. The contributions for Medicare are a part of the employer-employee conributions for Social Security overall.

"Hospital costs attributable to Medicare beneficiaries," the study said, "are projected to increase over the 1982-95 period at an average annual rate of 13.2 percent, but covered earnings are projected to grow at an annual rate of only 6.8 percent."

Borrowing Has Big Impact

Thus, it said, if Medicare is to remain solvent through 1995, it "will require outlay reductions that are much larger than program options currently under discussion, or very substantial increases in revenues."

The Medicare trust fund pays for hospital care, skilled nursing homes and home health services. The balance in the trust fund declined from $18.7 billion at the end of 1981 to $8.3 billion at the end of 1982, mainly as a result of borrowing. The old-age trust fund of Social Security borrowed $3.4 billion on Dec. 7 and $9 billion on Dec. 31 of last year.

Continued on Page 9, Column 1

Continued From Page 1

The interest rate on both loans was 10¾ percent.

In its report on the Medicare fund, known officially as the Federal Hospital Insurance Trust Fund, the Congressional Budget Office said, "The balance is projected to decline slowly though 1986, and then decline rapidly, as outlays exceed income by an increasing margin."

The study projects a balance of $1.3 billion at the end of 1986 and says that, with no change in existing law, the trust fund would show steadily growing deficits: $7.6 billion in 1987 and $70.2 billion in 1990, rising to $221.5 billion in 1993 and $402.9 billion in 1995. The estimates assume that Social Security will not borrow any more from the Medicare trust fund, but that the existing loans will not be repaid.

The study by the Congressional Budget Office is to be issued next month at a hearing of the Senate Special Committee on Aging. Senator Heinz, a Pennsylvania Republican who is chairman of the committee, said the data in the report were "ominous." He said he was determined to "come up with a comprehensive reform package for the Medicare system without shifting the burden of Medicare's solvency to those older Americans the system was originally designed to serve."

Legal authority for the loan from the Medicare trust fund expired on Dec. 31. The National Commission on Social Security Reform, headed by Alan Greenspan, recommended that borrowing authority be extended through 1987 as part of the compromise plan to preserve the giant pension system.

But hospital officials, who depend on Medicare for 35 percent of their patient-care revenues, expressed alarm at the prospect of more borrowing. Jack W. Owen, executive vice president of the American Hospital Association, which represents 6,300 hospitals, opposed any extension of authority for "interfund borrowing." He said it could "exacerbate the crisis that looms."

People become eligible for Medicare when they reach 65. The number of people 65 and over is expected to grow 2 percent a year between 1982 and 1995, according to the Congressional Budget Office. This tends to increase Medicare costs because the use of Medicare services increases with the age of the beneficiary. The Medicare trust fund spends, on the average, almost twice as much each year for a person over 85 as for a person age 65 to 69.

But the aging of the population accounts for less of the increase in Medicare outlays than is commonly believed. By far the biggest factor is the increase in hospital costs.

"Rising hospital costs account for 10.8 percentage points of the 13.2 percent per year projected growth in hospital costs attributable to Medicare beneficiaries, while aging of the population accounts for 2.2 percentage points," the Congressional Budget Office said.

Hospital room rates rose 13.3 percent in 1982 and 17 percent in 1981, according to the Bureau of Labor Statistics. In those years, the Consumer Price Index for all items rose 3.9 percent and 8.9 percent, respectively.

The elderly are admitted to hospitals more often than younger people, and they frequently have more serious illnesses requiring more costly care, the Congressional Budget Office noted.

The law authorizing the Medicare loans to Social Security does not say when they must be paid back. It says only that if the Secretary of the Treasury finds that the assets of the Social Security trust fund "are sufficient to permit repayment of all or part of any loans," then "he shall make such repayments as he determines to be appropriate." The Secretary is, by law, the "managing trustee" of both the Social Security and Medicare trust funds.

Social Security officials said they were tentatively planning to pay back $2 billion a year in 1985 and 1986, $4 billion in 1987 and $4.4 billion in 1988.

But Medicare officials said they were unsure whether the loans would be repaid, especially because it seemed that the bipartisan compromise recommended by the President's commission might not solve the financial problems of Social Security.

Ultimately, Congress and the Secretaries of the Treasury, Labor and Health and Human Services departments, who act as trustees of the two trust funds, must reconcile the rival claims of Medicare and Social Security.

The deficits facing Medicare are so large, according to the Congressional Budget Office, that the Federal Government will have to address the underlying problem, the rapid inflation of medical costs, as part of any long-term solution. "Maintaining solvency through 1995 will require substantial policy changes because the cumulative projected deficit is so large, $300 to $400 billion by 1995," it said.

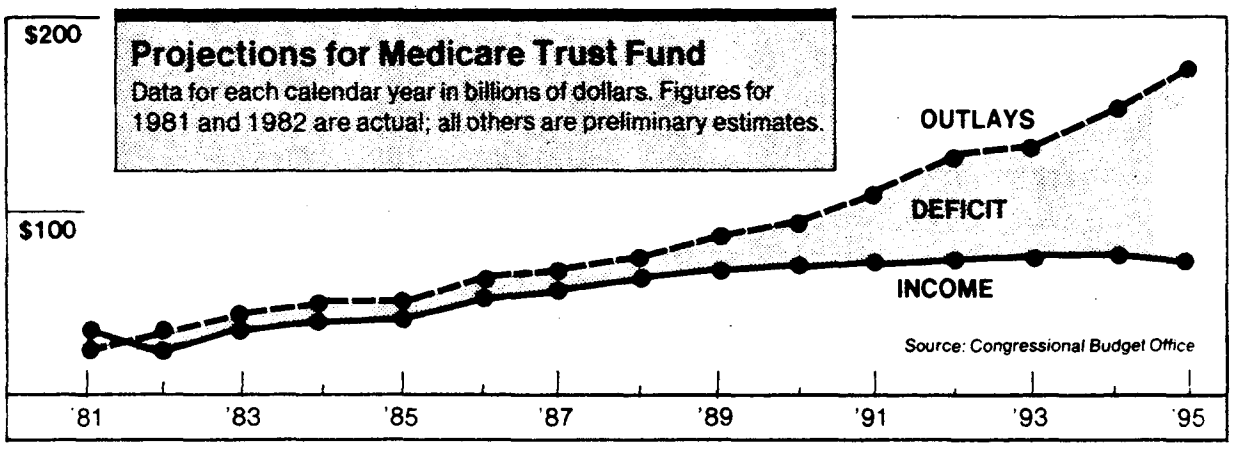
Possible solutions under study, higher payroll taxes, higher charges for Medicare services, hospital cost controls, would have to be much more stringent than anything proposed to date if they are to keep Medicare solvent, the study said.

To help finance the Medicare trust fund, employers and employees each pay a tax equal to 1.3 percent of the first $35,700 of covered yearly earnings. The rate is scheduled to rise to 1.35 percent in 1985 and 1.45 percent in 1986. To keep Medicare solvent through tax increases alone would require a steady rise in the tax rate, up to 2.5 percent in 1995, according to the study.

When added to the payroll taxes for Social Security retirement and disability programs, this would produce an increase in the rate "substantially larger" than in any other rate in United States history, the researchers said.

Alternatively, if Congress tried to avert a deficit in the Medicare trust fund by limiting reimbursement of hospitals, the limits would have to be much tighter than any now contemplated. Under this option, the rate of increase in Medicare hospital rates would have to be less than the general inflation rate. Such a change is almost inconceivable, given the experience of recent years.

Social Security officials and actuaries have often underestimated the financial needs of the retirement system. Last April, for example, in their annual report, they assumed that they would need to borrow $5.3 billion from the Medicare trust fund in 1982. In fact, they had to borrow $12.4 billion. Medicare officials cite that experience as a reason for their uncertainty about prompt repayment of the loans.



The New York Times / Feb. 21, 1983

hand-out from
West Metro Hospital Trustee
Council
March 1983

THE WALL STREET JOURNAL, MONDAY, MARCH 21, 1983

Some Do's and Don'ts for Directors

Manager's Journal

by Thomas L. Whisler

For the past three years I have been part of a team that has been interviewing outside directors of major companies. In almost all the companies we have studied, we have found a common "culture of the boardroom"—an unwritten set of rules which directors accept and abide by.

Some of these rules govern how board members define their responsibilities:

We are here to give counsel, make judgments and oversee the commitment of corporate resources. While these responsibilities sound very broad and general, they become useful policy guides for our behavior as directors. We should, self-consciously, check what we are doing at any moment to see if the activity fits the guidelines. If it doesn't, it means that, with few exceptions, we are doing something that is properly the province of management.

We are responsible for assessing and, if necessary, replacing top management. This is uniquely our responsibility and authority. It is a responsibility only occasionally exercised, but we should never forget it.

We don't manage the company. This is a rule that the rest of the world finds difficult to understand. After all, the board is always shown at the top of the organization chart. But a moment's thought should convince anyone that a group of individuals who get together every month or two cannot be seriously regarded as managing the company. We govern; the executives manage.

We don't set strategy. This rule is full of subtleties. To begin with, if the board were to set strategy it would, in the process, give away its power and responsibility for questioning and evaluating strategy alternatives. It would also be separating the responsibility for setting strategy from that of implementing it—a fatal split. Remember the snake-swallowing-its-tail folk-wisdom of management: Those responsible for implementing a strategy should be strongly influential in developing it; those who set strategy should be responsible for its implementation. Hence, those who set strategy (top management) explain it and defend it before a group of wise and experienced individuals (the board!). Despite these caveats, the board bears the basic responsibility for insisting that the CEO develop a sound and explicit strategy for the company.

We are responsible for assuring long run survival of the firm. We must always be mindful of the forces affecting the welfare of the company—social, political and economic—and see to it that their implications are analyzed and evaluated by management and the board. We are expected to have the broad, objective view of the true generalist. Managers come and go; the internal structure changes; there are acquisitions and divestitures. The board persists, dedicated to maintaining the viability of the corporation.

Officially, we are here to act in the shareholders' interests. This rule is a rhetorical convenience that, unfortunately, has led to foolishness in lawsuits and, occasionally, in annoying shareholder behavior at the annual meeting. Shareholders can have all sorts of diverse and conflicting individual interests. Fortunately, an exchange exists where conflicts and changes can be resolved through buying and selling of shares. Strictly speaking then, we don't seek to serve these interests directly. We do, however, watch shareholder sentiment in the market, for it tells us how well we are doing. The behavior of the price of our shares is a measure of collective judgment of investors about the long-run prospects of our company. A more accurate statement would be that we act to maximize the economic value of the firm. This is a hard one to explain to the rest of the world. So, we are stuck with an "official" rule ... but we should keep our own thinking straight.

Don't forget that a boardroom fight can raise questions in the minds of investors about the quality of corporate governance and, hence, the future health of the company.

Other rules govern behavior within the boardroom. To function effectively, directors must above all be "peers" who trust and respect one another: After all, most are princes in their own kingdoms. Most of these internal rules are intended to maintain that equality, trust and respect:

No fighting. In reaching decisions on the use of corporate resources, directors face great uncertainty. Agreement and rational decisions are possible only through analysis and dialogue, not through aggression and threat. Respect for others' opinions, clarity in presenting one's own and a sense of stewardship are the marks of a good director. A need to win is not. Don't forget that a boardroom fight can raise questions in the minds of investors about the quality of corporate governance and, hence, the future health of the company.

No crusades. The basic goals and purposes of a business corporation are surely known to all directors: We seek not to reform society, but to serve its needs through effective corporate performance in providing goods and services. Do your crusading elsewhere.

Do your homework. You have been chosen to be a director because you have proven your competence, wisdom and good judgment. But don't forget that today the fight for corporate survival and growth involves knowledgeable adversaries. One wins through thoughtful planning and staying on top of current problems. Study the information given to you. Call for more if you want it. Directors are expected to be sharpshooters, not hipshooters.

Participate. As directors we play a unique role in the corporation. While some things that we are legally required to do are pedestrian (such as banking resolutions), we must be prepared to make an occasional fateful and difficult decision requiring all of the wisdom that we can muster. So be present, be thoughtful, be participative. This is not a spectator sport.

Support your CEO. You, the board, chose him (or you choose to keep him). His success validates your wisdom; his failure calls it into question. His job is a complex and demanding one; the pressures are enormous. In working with him, you as a director must distinguish between counsel and criticism. He will, or should, heed the former. Too much of the latter means that one of you should depart.

Serve your apprenticeship. If this is your first directorship you have a lot to learn. If you have been on other boards, then you know that every board has its own culture, its own practical rules for working together. In either case, listen, watch, and learn after you join. Ask questions of your fellows—in the cloakroom, not in the boardroom. Make your apprenticeship intensive but short. You have been invited onto the board with the expectation that you have a contribution to make. The board is waiting for it.

Keep your distance from subordinate company executives. This rule is full of ambiguities. To start with, most boards have some subordinate executives who are also directors privy to the same information as outsiders. These executives often have the same status (except that they usually get no directors' fees and they may be barred from certain board committees such as audit and compensation). As directors they are *peers* inside the boardroom. As executives outside they are something less, and distance must be kept from them as with other second- and third-line executives. Scrupulous avoidance of even the appearance of going around the chief executive is the reason.

Be prepared to counsel with the CEO. In the popular debate about what boards do, or should do, seldom is mention made of the role of the director as counselor. This is one-on-one activity between you and the CEO that starts initially with the assumption that you are a person of good judgment. But it is nurtured by the discovery that there is "good chemistry" between you and the chief executive. "Being prepared" has an active aspect, where you offer counsel when you think it is needed, and a passive one where you respond to his request. *Caveat:* Don't ever allow this activity to put you at odds with your fellow directors. There is no place for a Rasputin on a board.

Don't discuss company business with others. This rule seems too obvious to require elaboration. But leaks of critical information do occur and, occasionally, a foolish director is at fault. If you value your reputation as a director (and this reputation has value in the marketplace), don't discuss anything that isn't already in the public domain. A close-mouthed director is a good director.

Watch for straws in the wind. As a director you are never off duty. The company, its needs, its vulnerabilities and its plans for the future should be in your head wherever you go. That way, any information you acquire, or events that you witness, can be automatically assessed for relevance to the welfare of the company. Use the telephone and pass things on to the CEO for exploration, or to fellow directors for evaluation. The close-mouthed director can afford to keep his ears and eyes open.

Delicate Psychology

Officially, deprecate the personal significance of your director's fee. The psychology of this rule is delicate. You are *invited* onto a board; you are not hired. You are a wise counselor, not an employee. You are an eminent person (usually with a high income); no company can offer you a fee that is adequate compensation for your time. Prestige, admission to the elite make up the difference. On the other hand, five or six directorships can produce a gratifying income. But obey the rule. (True story: One eminent public figure, tentatively offered a directorship on a major corporate board, responded by asking how much it paid. The offer was withdrawn. Moral: Never ask. You can always look up the fee in public documents.)

Mr. Whisler is professor of business policy at the University of Chicago's Graduate School of Business. His article is excerpted from his forthcoming book "Rules of the Game."

Minutes

Finance Committee
University of Minnesota Hospitals & Clinics

April 14, 1983

Special Meeting

Members Present:	Al France, Chairman David Brown, M.D. Clifford Fearing Seymour Levitt, M.D. Virgil Moline David Preston C. Edward Schwartz
Members Absent:	Steve Gerberding Jack Mason John Quistgard Margaret Sandberg George Winn, D.D.S.
Staff:	Nels Larson Jane Morris
Guests:	Gregory Hart Nancy Janda Donald Van Hulzen Ronald Werft

Call to Order: The special meeting of the Finance Committee was chaired by Mr. Al France and was called to order at 9:25 a.m. in room 608 of the Campus Club.

Preliminary Operating Budget for FY 1983-84: Mr. Schwartz gave a brief introduction regarding the Hospitals' preliminary operating budget for 1983-84. The highlights of this budget include a 9.7% price increase, cost increases of 7.1%, and a projected positive cash flow of $16,366,000.

Mr. Fearing then gave a detailed explaination of the budget as contained in the Preliminary Budget Letter for fiscal year 1983-84. He stated that two major elements effecting this budget are: 1) changes in federal reimbursement systems, and 2) the Hospital's responsibilities under the Series 1982 Bond Indenture. Mr. Fearing listed objectives that were established in order to meet the requirements of the 1983-84 Hospital budget. It was agreed by the members of the committee to change the order of these objectives to reflect their priority.

Mr. Fearing discussed several specific factors that have been used as basic elements within the 1983-84 budget including:

- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) UMH&C will be reimbursed for patients covered under federal programs under a target rate method which will provide an average reimbursement per case of $6,311 (current year's average was $5,800 - $5,900).

- Demand Analysis
  Forecasted declines in patient days and admissions require that adjustments be made to the number of full-time equivalents (FTEs), ancillary utilization and revenues.

  In addition, Mr. Hart stated that UMH&C was not successful in negotiations for participation in Blue Cross/Blue Shield's AWARE program. This budget has taken into consideration losses that may occur with AWARE patients who come to UMH&C and are not fully reimbursed. Mr. Schwartz asked that an explaination of this program and its effect be included in the revised budget letter for presentation to the full Board of Governors.

- Series 1982 Bonds
  UMH&C is required under the Bond Indenture to contribute $4 million in equity to the Renewal Project, amortize $2.8 million of abandoned planning costs and provide for $9.25 million in capital needs.

- New Programs
  New programs have only been included if they were offset by other operating cost reductions or could be supported by non-patient revenue. Approximately 16.5 FTEs will be added overall. Mr. France asked that an outline of these additions be prepared for the presentation to the full Board of Governors.

- 1983-84 Budget Base
  The primary basis for the 1983-84 budget is the current year experience. This data is then adjusted for changes projected in the Touche Ross Feasibility Study, requirements of the Indenture and new federal reimbursement regulations. Mr. Fearing gave descriptions of how major elements effect the 1983-84 budget (demand, FTEs, expenditures, Bond Indenture requirements, deductions from revenue and non-operating and other revenue) and explained the corresponding schedules.

- FY 1983-84 Cost, Price and Revenue Increases
  UMH&C will require a 9.7% price increase to finance the expected increases in costs, revenue deductions and Renewal Project needs. (Touche Ross had projected a 10.38% increase in charges.)

Adjournment: There being no further business, the meeting of the Finance Committee was adjourned at 11:30 a.m.

Respectfully submitted,

Jane E. Morris
Recording Secretary

Board of Governors

University of Minnesota Hospitals and Clinics

January 19, 1983

CALL TO ORDER: The meeting was chaired by Vice Chairman David Cost who called the meeting to order at 1:40 p.m., in Room 555 Diehl Hall.

ATTENDANCE:

Present:
David Cost, Vice Chairman
JoAnne Barr
Leonard Bienias
Dionisa Coates
Al France
Steve Gerberding
Robert Goltz, M.D.
Fannie Kakela
Mary Lebedoff
Paul Quie, M.D.
John Quistgard
C. Edward Schwartz
Dean Lawrence Weaver
Paul Winchell, M.D.
George Winn

Absent:
Harry Atwood
Debbie Gruye
Al Hanser
John Mason
Virgil Moline
Sally Pillsbury, Chairman
Margaret Sandberg
Timothy Vann

MINUTES APPROVED: It was moved that the minutes of the meeting held December 15, 1982 be approved as submitted. The motion was seconded and passed unanimously.

Vice Chairman Cost reported on the January 19th meeting of the West Metro Trustees Council indicating that the council had discussed developments in price disclosure as well as the repeal of the Certificate of Need Law.

Vice Chairman Cost reported that the Board of Regents at their January 14th meeting had approved the Report of the Task Force on Governance and Organization. It was added that a schedule implementation of task force recommendations would be available by the February meeting.

REPORT FROM THE DEPARTMENT OF NEUROSURGERY:

Mr. David Cost introduced Dr. Shelley Chou, Professor and Head of the Department of Neurosurgery. Dr. Chou presented an outline of the Clinical Staff of the Department of Neurosurgery indicating the subspecialty interest of each member of the staff which included vascular lesions of the brain and spinal cord, spinal deformities, pituitary lesions, spinal fractures, microvascular lesions, chronic pain, CPA tumors, neurovascular compressions, seizure surgery, seizure disorders, and stereotaxis. Dr. Chou addressed a number of questions regarding some of the above procedures. He further presented volume data for the year 1979-80 through 1982-83 year-to-date.

FINANCE COMMITTEE REPORT:

Mr. Al France began the report of the January 19th meeting of the Finance Committee. Mr. Cliff Fearing reported on the Statement of Operations through November 30, 1982 indicating that University Hospitals had experienced a relatively stable expense base with increasing revenue. He reported that admissions were 2.5% above budget and that due to an increasing length of stay patient days were 3.3% above budget at 84,768. Outpatient census through November was reported at 88,798 visits, 2.2% above budget. Mr. Fearing also reported that revenue days in accounts receivable were at their lowest level since 1971 at 73.6 days.

BAD DEBT REPORT

Mr. Al France moved that University Hospitals Board of Governors write-off $776,876.12 as bad debt for the second quarter of fiscal year 1982-83. In response to a question Mr. Fearing indicated that the recommended amount represented approximately $20.00 per patient day in bad debt. The motion was seconded and approved unanimously.

Mr. Fearing then presented a summary of a letter from Vice President Fred Bohen to the Board of Regents outlining the closing on the sale of bonds for University Hospitals Renewal Project which took place December 30, 1982. It was reported that the Bond Endenture Statement is available through Mr. Fearing's office.

Vice Chairman David Cost reported on the January 18th meeting of the Joint Conference Committee indicating that Dr. Clara Bloomfield had reported on the Tissue and Procedure Review Committee and had presented an audit of transurethral prostatectomies. He added that the committee had discussed the quality assurance plan for 1982-83. Dr. Paul Quie summarized the quality assurance work plan and discussed the process of quality assurance at University of Minnesota Hospitals and Clinics.

It was moved that the 1982-83 Quality Assurance Work Plan be approved by the Board of Governors. The motion was seconded and passed unanimously.

GENERAL DIRECTORS REPORT: Mr. C. Edward Schwartz commented on the efforts of the Task Force on Governance and Organization indicating that governance of academic health centers is a national issue. He added that the report of the Consortium for the Study of University Hospitals will be available in February.

ADJOURNMENT: There being no further business, the meeting was adjourned at 3:05 p.m.

Respectfully submitted,

Ron Werft

Ron Werft
Executive Assistant
to the Board of Governors