

THE OHIO STATE UNIVERSITY
OFFICIAL PROCEEDINGS OF THE
FIRST MEETING OF THE
WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, December 16, 2013

The Wexner Medical Center Board met on Monday, December 16 at Longaberger Alumni House, Columbus, Ohio, pursuant to adjournment.

December 16, 2013 meeting, Wexner Medical Center Board

The Chairman, Mr. Wexner, called the meeting of the Wexner Medical Center Board to order on Monday, December 16, 2013 at 12:02 am.

Present: Leslie A. Wexner, Chairman, William G. Jurgensen, Cheryl L. Krueger, Michael J. Gasser, Stephen D. Steinour, John F. Wolfe, Robert H. Schottenstein, Joseph A. Alutto, Steven G. Gabbe, Geoffrey S. Chatas, Charles J. Lockwood, E. Christopher Ellison, Michael A. Caligiuri

Mr. Wexner:

I am going to call this meeting to order and ask Ms. Link to note the attendance.

Ms. Link:

A quorum is present Mr. Chairman.

Mr. Wexner:

At this time, I would like to call Bob Schottenstein, Chairman of the university Board of Trustees.

Mr. Schottenstein:

Thank you Mr. Chairman.

Welcome everyone. This is a momentous and exciting time, certainly a time of great opportunity to The Ohio State University. This meeting has certainly been a long time coming. We are very proud of our academic medical center. It's a very significant part of the university, as I think everyone in this room knows.

The medical center comprises approximately half of the university's budget; a very significant part of the financial structure of the university. It's a very important part of who we are in terms of our reputation, brand, and commitment to quality. Our medical center has an extraordinary history and I know a wonderful future.

This is a brand new governance structure. It's one that has come about as a result of more than one year of thought and planning. It really sprung from a series of conversations that first took place during the very early stages of a strategic planning process for the academic medical center. In connection with that strategic planning process, one of the big questions that surfaced was what should be the optimum governing structure for the medical center?

Our medical center has been around for a long time and has grown. As it grew, various parts were developed; starting out as University Hospital, the emergence of the James Cancer Hospital, the Ross Heart Hospital, Harding Hospital, and University Hospital East. As these hospitals were created, they each were created with their own governance boards, all of which were linked with ultimate oversight resting with The Ohio State University Board of Trustees.

The way that The Ohio State University Board of Trustees had sought to provide that oversight was through one of our board committees called the medical affairs committee. That committee was connected to the four or five operating boards of the hospital. For a variety of reasons, and not just simplicity, we took a look at the national landscape and looked at how other academic medical centers were structured, and asked ourselves the question: is there an optimal structure? Is there a more efficient way? Is there a more effective way to make sure that there is not just vertical alignment but a horizontal alignment among the various pieces and parts?

Particularly, not just because of the day that we live in where the national landscape, all of the various macro-economic factors that influence reimbursement rates, research funding, and so many of the revenue sources for the medical center, are going through radical change and as we want to continue to

grow within our medical center, the question was what is the best structure? We settled on this one. Hopefully that decision will prove to be a smart one. We think it will.

We were in the process of folding in to this one board the various hospital boards which will be repurposed. What was the medical affairs committee has now been replaced by this board. This board reports directly to The Ohio State University Board of Trustees. This board is charged with oversight. This board will work very closely with the chief executive officer (CEO) of the academic medical center as well as the president of the university in providing the kind of board oversight that we think is essential in this day and age.

The structure that we have created initially calls for a board of up to 15 members; six of whom are selected from The Ohio State University trustees, most of them are here with us today, those individuals have been named and up to six community members, I will talk about that momentarily. The other three positions consist of the president of the university, the chief financial officer of the university, and the CEO of the medical center: President Alutto, Geoff Chatas, and Dr. Steven Gabbe.

As part of the bylaws, one of the first responsibilities that The Ohio State University board had was to identify an individual to chair this newly formed Wexner Medical Center board. I know I speak for the entire board that we are very fortunate, Les, to have you take this on. Les' commitment to Ohio State over a long ark of time is without equal. I don't think anyone would dispute that. His extraordinary leadership at The Ohio State University board level, he chaired that twice, has just been a very powerful force in helping to shape the strategy of the overall university. He has a very keen interest in the medical center. We are very fortunate to have you take this on. I speak for everyone when I thank you for doing this. I think I also speak for Les in saying that we are excited to start this process.

Les was one of the first community members selected. We are also very fortunate that we have been able to identify two other community members who have agreed to serve on this board. The first is John F. Wolfe, seated to Les' right, who is the chairman and chief executive officer of the Dispatch Printing Company. John's commitment to Ohio State, his interest in the James Cancer Hospital, and his interest in health care is well known. He brings tremendous wisdom and judgment that will serve us well.

Steve Steinour, seated to John's right, is the chairman and chief executive officer of Huntington Bancshares, has also agreed to join us as our third community member.

We welcome both of you and thank you for taking on this very important role.

The Ohio State University trustees that are initial members of this board consist of myself as Chair, Mike Gasser. Under the terms of our bylaws, we have identified a lead trustee to serve as a liaison or a link between the work of this board and The Ohio State University board. Mike, in addition to being here as a board member, will also be the lead trustee. Jerry Jurgensen who chairs The Ohio State University board finance committee is a member of this board along with Cheryl Kruger. The other trustees, neither of whom could be here today unfortunately, are Janet Reid and Corbett Price. Alex Shumate who is a member of The Ohio State University board is here as a guest, a very welcomed one.

At this point, this is the initial 13 of 15 members.

I will say that we have also asked, and I am very pleased to share with you that at the next meeting of The Ohio State University Board of Trustees, I will recommend the ratification of the appointment of two additional community members. One of whom is Abigail Wexner. Abigail is the founder and chair of the Center for Family Safety and Healing, previously served for a number of years, very successfully, as the chair of Nationwide Children Hospital's board as well as a number of other community activites including being on the Pelotonia Board. In addition to her, the other community member will be David Fischer, who I hope all of you know. David currently serves as the CEO of Greif and has a tremendous interest in healthcare as well. We just couldn't be more pleased to have all of these folks sit around the table. I think that everyone brings a unique perspective.

I know I speak on behalf of The Ohio State University board in saying how grateful we are for all of your willingness to take on this important task.

With that, Mr. Chairman, I will turn this back over to you.

Mr. Wexner:

Thank you.

We really have a couple of things to do today. One is a report from Dr. Gabbe on the medical center, Geoff Chatas on the financial update, and Jay Kasey on the building project. With that in mind, Dr. Steve Gabbe.

Dr. Gabbe:

Thank you very much. A brief update for the board on the medical center. I think it is noteworthy that the medical center had 183 of our physicians, that is about a quarter of all of the physicians that practice at the medical center, were recognized as being the top 10 in patient satisfaction nationally. This is a remarkable accomplishment. I think that is in line with the fact that if you look at Columbus Monthly's list of the best doctors in Columbus, 80% come from the medical center. I have practiced in many large cities, I have never seen a city where so many of the top doctors came from one medical center and came from the academic medical center.

Many of you are familiar with our executive health program and it was recently named to receive the Press Ganey Beacon of Excellence Award. This is a very prestigious award for their outstanding service. In fact, we have had other Beacon Award winners: the second floor of the Ross Heart Hospital, the fourth floor of Ross Heart Hospital, our Critical Intensive Care Unit, and our 8 Rhodes Progressive Care unit. We have more Beacon Award winners than any other hospital in the state of Ohio.

I want to congratulate Mike Caligiuri, Jeff Walker, and their team for the James receiving Magnet Nursing Status just recently. Only a few percent of all hospitals in the country are designated for that nursing distinction; the University Hospital and the Ross Heart Hospital, as being Magnet recipients.

Of course, we are all celebrating the incredible success of Pelotonia this past year. Just a week ago Mike, it was announce that Pelotonia, in its fifth year, raised over \$19 million dollars. The total for 2012 was \$16.9 million so it continues to grow and in over five years has raised more than \$61 million. Team Buckeye, which this past year had almost 2,000 members, raised \$2.3 million. I want to thank all of our members on Team Buckeye. Pelotonia is already making a difference by funding significant new opportunities for innovative research thru the idea grants program.

I also wanted to make sure the board knew that today we will be submitting a request for \$21 million of funding from the state through the Ohio Third Frontier program. This is going to be for the Neuro-Modulation Innovator Translator Program led by Ali Rezai.

We have to have significant matching funds and we already have \$20 million from Medtronic. It's the first time they have gone outside of Minnesota to support these efforts and we are looking forward to having this supported by the state. Dr. Rezai pointed out that it is his hope that Ohio and Columbus will become the Center for Neurologic Pace Making, just as Minnesota, the Mayo in Minneapolis, became the Center for Heart Pace Making. It's a big idea that we are actively encouraging and supporting.

I want to move to the approval of our medical staff bylaws. As you know, in our Wexner Medical Center bylaws, we have a quality and professional affairs committee. This is the first meeting of our group so I wanted to point out that this quality and professional affairs committee is charged with reviewing and evaluating our patient's safety and quality efforts, overseeing patient care in all of our facilities, monitoring quality assurance to be sure that we are practicing well above the standards that are set, and approving the medical staff bylaws. The bylaws that we will be acting on today have been approved by the university

hospital's medical staff at meetings in July and November. We distributed those bylaws changes to you. I am happy to review them very quickly.

They relate to a new credentialing for physicians who have what's called a conceded imminence certificate for another category or another category would be the clinical research faculty certificate. Basically, these are for outstanding physicians who have trained abroad, who haven't trained in this country so ordinarily wouldn't be eligible for licensure unless they went through the Educational Commission for Foreign Medical Graduates (ECFMG) process which is quite gregarious for a surprising rising number of examinations. Because they are outstanding physicians who have been recognized in other countries or other medical centers where they have practiced, the state of Ohio has enabled us to credential. For example, Dr. Shinoka from Yale came to Nationwide Children's Hospital and he was awarded one of these certificates so that he could practice there because he is recognized to be an outstanding physician.

Another change that was made was to allow us to take care of patients who come to us for mental health conditions without having an updated history and physical in their chart. Why? Because they may be seen by a psychologist, they may be seen by a social worker, they may be seen by a practitioner who doesn't have the credential to do a history and physical. We need to care for them so we will care for them and then at the appropriate time we will make sure that they get a history and physical placed in their chart.

Those are the main changes. Andy, anything you would like to add?

Dr. Thomas:

No, that is a good summary.

Dr. Gabbe:

Thank you. I will ask that we move these bylaw changes Mr. Chairman.

Mr. Wexner:

Any question or comments?

May I have a motion to approve the amendments to the medical staff bylaws?

**AMENDMENTS TO THE BYLAWS AND RULES AND REGULATIONS
OF THE MEDICAL STAFF OF THE OHIO STATE UNIVERSITY HOSPITALS**

Resolution No. 2015-1 WMCB

Synopsis: The amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals are recommended for approval.

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff on July 12, 2013 and November 8, 2013; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were reviewed and recommended by the Quality and Professional Affairs Committee of The Ohio State University Wexner Medical Center Board on December 16, 2013:

NOW THEREFORE

BE IT RESOLVED, That the attached *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals are hereby adopted, effective immediately.

(See Appendix I for background information, page 21)

Upon motion of Mr. Jurgensen, seconded by Mr. Steinour, the Wexner Medical Center Board members adopted the foregoing resolution with ten affirmative votes, cast by board members Mr. Wexner, Mr. Jurgensen, Ms. Krueger, Mr. Gasser, Mr. Steinour, Mr. Wolfe, Mr. Schottenstein, President Alutto, Dr. Gabbe, and Mr. Chatas.

Mr. Schottenstein:

I forgot to mention something in my opening remarks and I apologize. In addition to the 15 members, we also have three additional *ex officio*, non-voting members, but very important people that will be seated with us around this table during each and every one of our meetings. They consist of the Dean of the College of Medicine, Dr. Charley Lockwood; CEO of the James Cancer Hospital, Dr. Mike Caligiuri; and the head of our faculty practice Dr. Chris Ellison. Welcome, are very thrilled to have you all here. Sorry for the omission during the onset.

Mr. Wexner:

Bob is sincerely apologetic. Thanks Bob.

Geoff, are you ready?

Mr. Chatas:

You all should have in your book a financial tab. It is hard to tell the difference between yellow and green; suffice to say that it is mostly green. This is the health system for the five months that ended November 30. This is what I really want to talk about very briefly in two pieces.

The yellows that you see are related to the variances of inpatient activity and surgery versus outpatient activity and surgery. The financials are all green and I will come back to that in a minute.

Inpatient activity is up 1.6% from the same period last year but slightly below budget. You will see that our total surgeries are below both last year's totals year-to-date and against the budget. We are seeing some softness in urology, ENT, and open heart surgery against what we had forecasted for the year. Having said that you are seeing the continuation, in outpatient visits, of a multi-year trend here where our outpatient visits are up 10% both to budget and prior year activities. You can see we almost had 160,000 more visits for outpatient procedures in five months than we had budgeted this year and 60,000 more that we had in the same period last year.

When you go down into the financial piece of this, you can see the operating revenue for adjusted admits; this adjustment is related to trying to convert outpatient activity to an inpatient equivalence so we can be talking apples to apples. You can see that, both against the prior year and against the budget, our operating revenue per admit is up 2.8% from the prior year and up .4% for the five months against the budget for this year.

At the same time, looking at operating revenues, you can see we are basically flat to budget at \$881 million but up from \$835 million for the same period the year before. We are reflecting that increase in adjusted admits taking in account the outpatient nature of a lot of that increase but receiving slightly more revenue per adjusted admit that we did against both the budget and prior year.

At the same time expenses, which for the period were \$794.5 million, are below what we had budgeted but above last year which reflects about a 3.5% year over year increase in salary, benefits, and pharmacy costs. We are basically less than 1% on other supplies and services. That has allowed us to generate this margin or gain from operations of \$86.6 million which is 11.6% above last year and 3.6% above budget. When you go down to that bottom section, you will see that our operating margin is at 14%. That is quite robust against other academic medical centers. It is above both prior year and the budget for the year

which has resulted in more days cash-on-hand that we had budgeted; slightly 62.3 days versus 61.4 days.

You will notice that service coverage is going down. It was 6.4 last year, its 5.9. It's because we have taken on additional debt related to the medical center expansion which we will come back to in a minute.

When you look at the hospitals, you will see this is the five hospitals across the bottom, the University, Ross, and James, all profitable at or near budget. The University is above margin, the Ross at margin, and the James slightly above. East and Harding both have a loss as projected for the year. The remainder is eliminations and certain physician practices, like anesthesiology, which operated a loss but support the other hospital activities; fairly straight forward.

Finally, this resulting in a quick snapshot of the balance sheet, you will see there is significantly more cash than there was a year ago; it was \$274 million, today it's at \$310 million. This includes operating cash as well as funds set aside for capital, research, and debt services. Some of that cash is going to be spent as we build out the building; we haven't paid all of the bills yet.

You can see down in liabilities, as I have mentioned, the debt growing from \$554 million to \$850 million. That will increase by another \$300 million when we borrow the remainder of the debt to build out the remainder of the expansion in the upcoming 12 months.

Mr. Schottenstein:

Geoff, going back to the first slide with the five month financials and I know that there is a lot of information on this but I have one question and then one comment. The comment would be, in future meetings to perhaps have a column for the goal for the year so that when you look at things like gains and operations and see that we are at \$86 million, we understand what the goal is for the full fiscal year.

Mr. Chatas:

Ok.

Mr. Schottenstein:

Knowing what you know, where do you expect this current fiscal year to end up in terms of gain and where does that relate to what we are budgeting?

Mr. Chatas:

We have no expectation of not meeting budget. We haven't seen anything on the horizon that would cause us to alter the budget for the year. We will continue to watch the patient mix and the reimbursement rate.

Mr. Schottenstein:

What is the budget goal for this year?

Mr. Chatas:

Pete, do you have that?

Mr. Geier:

A little over \$200 million on the bottom line and a little bit over for the gain on operations.

Mr. Gasser:

Geoff, any impact from the government shut down in terms of receivables or Medicaid?

Mr. Chatas:

No.

Mr. Geier:

Medicare was excluded from the shutdown.

Mr. Chatas:

We will know our receivables are on time and on budget.

Mr. Gasser:

But it impacts cash?

Mr. Chatas:

Some research funding but not much on the Medicare/Medicaid's. We have been receiving our payments within a reasonable time period.

Dr. Gabbe:

Our research funding was hit by about 5% from the sequester and of course this sequester included a 2% reduction in Medicare.

Mr. Wexner:

Geoff, I was just curious about the borrowings to finish the construction project. That's about \$300 million? Could you borrow that now?

Mr. Chatas:

We could. Just to remind the board, we borrow for all of the university's activities essentially through a treasury function. We are constantly managing a 36 month view of the cash needs, in and out. We also run an internal bank. To the extent that we have the cash proceeds available within our internal reserves over the upcoming 18 months; we may borrow less than the full \$300 million.

Mr. Jurgensen:

It's really an investment income versus interest expense arbitrage. There is a never ending judgment. Our rates are going up and down but you try not to be too much of a rate-guesser. We are sitting on \$300 million in cash; we are constantly looking at it.

Mr. Chatas:

We are and if we ever felt there was going to be a significant move in rates, we could move very quickly.

Mr. Wexner:

I was thinking that when we did the 100 year bond; the \$500 million that was borrowed without a designation, just taking advantage of the market; the university would have earned about a 5 or 6% spread.

Mr. Chatas:

On the portion that has been invested in the long-term investment pool of our funds, yes, it would be approximately 4.5%.

Mr. Jurgensen:

You are right but I take earned with a little grain of salt because part of the "earn" on that is the evaluation of where things stand at the moment and tomorrow they could be at another place. It's not like it's turned to cash in the long term.

Mr. Schottenstein:

We keep thinking this is the time to maybe lock in because rates are likely to go up.

Mr. Chatas:

Of course. We can certainly lock in without issuing so I will look at that. Because we have identified these we can do that.

Mr. Wexner:

It wouldn't be hard to match a 4% yield, would it?

Mr. Chatas:

On the income side; if you keep it in the short and intermediate. Our short term funds are running about 10 basis points right now; a little bit more from the Huntington, thank you. In general, it's around that area. The intermediate pool is at about 2%. The long term pool finished the year at 11.6% but we in general don't move specified funds in and out. In the last year, we have moved \$300 million or \$400 million into the long term pool.

Mr. Jurgensen:

Maybe what we can do because I think everyone would benefit from revisiting how we look at this. There is a reoccurring discipline process of how we decide what to do, when to do it. We ought to just bring everybody in.

Mr. Wexner:

If we have the cash and can borrow the money at a very low rate and it's fundable. If I said this is what we are earning in the long term and this is what we are earning in the short term and you put it all together, your earnings are likely to swap; what's long or short.

Mr. Chatas:

I would just add for public session we, under the constitution, only borrow for building per-say. That is an important distinction and within that we have flexibility.

Mr. Wexner:

Any questions for Geoff?

Mr. Wolfe:

Geoff, where you have corporate allocations; will you explain what that is and how you allocate those.

Mr. Chatas:

Sure. Corporate allocation is in essence the university overhead and some other things that has to be covered by the medical center. It is the allocated portion of the cost of running the university. Within the units, there is a separate allocation methodology which attributes a portion of that to each hospital. Pete, is the methodology the beds?

Mr. Geier:

It varies by category but the bulk of it is number of beds.

Mr. Chatas:

Many hospitals will use revenue. If you look at this page, you will see that the James and University Hospitals have roughly the same revenue profile but have a significantly different overhead allocation because the James has fewer beds. This was decided a decade ago.

Mr. Jurgensen:

Suffice to say that it is as much of an art as it is a science. It causes me to always look at the net margins at the bottom but take them with a grain of salt.

Mr. Chatas:

I would say there are two lines in which we can all discuss in further detail at some point. The expense line also involves significant transfers of cost between units; if you are a James patient and getting a MRI at University Hospital, the charge for that may be at a different rate than if it had been done externally. Both of these factor into that discussion around margin although it doesn't significantly move the needle at the end of the day. It would create some variance and you would factor overhead and expense allocation into the analysis.

Mrs. Wexner:

What types of things would you incorporate into allocation?

Mr. Chatas:

Bricker Hall office, the cost of administration, the cost of keeping the lights on at the institution; the costs that don't have a specific home in the \$5 billion enterprise. An example, the Athletics Department pays an overhead charge and each of the earning units have to pay an allocated piece for everything that doesn't have a home but requires dollars to pay for the expenses; IT, central services, finance; all of those things.

Mr. Jurgensen:

I would say that for any big company that has unallocated corporate overhead, that is what it is. Its G&A (general and administrative) and things that every big company has.

The treasury function is not in the hospital, it's in the center. The medical center and every other unit uses that treasury function, uses the data charter function, uses the IT function.

Mr. Chatas:

We have other accounts. We do have the overhead of paying PwC and all those things.

Mr. Schottenstein:

Geoff, so I can have more detail on this, there is \$86 million of corporate charges spread across the health system. If I think of the health system, roughly half of the university's budget, in terms of allocations, is there another \$86 million going to the academic side of that?

Mr. Chatas:

Yes, it goes all over the place though. It is based on revenue and I can bring those forward.

Mr. Schottenstein:

No. So, all of those things that make up the corporate allocation; it's about twice this amount?

Mr. Chatas:

I have to get the exact number because there are some different methodologies from different units so I hesitate to say it. It is not as straight forward.

Mr. Jurgensen:

The reason that I don't think it is exactly that way is that the allocation methodology is not revenue. So when we say that the medical center is half the university, we need to be very careful. It is in one dimension but it's not in 17 others.

Unless you go through each individual item and ask what is the methodology employed, you can't get to the conclusion.

Mr. Chatas:

Let me add it to my list. Let me come back to a much fuller description because I know and understand the issues here, so that we understand what is being allocated and how and what the expectations are for where we are going.

Mr. Wexner:

This is always a sensitive subject at two levels; the university's allocation to its parts and the medical center's allocation to its parts. I have asked Geoff about it and he thinks it is fair. Everybody would think it is unfair; the charges, and the charge orders because there are so many puts and takes.

This is one that you will never get an agreement on no matter what you do unless it is zero to everybody. Then only the payers will be happy.

Mr. Jurgensen:

One other thing on the scorecard, just for the benefit of our new community members; not just with respect to the medical center, all of the scorecards that we utilize in the university are becoming a topic of increased conversation and increased scrutiny. Are they effective? Are they telling us what we need them to tell us?

I am going to make up an example to make a point. We could have things in the university that we have been following on the scorecards for years. We see nothing but green, maybe an occasional yellow here or there and then we wake up some morning down the road and we are in some huge problem. You think wait a second, how in the world did we wake up in this enormous strategic crossroad when all we have been looking at is green for the last five years?

The scorecards have been green for the last five years; and not just the medical center. This is true on the university, the academic side, everywhere where we employ them. We are talking about what are all of the things we need to know and pay attention to and follow. For example, most of the scorecards tend to be much more annual in their orientation, much more about budget, and maybe variances to last year in their orientation. Very few scorecards bring in intermediate and longer-term issues. They don't bring in the strategy and they don't bring in the tactics in pursuit of a long term strategy. If we have something that is going to take us five years to do, we don't have bench marked how we track on how we are doing along the five years.

They tend to be significantly more internal in their orientation than external. You don't see much about competition and what is going on in the environment and what are the influences on this business that I am monitoring on the scorecard.

The metrics are presented as if they are all equal but we know they are not. Surgeries matter more to our margin than admissions. You wouldn't know it necessarily by looking at this. We need to go through and ask ourselves, for everything single thing we are putting green and yellow on, how important is it and does it really matter. How does it matter to cost, how does it matter to quality, how does it matter to reputation, and how does it matter to our financial efficiency and effectiveness?

In certain businesses we have multiple purposes and missions. In medicine, we have a three-legged stool: teaching, research, and clinical; but our scorecards are clinical. Everybody gets that, everybody knows that, the management know that, finance knows that, the board knows that. In the finance committee of the board, Geoff and I have been talking about this for a while. We don't have all the answers for you. I wanted to plant with you that we all recognize we need a lot more than what we are looking at here to really run the business.

Mr. Wexner:

Any other questions?

Ms. Krueger:

Just to back that up, I was at Brigham and Women's Hospital last week for four days and spent a significant amount of time with Dr. Chiocca and we were talking about corporate allocations as the first subject. He said that compared to Ohio State, theirs is so much more sophisticated. I agree with what Jerry just said. I think that there is going to be a huge opportunity in how we allocate things and does it make sense to a level of detail that we need allocated to. It appears to me that there is opportunity out there to try to get a more realistic picture of what we are really trying to capitalize and our investment capital plan.

Mr. Wexner:

I think that is the work of the work. Hopefully a year from now, we will answer our own questions and go through this and have thought it through and do some benchmarking to understand these issues.

Any other questions for Geoff or Jerry? Any comments? Jay, you are next.

Mr. Kasey:

Thank you, Mr. Chairman. I wanted to take this opportunity to bring everybody up to speed with where we are on the Medical Center Expansion Project. It is moving forward. It has been underway for the past six

years and it has another year before we believe that we will be occupying the building with patients. Let me walk through that and say that this is an encompassing project and today's meeting, the first one of this board, we plan to be broad so that we can bring everyone up to speed with where we are and how we got to where we are and then in coming meetings, we hope to drill down into individual areas of problems or progress that are important up until the actual transition plan of moving patients and how that kaleidoscope of activity is going to occur.

I want to remind you that this is a project that started six years ago. There were a number of enabling projects that had to be completed prior to actually putting the tower in place and launching the infrastructure so you will see that up at Twelfth Avenue, the north Doan faculty office building was constructed. The MRI additions and the Campbell hall renovation were completed so that the demolition of Means hall and Cramblett hall could be accomplished. Those two things had to be demolished so that the tower, the jewel and the crown of this project, could be completed.

So many things have happened over the past six years or so. The replacement of infrastructure I will go into in just a moment but currently, among all these different projects, we have still underway the tower itself, the Critical Care Cancer Tower, and the construction of the Jones Legacy Park that is well underway and the renovation of the South Cannon Garage to support the new tower is also underway and moving forward. Many things have been completed and we are now at a point where we can see the end is in sight, we believe, and we are very pleased with that.

I want to walk through each of the major phases of the project again as background for you. We manage the project in what we call "project silos." All those boxes that you saw on the preceding slide are managed in five large categories. The first is the tower and then there is another category team working on infrastructure roadways. The Rhodes, Doan, James (the RDJ) upgrades are electrical and heating ventilation and cooling and a number of other infrastructure upgrades and then much smaller groups are landscaping, Spirit of Women Park and the demolitions that had to take place.

I would like to just remind you what is in each of those silos. The Cancer and Critical Care Tower is about \$700 million of the \$1.1 billion budget for this project. It includes the seven acute care beds for cancer, the bone marrow transplant floor. We have finished half of the ICU beds or spaces and we have left shelled half of 72 of the critical care hospital floor rooms and one and a half floors. We are building 14 new operating rooms that will be added to our cohort of ORs across the Medical Center. There are five interventional radiology suites and 52 out-patient exam rooms. Those out-patient exam rooms are clustered by types of out-patient cancer, driving out-patient services in the building.

In addition and also in the tower, you see sixteen clinical trial stations for primarily out-patient. Radiation oncology was an addition to the building funded by a \$100 million grant from the CMS and has been inserted and is being completed on the same time table. There are 40 chemotherapy stations. There are 21 bone marrow transplant stations to serve that clinic. The 16 emergency department treatments and 16 immediate cancer care beds are located adjacent to each other and serve as really the immediate and emergency services addition for this project.

This diagram is very busy but I do want to point out a couple things. This building marries up and moves patients. The first four floors are tandem with their same function, surgery to surgery for example. in the existing Rhodes hall where we will still have the majority of our patients so that we can move patients efficiently and in a lean way across our organization. Additionally, up on the ICU levels, there is another bridge up in the air to allow for the efficient flow of patients and materials. This, among many other things, is what will make this building work well with the rest of the medical center so that we don't have to take patients always vertical before we can take them horizontal.

As you look at RDJ MEP (mechanical, electrical, and plumbing) upgrades, I won't go into all of these but for your review, there is a large investment. This was about \$56 million of investment in our budget. These projects are almost complete and are just finishing up. One thing that I will say is that the air handler units in the ORs and the emergency department are just so important. It is now cold in surgery year-round. It

was always cold in surgery during the winter months but in the summer months it was cool. We have a very significant investment on the fourth floor of our surgical suites.

In our infrastructure and roadways, this is a general list of many of the things that have happened and have been invested in. These are our highest priorities for infrastructure improvements across the medical center. Many of these items are completed. We are still working on the Dodd loop around the Jones Legacy Park and we still have a little chiller water distribution work that we don't have to go into but many items have been completed.

This is just an example. I am kind of unnerved about these things. This is really important to me. We went from five docks to 10 docks in this project and again the just in time work of taking materials and waste out of the building and bringing new things into the building has been tremendously enhanced by the addition to this project.

The chilled water loop has been completed around the medical center. This allows us, over the course of the next generation, to start to decommission the rooftop chiller units that we have and we have depended on for many years across the medical center. As they time out, we will dispose of those and not have to invest in those as standalone. This is also a much more efficient loop for bringing HVAC to our campus.

We made a big commitment to the green spaces on campus and whether it is the Spirit of Women Park or the new Jones Legacy Park, they can be matched by the terraces on the 14 floor, which are tremendous improvements for patients, particularly cancer patients that have a long-term length of stay.

I want to also highlight that still in construction is the new oval, what will be called the new oval, which is in the Jones Legacy Park. We believe that this is part of some of the changes that we brought to the project in the spring months of this year. We redesigned the Jones Legacy Park to reflect the better elements of what we believe are our brand is at The Ohio State University and we think this is going to be a great enhancement to the rest of the green spaces across the medical center.

At a very high level, I want to bring you up to speed with the budget for the project and what we have spent in our budget. The budget has always been \$1.1 billion. That funding has been released from the Board so that we can acquire it. It was released in incremental pieces across each six months of the projects life. Contracts to date are a little over a \$1 billion. We have about \$95 million left to commit to contracts and we have actually spent \$754 million. There was an audit of the project in October. The audit brought us some recommendations which I can review in future meetings but the budget and the schedule was felt to be appropriate and going forward, under control.

Finally, I want to mention to you that the project is scheduled for completion of construction of the project before the end of the September of the coming year. We are inside about 10 months of that and following the completion and delivery of different floors, as you see here, the medical center will be awarded the project from the construction team and then we will have October and November to bring in our IT services, furniture, to clean, and to also do education on the units so that when we start receiving patients about the second week in December, during that two week period, all our teams will be ready to hit the ground running and be prepared to give great patient care.

That is the presentation for today. Can I answer questions or go deeper?

Mr. Wexner:

Any questions?

Mr. Steinour:

Jay, any back end risk in terms of overruns or change orders or things of that nature?

Mr. Kasey:

Yes, there are. We have about 10 months left before we really punch this project out. These are 10 months in which the users have started to look at the building and think about what they didn't think about four years ago when they put their plan in design. There is a team of people headed by myself and Friedl Bohm, Geoff Chatas, Chris Culley, and Pete Geier who are meeting now regularly to make sure that any changes that come through the building are appropriate and approved. We greatly slowed that process but there will be some challenges that we intend to bring to you as this board continues to meet.

Mrs. Wexner:

On that note, how much contingency is there?

Mr. Kasey:

There is, and I will get into this a little later, but there is about \$26 million of contingency left. There is some risk against that contingency already that we will get into but when it comes down, we think worst case we will have a little over \$5 million of that \$26 million.

Mrs. Wexner:

Left?

Mr. Kasey:

Yes, that is unspoken for.

Mr. Wolfe:

What was your budget originally six years ago? I mean your actual budget figure for the whole project?

Mr. Kasey:

The whole project was \$1.1 billion.

Mr. Wolfe:

It started out at a billion, right?

Mr. Kasey:

It started at a billion and then we added \$100 million.

Mr. Wolfe:

How do you think you are going to come out relative to an original budget figure?

Mr. Kasey:

Well, we took \$25 million out of contingency about a year and a half ago and we feel confident that we won't need it. We built out another floor and four more ORs with that \$25 million. I consider that already a win but I think that we will be very close to our final budget when we finish this up. I think we will be on the positive side of our final budget, or very close.

Mr. Wolfe:

And we will have built more than we originally planned to build?

Mr. Kasey:

We will have built almost a 100,000 square feet, a whole floor plus some surgery rooms. We can bring to you a note on price per square foot of what was intended and where we end up.

Mr. Steinour:

When those savings were realized, that \$25 million, it came back to the Board of Trustees and asked their approval to build 36 additional cancer beds, four additional ORs, and office space for the new radiation oncology floor.

Mrs. Wexner:

Jay, under what you can anticipate currently, when would you need the built out of those shelled spaces?

Mr. Kasey:

We think that by March of this year, maybe April, the last \$95 million of budget will be committed and we will know what type of savings we have against the entire project. We will feel much more confident in what we have extra, if we have extra, in the project by April 1st or so.

Mrs. Wexner:

I was asking more really on the demand side on the shelled spaces. When do you anticipate requiring that space?

Mr. Kasey:

We are not anticipating doing that in the scope of this project.

Mr. Steinour:

How much shelled space is there, Jay?

Mr. Kasey:

There is a floor and a half of ICU rooms, that is a total potential of 72 ICU rooms, and then miniscule scattered small amounts of shelled space in the lower level of the building

Mrs. Wexner:

But at the growth rates that we are seeing? I am just trying to understand the sensitivity.

Dr. Gabbe:

By 2020 we will need to build out that space, the critical care space. The cancer beds will all have been built out. It will just be those 72 critical care beds in demand. Andy will tell you, who is our Chief Medical Officer and has been great, while we will be adding new beds, we will also decommission some of the older beds in Rhodes hall ICU. We are moving our neuro critical care unit into the new hospital so that will take up some of those 72 beds. Thirty beds will be designated for the James as critical care beds as required by CMS (Centers for Medicare and Medicaid Services). We anticipate in the coming years we will need to build those out. The James now has 237 beds; 160 were from the original James and 77

leased from University Hospital. They are full and we have 276 James beds so we anticipate we may need more beds.

Mr. Jurgensen:

Steve, I think it would be fair to say to try to answer your question, it depends what strategy you take in the analysis. We are going to have a conversation about it. That is going to have both an impact on what is going to happen with respect to the new tower but it is also going to influence in a meaningful way the backfill strategy.

Mr. Kasey:

That's the key. The decision matrix should be heavily reviewed under the context of a backfill strategy; what do you keep operating in the existing building.

Mr. Schottenstein:

The existing James?

Mr. Kasey:

Rhodes and Doan. The James could acquire more of those shelled beds if you keep more operating University beds in Rhodes hall.

Mr. Wexner:

Questions? Comments? The only comment I have is, you know, Jay said this project has been going on for six years and it is at least that. The project in its present form has been going on for four and Jerry's point of view is well made that the medical center is half of the university if you look at it in budget. If you look at it in development or development opportunities it is significantly more than half the university's development opportunities because medical centers are more appealing than other things. If you looked at dorms and student housing it would be insignificant. Still reputationally, it is probably most significant or ties with athletics.

Specifically, when the project was started six years, and we said this with some of the university trustees who are newer to the board in the last six or seven year periods and the hospital board members, there was a hospital plan. Two years of planning went into it. It was also planned in a floodplain and it was completely disconnected from the rest of the buildings. The need for oversight from the university board for what it does and its oversight of the Medical Center Board and active participation with the Medical Center Board is really very much needed. If we would have actually built the hospital on a floodplain it would not have been a good thing.

We hit the pause button. Part of that, and this relates to the Medical Center Board, is that there was no master plan of the medical center. There was nothing that a land planner or architect would say was a master plan. So when asked the question, if there was a master plan, the answer was yes there was but the same answer was true for the university; that there is a master plan and university architect, except there is no master plan with the university existing today.

The master plan of the medical center was undertaken, and this is important, because it surveyed all the buildings, aligned them, and then made tentative plans into the future what buildings would be demolished, how the medical center might expand not knowing exactly what would happen, but at least looking at options. That actually does exist. There was no traffic plan for the university then and there really is none now. Very significant to the success of the university and the medical center is the boulevarding of Cannon Drive so there is a way to get across the university north to south. The only way you can do it is if you get on 315 or High Street, which has a great impact on the medical center because

often a lot of people arrive by ambulance and the medical center probably has more visitors and traffic than the university does 365 days a year, except for football Saturdays.

The complexity of the medical center inside the complexity of the university, if you look at it from the physical planning and capital expenditure and then connecting it and balancing it academically. Financially this is very complex stuff. We are at the beginning of the beginning, I think in my view of the university and the medical center, of really understanding the complexity and trying to sort it out rather than adding more complexity. It is a solution for the complexity.

The planning of the building and the whole site plan is quite significant. The fact that, as Jay mentioned, the symbol of the oval or parks of the university, is it important for the university to have green spaces between buildings? It never was really considered post the oval. Everyone likes the oval but no one said green spaces weren't important and in the original plan for the medical center, the park didn't reflect the university. You might have a green space that was alienated from the university so the symbolism of ovals or those kind of shapes, geometric forms that reinforce the university, is the beginning of a lot of important stuff that the university is going to do. Every part of it, whether it is the academic connection, communications, this is really complex stuff. Jerry worked at a large multidivisional company. My business isn't so big but it has complexity. This is a monster because the complexity of all the parts and then the complexity of the total and then you get simple issues where it is just like allocations. It is like God couldn't find a solution. There are a lot of moving parts so I think we are making progress.

This project, as I have understood it, has been well managed financially in terms of getting it done on time, on budget, and the contingencies, building out the shell, the \$100 million grant while steel was going up, that building had to be redesigned to put the radiology equipment grant on this upper floor is just the structural decision. This has been a reasonably complex project and I think when you look at the original budget, how it was bid, as I remember from being on the board and then the contingencies and from everything I have heard over the last four years while it has been in progress, pretty well managed financially considering all the variables.

Mr. Schottenstein:

If I could follow on that and this really relates to your question, John and for you sitting in the back of the room, for us to be where we are given everything you just said, going into this enormous project, which was the largest in history. Even today it is still the largest in history to the university. To know that we actually increased the scope and yet we still believe, we don't know yet because we aren't done, but that we are going to be on the north side of our contingency when we are done.

I don't have to say it because our friend but Friedl has done an extraordinary job working hand and glove with you and the senior team on this; just one percent here and one percent there when you are talking about \$100 million.

Mr. Kasey:

Friedl knows this, but I just want to echo that, Friedl is here because we asked him to come. He doesn't seek these opportunities out. I will just say that Friedl has meant months if not years to this project on the positive and millions of millions of dollars. It goes back, if I can Mr. Wexner, to that original four years ago when we redrafted what this was going to look like.

Mr. Jurgensen:

I would also say there are some people on that side of the table who were extremely helpful in construction reform and that has paid a meaningful dividend in this project as well.

Mrs. Wexner:

Sorry to harp back to the shell space. I only raise it because when we disbanded the other Medical Center Board, whatever it was called, I remember there being a particular concern on the cancer beds at the time of opening and how tight we are or would be. I understand that you need to have a strategy around it, except that my impression from those meetings is that we had a problem one day when we opened in terms of capacity and any expansion there. I am just trying to understand whether that has changed or whether there is different thinking there.

Dr. Gabbe:

Well that led to the build out of that 21st floor, the 36 beds, as well as the build out of the four operating rooms. In retrospect, that was a very wise decision because since then Mike and Jeff and their colleagues have recruited Raphael Pollock from MD Anderson, who was the leading surgical oncologist there, so there is a need for those operating rooms. Mike, if you want to comment?

Dr. Caligiuri:

I think right now, as Steve said, we have 237 beds and those are non-ICU, just cancer beds and when we open we will have 276 non-ICU cancer beds. There will be about a 10% gain in absolute beds and cancer beds.

Mrs. Wexner:

And that again, we would hope would carry us through 2020?

Dr. Caligiuri:

At our rate, I don't think that will carry us through 2020 and that's where Steve's point is where we can take some of the 48 critical care beds that are currently shelled and take some of those out and put them to UH or one of the other remodels and build those out for cancer. They are contiguous. They fall within our exception so there is the capacity there. Is that fair?

Mr. Kasey:

That's for future discussion. There are 72 more in-patient treatment spaces available.

Dr. Caligiuri:

But to your point, at the rate of growth that we have had, those 10% beds won't hold us for the next five years if we continue at the same rate. That could change with payer mix, reimbursement, etc.

Mr. Wexner:

Thank you. At this time, we would like to recess into Executive Session to consider business sensitive trade secret matters required to be kept confidential by Federal and State statutes. May I have a motion for adjournment?

Upon motion of Mr. Jurgensen, seconded by Ms. Krueger, the Wexner Medical Center Board members adopted the foregoing motion by unanimous roll call vote, cast by board members Mr. Wexner, Mr. Jurgensen, Ms. Krueger, Mr. Gasser, Mr. Steinour, Mr. Wolfe, Mr. Schottenstein, President Alutto, Dr. Gabbe, and Mr. Chatas.

Mr. Wexner:

We are adjourned. We will move upstairs for our executive session.

December 16, 2013 meeting, Wexner Medical Center Board

Attest:

Leslie H. Wexner
Chairman

Heather A. Link
Associate Secretary

(APPENDIX I)

AMENDMENTS TO
THE OHIO STATE UNIVERSITY HOSPITALS MEDICAL STAFF BYLAWS
THE OHIO STATE UNIVERSITY HOSPITALS (4.5.2013)

Chapter 3335-43

3335-43-01 Medical staff name.

no change

3335-43-02 Purpose.

(A)–(D) no change

3335-43-03 Patients.

(A)–(C) no change

3335-43-04 Membership.

(A)–(D) no change

(E) Procedure for appointment.

(1)–(2) no change

(3) An application for membership on the medical staff shall be considered complete when all the information requested on the application form is provided, the application is signed by the applicant and the information is verified. A completed application must contain:

(a)–(c) no change

(d) Satisfaction of ECFMG requirements, if applicable. If an individual receives a conceded eminence certificate or a clinical research faculty certificate from the state medical board of Ohio, the requirement for ECFMG certification may be waived at the discretion of the medical center board.

(e)–(m) no change

(4)–(8) no change

(F)–(G) no change

3335-43-05 Peer review and corrective action.

(A)–(F) no change

3335-43-06 Hearing and appeal process.

(A)-(E) no change

3335-43-07 Categories of the medical staff.

(A)-(I) no change

3335-43-08 Organization of the medical staff.

(A) no change

(B) Names of clinical departments and divisions.

(1)-(14) no change

(15) Psychiatry. The following divisions are designated:

General psychiatry
Child and adolescent psychiatry
Geriatric psychiatry
Health psychology

(16)-(20) no change

(C)-(D) no change

3335-43-09 Elected officers of the medical staff of the Ohio state university hospitals.

(A)-(G) no change

3335-43-10 Administration of the medical staff of the Ohio state university hospitals.

(A) no change

(B) Chief quality officer.

The chief quality and patient safety officer of the Ohio state university medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer [for administrative and operational issues and has an independent reporting relationship to the senior vice president for health sciences regarding quality data and patient safety events. The chief quality officer](#) ~~and~~ works collaboratively with clinical leadership of the medical center, including the director of medical affairs for the James cancer hospital, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

(C)-(M) no change

3335-43-11 History and physical.

(A) (1)(a)-(5)(b) no change

(c) For admitted patients or patients undergoing an outpatient/ambulatory procedure or outpatient/ambulatory surgery, the history and physical examination may be performed or updated up to thirty days prior to admission or the procedure/ surgery or the visit. If completed before admission or procedure/ surgery or patient's initial visit, there must be a notation documenting an examination for any changes in the patient's condition since the history and physical was completed. The updated examination must be completed and documented in the patient's medical record within twenty-four hours after admission or before procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff or his/her designee, who is appropriately credentialed by the hospital, and be signed, timed and dated. In the event the history and physical update is performed by the medical staff member's designee, it shall be countersigned, timed and dated by the responsible medical staff member.

(d) no change

(e) Ambulatory patients must have a history and physical at the initial visit.

(f) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:

i. within the past six months prior to the initial visit,

ii. at the initial visit, or

iii. within 30 days following the initial visit.

3335-43-12 Meetings and dues.

(A)-(B) no change

3335-43-13 Amendments and adoption.

(A)-(D) no change

3335-43-14 Rules of construction.

(A)-(B) no change

APPENDICES

APPENDIX I.
COAT OF ARMS OF
THE OHIO STATE UNIVERSITY HOSPITALS-no change

APPENDIX II.
COAT OF ARMS OF THE MEDICAL STAFF
OF THE OHIO STATE UNIVERSITY HOSPITALS-no change