THE OHIO STATE UNIVERSITY

OFFICIAL PROCEEDINGS OF THE

FOURTH MEETING OF THE

WEXNER MEDICAL CENTER BOARD

Columbus, Ohio, April 2, 2014

The Wexner Medical Center Board met on Wednesday, April 2 at Prior Hall, Columbus, Ohio, pursuant to adjournment.

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Minutes of December 16, 2013, January 29, 2014, and February 28, 2014 were approved.

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The Chairman, Mr. Wexner, called the meeting of the Wexner Medical Center Board to order on Wednesday, April 2, 2014 at 2:04 pm.

Present: Leslie A. Wexner, Chairman, Janet B. Reid, William G. Jurgensen, Cheryl L. Krueger, Corbet A. Price, David B. Fischer, Stephen D. Steinour, Abigail S. Wexner, John F. Wolfe, Robert H. Schottenstein, Joseph A. Alutto, Steven G. Gabbe, E. Christopher Ellison, Michael A. Caligiuri

Mr. Wexner:

Good afternoon. I would like to convene the meeting of the Wexner Medical Center Board. So that we are able to conduct the business of this meeting in an orderly fashion, I would ask that the ringers on all cell phones and other communication devices be turned off at this time.

Ms. Link, please note attendance.

Ms. Link:

A quorum is present Mr. Chairman.

Mr. Wexner:

The minutes of the previous meeting of the Wexner Medical Center Board were distributed to all members of the Board. Are there any additions or corrections?

Dr. Gabbe:

There is a correction. On page 12, we talked about our new James Cancer Hospital Critical Care Tower. We said that it includes seven acute care beds but I think it should say seven acute care floors.

That is the only change.

Mr. Wexner:

I am glad somebody read the minutes.

Mr. Jurgensen:

I made a comment to some folks. I am not sure verbatim minutes make a lot of sense.

Mr. Wexner:

They don’t to me. Everyone gets hung up on the rules that the state may or may not have.

Mr. Jurgensen:

We need to find out if there is a legal requirement to do it. In corporate America, we shy away from verbatim and minutes get reprised.

Mr. Wexner:

Let me find out. I know there is a requirement for recording.

Mr. Jurgensen:

They have to be recorded to be done this way. We have had our issues with tapes.

Mr. Wexner:

Yes. Good point, thank you. I will take this and follow up and also take the correction to the minutes.

If there are no other corrections, they will be approved.

Steve Gabbe is going to give his report and also make the report that Geoff was going to make.

Dr. Gabbe:

I wanted to bring the board up to date on a number of important issues at the medical center.

First, you may have seen U.S. News and World Report's rankings of the 128 medical schools and 25 osteopathic schools in the country. Two years ago, our College of Medicine was ranked 39th, last year 38th. This year we have moved up to 34th among the research medical colleges, where the emphasis is on NIH funding. We were also ranked 29th in primary care where the emphasis was on how many of the students go on to careers in primary care. Among the public universities, we were ranked 12th for research and 20th for primary care, which overall, is very good.

Why did we move up in the rankings? We moved up because our NIH funding increased, residency program directors gave us higher ratings, and because our entering students have increased their GPA to 3.70, one of the metrics used in the ranking system.

Last week, we had a very important accreditation visit from the Liaison Committee on Medical Education (LCME). This committee is charged by the Department of Education with accrediting all medical schools in this country, as well as in Canada. It is an 18 month process to get ready for the visit. It is an enormous amount of work. They have over 120 standards that they use to judge the quality of our medical school.

I chaired the group for three years and was on it for six. The findings for our medical college are one of the very best that I have ever seen. They praised us for the career advising system that we have for our students. They praised us for the portfolio program that monitors students' progress through the new "Lead, Serve, Inspire" curriculum.

They wanted us to closely follow our efforts to enhance faculty, diversity, and graduate medical education. They wanted us to closely follow our financial stability.

They will probably only have one finding of noncompliance. They feel that our faculty should have a greater opportunity to directly engage in committees overseeing the medical education program. Right now, we rely on department chairs or other administrative leaders to nominate faculty for this position. They would like to see the faculty be able to do that directly. That is not a very large area of concern and we can certainly address that.

The LCME visit went well.

Mr. Wexner:

Ed, did you want to add anything to this?

Dr. Funai:

We will get a final determination from LCME in October. From what we have heard, this has been one of the most favorable reviews that many have seen in years. I expect that it will result in an eight year reaccreditation down the road.

Dr. Gabbe:

We had "match" day last Friday. This is the day that our students find out where they are going to do their residencies and we find out who is going to come here to train with us. It's called "match" because the students and hospitals enter their list of preferences in the computer and they are matched up.

Some key statistics for our "match", which overall, was very successful: 42% of our students are going to stay in Ohio, which has a class of about 206; 25% of our incoming residences for our medical center will be from the Ohio State class. Nearly half of our students, 49%, were matched in primary care. This includes family medicine, internal medicine, pediatrics, and OB/GYN. We filled all but four of our 154 positions the first day, and the remainder were filled the next day. We had a complete "match". 19% of our incoming residents are from top 25 ranked medical schools.

Nationwide Children's had 33 residency positions that "matched" and eight of them were Ohio State students. That is the usual number, about 6 to 10 of our students go to Nationwide.

Some of you may have seen, it was pointed out in an editorial in the Dispatch and Mike was quoted, a reference to the licensing of an anti-cancer vaccine. This is the result of decades of work done by Pravin Kaumaya, who is a member of the OB/GYN department. I actually recruited him here many years ago. This was licensed with MedVax Technologies Inc.

This is very exciting work. It is a vaccine that works against the HER2 marker and was funded by Pelotonia. This is something we can all be proud of.

We have been very busy in transplant. We completed our 100th lung transplant. The week of March 7-14, there were 21 organ transplants. I don't know if that is the busiest week we have ever had but it I am sure is was among the busiest.

Some of you may have seen press that was related to a paper by Courtney Lynch, who is a member of our OB/GYN faculty, titled "Preconception stress increases the risk of infertility: results from a couple-based prospective cohort study - the LIFE study." This has received world-wide media attention. She noted that women who were stressed by a number of biologic markers were about 30% less likely to become pregnant.

Finally, Dr. Andrew Glassman has been named Chair of the Department of Orthopaedics. We are very pleased with this. At this point Ed, I think that all but one department chair has been named.

Dr. Funai:

Exactly. With the exception of pathology and that one is currently in negotiations.

Dr. Gabbe:

That is something else that the LCME looks at very carefully when they come to visit.

Are there any questions about those?

Mr. Steinour:

Steve, could you describe the significance of the vaccine, the research during that period of time, and what this might mean for health care and even the hospital?

Dr. Gabbe:

I will call on Mike. I think Pravin came here in 1990. Why OB/GYN? We had a scientist, Vern Stevens, who is working on a contraceptive vaccine. He came to work with Vern.

Mike, do you want to comment?

Dr. Caligiuri:

Sure. Pravin is a pepti chemist. He makes very tiny partial proteins and has been working on this for about 20 years. This vaccine activates the immune system to create an antibody against HER2. One of the big break-through drugs in the last 15 years in breast cancer has been Herceptin®. It cost about $300,000 a year for a woman to be on Herceptin® and sometimes they are on them for great lengths of time. This allows the body to make Herceptin® continually, from the vaccine, maybe with a boost every six months. In the first two phases of the clinical trial, where you are trying to find the right dose and stimulation of the immune system, we had one complete response of a patient out of about 10 or 12, and had a couple partial responses. That gets the industry very interested, very quickly. It's a good time to partner because you've paid for all of the 10-20 years of R&D and then industry can come in and partner and move things to the clinic.

At this point, it probably has about a 5% chance of making it to FDA for approval. That would be typical at this point for something that has gone through phase 1 and shown some activity. This has the possibility of revolutionizing the treatment for breast cancer and ultimately the prevention of breast cancer. It's big.

Dr. Gabbe:

As you know we have the Partners Achieving Community Transformation, the PACT group, working to bring improved housing and health care to the near east side; University Hospital East and CarePoint East are there. We received $300,000 of funding from a planning grant. We used that to write a grant for a Choice Neighborhoods Initiative grant. It is a $30 million grant. There were 44 applicants and six cities were chosen as finalist: Pittsburgh, Atlanta, Philadelphia, Norwalk, Tulsa, and Columbus. The HUD team came last week and said that they have $109 million to fund these grants. They also added that congress gave them an additional $90 million. We had a very successful site visit and will know if we will be awarded in the next five to six weeks. We are cautiously optimistic. This would allow us to spend $20 million on housing and $10 million on programs.

President Alutto, do you want to comment on this?

President Alutto:

This is very exciting. It is probably one of the more successful community development efforts that we have seen in an urban environment. That is why it has received all of the attention. It deals with all of the dimensions. It deals with educational issues, housing issues, and employment issues to the point that it affects every aspect of the development of that community. It's a great example of what can be done when you take a multi-dimensional approach to a problem rather than a one solution of either addressing education, or addressing housing, or addressing nutrition for young mothers. It is really an effort to bring all of those together and has been supported heavily by our medical center. We are delighted with it.

Dr. Gabbe:

Thank you. If there are no more questions, I would like to move on to the Medical Center Initiatives Scorecard. Some of these items will be covered when we go over the financial update.

The medical center expansion is going well and Mr. Kasey will give you an update on that. We will talk about the clinical metrics and the financial metrics on the next report. I would like to comment on the development dollars.

Our goal for the year is $100 million in philanthropy and $31.9 million in private grants. At the close of February, we raised $50.9 million in philanthropy and $24.2 million in private grants. Our shortfall is more related to the private grant activity in the Office of Sponsored Programs than it is philanthropy. I think it is important to note that of the $50.9 million in philanthropy, the James has raised $36 million of that.

We have data that Patty Hill-Callahan provided through the end of March and we have added nearly $9 million to our philanthropy. We are now close to $16 million and we have added $3.5 million in private grant support. At the end of March, we will have raised almost $87 million toward our goal.

If you look at research, you can see that our total research awards are red, $158.8 million versus $174.5 million. That is not because our NIH funding is short. Our NIH funding is close to budget. Most of the shortfall in our research is non-NIH federal awards, awards from other federal agencies that are not NIH. We think that a good part of this is related to the government shutdown, with the late grant reviews, grant decisions, and grant funding. Also, the NIH is cutting all of their awards. You may get funded but they will cut the grant substantially. We think that is impacting us in terms of NIH.

We will look at the final metrics within patient care, quality, and satisfaction, you can see that we are yellow. The inpatient satisfaction indicates how many patients respond to the question "during your stay, how would you rate this hospital?" and how many of them respond with a nine or a ten, the top two scores from zero to 10. For us, that is 73.3% versus our target to date of 74.1%. The question that our patients are asked for outpatient satisfaction is "would you recommend this provider's office to your family and friends?" and we are at 90.9% versus our target of 91.4%. We are just short of the target on the patient's satisfactory.

Mr. Wexner:

Any questions or comments?

Dr. Reid:

This is on the research piece. You talked about the effect of the government shut down. I also know with the sequester, NIH and other grants are going down. Is it also true that the length of those grants, where grants used to be led for three to five years, are effected as well so people will have to reapply more quickly than they had to in the past?

Dr. Gabbe:

We had a NIH fund that was cut at 5% during the sequester, which for us, is about $6 million that fell short. Mike, the cycling is shorter; the people are watching you closely and monitoring your progress?

Dr. Caligiuri:

It is more as Steve said. It is more the fraction that you get. Some grants go from five years to four years. We did just get three grants within the last 72 hours. We received a large grant, phase 1 study, in cancer for $4 million; Mike Grever's grant. We received two RO1 grants; each is about $1.5 million. We might be starting to see a little bit of the shutdown returning back to baseline.

Mr. Jurgensen:

This is not a huge deal. I think the optics of having a patient satisfaction goal of under 100% is an issue. I know how these things work and you probably can't ever get there but to say that we would be ok if only three out of four patients were satisfied is probably not what we want to say.

Dr. Gabbe:

Our goal is actually the top decile, the 90th percentile. To get there, we have to be at 78% and 93%.

Mr. Jurgensen:

It is just optics. If it gets expressed this way, rather than the percentile way, it probably should just say 100% and then we work to be as good as we can possibly be.

Dr. Gabbe:

Yes. We had our patient experience council meeting this morning, but I will take this back to them. I think it should be nothing less.

Mr. Steinour:

Steve, the outpatient success. Is there an area or two that you would attribute that to or is it across the board?

Dr. Gabbe:

We have some clinics that do exceptional jobs. One of them is the Head and Neck Cancer clinic, the Ross clinics. Ed, do you want to add any to this?

Dr. Funai:

Well that and across the industry, outpatient satisfaction tends to be much higher. Remember that with the inpatient environment, a lot of patients are being admitted for emergencies with non-scheduled issues. The overall approach to the visit is usually better. There is usually about 10-15% delta between outpatient and inpatient, no matter what your baseline is.

Mr. Steinour:

I am sorry, I should have been clearer. I was referring to the number of visits and if there is correlation with the visits that are well ahead of budget and the greater satisfaction than for inpatient.

Dr. Funai:

Probably modest if anything. Clearly people are satisfied enough to come back. I think this has to do with the ambulatory growth strategy and the places that we have located physicians.

Dr. Gabbe:

We do think that, for us, the inpatient satisfaction challenge is that we still have two patients in some of our rooms. We hope to eliminate this in the future after the opening of the new James. This does create some issues, as you can imagine, which impacts patient satisfaction.

Dr. Ellison:

Mr. Steinour, if I could make a comment on that. I believe that we have really gotten traction around our outpatient clinics in terms of standardization of processes. I think that is driving the patient satisfaction.

Mr. Steinour:

Thank you.

Mrs. Wexner:

Jerry raised a question about the U.S. News rankings. We get green lights based on some measure. At some point, I think we need a fuller discussion of what the objective really is so that moving one place doesn't remove green lights or at least we can understand why that would be.

Dr. Gabbe:

Our ultimate objective is to be on the honor roll. To be on the honor roll, you have to have many of the 16 specialties ranked and several need to be ranked in the top 10. That is our objective. We had, as you can see last year, 10 specialties ranked in the top 50. For comparison, there are only 27 hospitals in the country that have that many specialties ranked as we did. To be in the honor roll, we have to go a lot further.

Dr. Wadsworth:

If I may Steve. We had a safety score card at one point in addition to satisfaction, as I recall. Is that wrapped up into one of these measures?

Dr. Gabbe:

We don't have that for this meeting but will come back with it to share with you.

Some of that is reflected in the "best hospitals" ranking. The hospital rankings today are much more objective in terms of looking at patient's safety. It's in there. You are right, we had a scorecard and will bring that back to you with an update.

Dr. Wadsworth:

That's another one, by the way, where I am always uncomfortable with getting to a rate. If you plot human's hurt, you are never satisfied with the rate. It is equivalent to the issue of satisfaction. It is good to come up with a metric but express our aspiration of zero.

Dr. Gabbe:

We have followed the lead with Nationwide Children's Hospital and their zero hero program and we monitor every single incident.

Dr. Wadsworth:

I know you commented on that at our last meeting. Thank you.

Dr. Gabbe:

I think we can move on to the financial update. Overall, the medical center is running at budget with revenues and expenses, and is in line with expectations. We are also noticing, and Mr. Geier is here if he wants to comment on this, some evidence of Medicaid expansion, some decline in our self-pay patients, and an increase in Medicaid patients.

If you look at the bottom of our scorecard, you will see that our EBIDA margin is green, debt service coverage is green, and you will note days cash on hand is yellow with an asterisk. We had a delay in payment from the state on our health care assurance program funds for February. We received it in March. That would have made the days cash on hand green. It is yellow because the payment from the state was delayed.

If you look at the top of the page, you will see that inpatient admissions, while above last year, are nearly 2% below our projected budget. Our patients in beds, including observation patients, are above last year, but at about 1.2% below budget.

Our surgeries are soft, as you can see, 1% below last year and 3.5% below budget. As we have explained, we have had several of our busy surgeons leave suddenly and that has impacted our budget. We are recruiting, have recruited, and expect that to recover in the coming fiscal year.

As you commented, Mr. Steinour, our outpatient visits are extremely strong, nearly 9% above last year and 8% above our budget.

You will see our ED visits are down, below budget, by 1.5%. We launched the after-hours clinic at Morehouse this year. They are seeing about 600 patients a month. We would be above budget if those patients were coming to the ED. The idea was that they not come to the ED because they were patients of less intensity. The interesting fact is that our admissions from the emergency department are 5% above last year. We are seeing sicker patients coming to the ED and they require hospitalization.

The adjusted admissions is a metric that takes into consideration both the outpatient and inpatient activity. It is 2.5% above last year and .5% below our budget. Our operating revenue for adjusted admissions is green and our expenses are just shy of our budget by about $80 per adjusted admission. We have met our budget in operating revenues and our expenses leading to the excess revenue over expenses, nearly 4% above budget, and nearly 7% above where we were last year.

I can add that our salaries, as of now, are at budget.

Mr. Price:

The days cash on hand is very anemic. The target should be well over 100 days.

Dr. Gabbe:

It is.

Mr. Price:

It is imperative that we move toward that. If not, we put the platform at risk.

Dr. Gabbe:

You are absolutely right. We are trying to grow that three to five days a year. That has been our target. If we compare ourselves to other academic medical centers, that is the area where we are clearly falling short.

Mr. Price:

In terms of psychiatry, have you seen an increase in psychiatric patients coming into the emergency room?

Dr. Gabbe:

Dramatic.

Mr. Price:

You might want to tell the board why that could be a major problem for us in terms of eroding ability to see other patients.

Dr. Gabbe:

That's right. As you know, Columbus, as a community, is short over 100 psychiatric beds. The three adult systems work together. There is a phone system where they are on a call together every morning and discuss what patients are in the EDs and what beds are available. Unfortunately, few beds are available. The state system does not accommodate the number of patients we have.

We have more patients in the ED than we can handle. In response to that, we have opened a five bed unit to move patients from the ED into a quieter setting, and we have added eight psychiatric beds. That still presents problems for us. It adds a great deal of tension to the ED functions. It is obviously disruptive to other patients and for the psychiatric patient themselves.

When the new ED is built out, we will have twice as many beds as we do today. We hope that will help but we need more psychiatric beds in the community.

Dr. Funai:

There are new entrants in the community, but they are for profit, and are they are eroding our pairings.

Ms. Krueger:

With regard to outpatient, I know you are happy with being 8% ahead of budget. How does that compare to Ohio Health or some others. Outpatients, as a trend in general, are doing well. Is ours average, better than most, or how would you classify that?

Dr. Gabbe:

I do not know exactly what their growth rate is, I think all the systems are seeing pretty healthy growth in ambulatory, but I do not think we have that on Ohio Health.

Ms. Krueger:

I was just curious if ours was better. I am trying to get a relative understanding.

Dr. Gabbe:

That is a good question.

Dr. Funai:

It's a strange trend because the change in laws around admissions is driving traditional inpatient procedures to outpatient. That is not what we are experiencing when we show you these numbers but other systems may be showing that because hospital admission may be converted into something that is ambulatory. This is by site of service here, not inpatients that were coded as outpatient on the day that you see them.

Mr. Price:

We are actually in a better position to deal with outpatient because historically, when no one wanted outpatient and ambulatory care, we were providing quite a bit of it throughout our programs.

Dr. Gabbe:

The care points that we have opened, Care Point Gahanna, Care Point East, Care Point Lewis Center, are all doing well, they are all busy and are operating near capacity.

Dr. Reid:

That trend will continue.

Dr. Gabbe:

We are looking at expanding our usual hours of activity to weekends and evenings as well so we can accommodate that growth.

Mr. Jurgensen:

Is the surgery shortfall across the board, or is that concentrated?

Dr. Gabbe:

It is concentrated in a few areas Mr. Jurgensen. Growth areas for us have been neurosurgery and ophthalmology, but the areas that have been challenged are transplant. Although, I expect with that recent week I described, their lines will be up. Gynecology was one where one of our busiest surgeons was out ill. He is coming back to work now. Urology is one specialty where we lost a very busy practitioner and general surgeon. Of those, urology and gynecology are the two.

Mr. Jurgensen:

I am curious what kind of a variance it would take for this to be red? Given the margin contribution from surgery versus a lot of other things we could be doing. This is a line we really do not want negative variance in, right?

Dr. Gabbe:

Exactly.

Mr. Jurgensen:

It's the best thing we do. What would that number have to be for this to be red in your mind?

Dr. Gabbe:

Generally, if we are 5% off, we would be red. You are right; the tolerance should be less because it's such an important area for us.

Mr. Jurgensen:

The outpatient plus is offsetting it at the total revenue line. What I found counterintuitive is the margin. I would have expected, if surgery was off a noticeable number, I think three and a half is noticeable, that outpatient may cover up total revenue, but it cannot cover up margin. Ours is. Something is missing. The dynamic in/out patient must really be a lot better.

Dr. Funai:

There are some specific issues that Dr. Gabbe mentioned, related to surgeons. Nationally, the trend is flat, as far as surgical volume. There is a connection between ambulatory and surgical volume. In some disciplines, it takes 20 ambulatory visits to yield one surgical case. The more that grows, we would expect to see more surgically. There is a connection.

Dr. Caligiuri:

The other piece, Jerry, is that radiation oncology has picked up enormously in the last year. That can very often be non-surgical cases that are big, important, and expensive technical procedures.

Dr. Wadsworth:

These scorecards, which we implemented, need to be visited, especially in the climate of Obamacare. The benchmarking that was implied by your question would come into play. You really need to know the target against the standard that you are shooting for. I think with all of them, across the university, we should be taking a look at scorecards on a periodic basis.

Mr. Jurgensen:

We are. We talked about this last time, everybody on the inside agrees with you. Again, sometimes we get in a rut. We look at the same thing over and over again.

Dr. Wadsworth:

I think this discussion has made the point that it needs to be live.

Dr. Gabbe:

One area that I want to point out, which has really been doing well, is the outpatient surgery at the Eye and Ear Institute. They are actually 4% above budget for their volume. I think they are at 97% for outpatient satisfaction. They are among our highest.

Dr. Funai:

They are our most efficient with turnover times as well.

Mr. Jurgensen:

You can get in and out of there easy. As simple as that may seem, that is probably our best ingress and egress building we have.

Dr. Gabbe:

Thank you.

Mr. Wexner:

Now we will hear from Jay.

Mr. Kasey:

Thank you Dr. Gabbe. Mr. Chairman, I am giving you an update on the Medical Center Expansion project. I will start at a pretty high level on budget and schedule and take you through topically a little bit on how we are progressing.

The first summary is our budget and the funding that you have allowed us to release from the budget, our commitments, and our spend-to-date. You see, as we are entering the last six months of active construction on the project, we have reached a point where our commitments are shy of our total available funding. Most of the funding that has not been released is for furniture and other minor equipment, major equipment has been committed, and some for the commissioning that has to be done in the final phases of the project before the building can be turned over to us.

The spend-to-date is approaching the final phases. Most of that probably won't be completed until after the project is closed out and gets to a final spin. There are a series of other small projects that have been fully funded by development funds that are not part of the original scope of the project. About $1.5 million

from five different small projects were brought into the management of the project because they impacted different elements within the building. This is our update through February.

You are always interested in our contingency summary since these are the back-stop of funds that are available to us if there are elements of the project that become problematic. Our total remaining contingencies at this time are a little over $16 million. We break these into potential contingency uses because we want to know, just not what is there, but what do we expect to spend of that amount. The $5.8 million remaining at this time is up $2 million from our report to you at the last meeting. The reason that came up is because the pending change order request category for other projects, as we have closed out a number of other projects, the money that was left has been swept back into the contingency account. The project windfall that we didn't spend on those projects is rolled together and continues to be managed within the project. We expect that as we close out the remaining parts of the project, and have reserved almost all of our remainder for the Cancer and Critical Care Tower (CCCT), we will try to replenish our contingency line and return money to the medical center as the project concludes.

We have a responsibility to report back to the board the percentage of EDGE (Encouraging Diversity, Growth and Equity) contracts. These are minority owned companies that have been contracted for the project. You may recall that the state of Ohio has a target for state projects of a 7% spend with minority contractors, EDGE contractors. Long ago, as we have moved this project forward and advanced it as a lever to encourage construction reform across the state of Ohio, we committed to a 20% EDGE goal. We are actually going to reach close to 30% of EDGE contracting with this project. We are quite proud of that and think it has made a huge difference with the development of new minority contractors. Almost 87% of our contracts for the portion managed by construction reform are with major Ohio companies, companies that have a major presence or their home office in Ohio.

Dr. Reid:

Jay, I have a quick question. I can't recall if EDGE is for just minority owned companies or is it minority and women owned companies?

Mr. Kasey:

In the state's definition, there are seven minority groups and women are one of those.

Dr. Reid:

Ok, minority including women. That includes veterans and others?

Mr. Kasey:

Yes, women are part of the minority count.

Other questions?

South Cannon garage is one of the final portions of renovation to prepare for the opening of the Tower. We are adding a new East Entry which will come off of the floor court of the Tower. We are also adding a West Entry so that the garage will empty out efficiently onto Cannon Drive. We will be opening 10th Avenue, which has been closed for some time, by the end of April.

The Jones Legacy Park was delayed during the harsh winter months.

Mr. Schottenstein:

Jay, just a quick question regarding the South Cannon garage. One time, there was discussion about cladding the exterior with something so that it was more attractive than just the washed-out concrete look, greenery, vines, something to give it life. I know that was pursued but have not heard what was decided.

Mr. Kasey:

The serious option that was looked at and developed was a type of metal linkage that we have used on a couple other garages around campus. The RPAC garage has a stainless steel chain link that has a nice look to it. That was about $1.9 million in additional cost. As we were committing to this renovation and the new entrance and exit, we didn't think we could afford the additional cost. We have upgraded the lobby areas in the garages and the connection between the lobby areas of the garages and the interior of the building.

I will go on with the updates for the Jones Legacy Park. You can see the very beginning of what we are designing as the new medical center oval, which will extend through the park like the oval on main campus, and add a lot of other enhancements to the park.

The Emergency Department (EMS) entrance was opened in early February. We now have all ambulances coming to the back of the 12th Avenue entrance of the building.

The Rhodes Hall Concourse is ready to open, and we expect to open it by the end of April. It really is a very beautiful addition to the entire medical center. It is part of the project that where ever you are in the medical center, the Tower, Rhodes Hall, or the existing James, you gain benefit from the great organization of transportation across the medical center.

The Emergency Department will be the first area opened and delivered to us. It is nearing completion and will double the capacity in the Emergency Department. It will be one of the ways we assist with the overburden of psychiatric patients that we receive in the Emergency Department. We routinely have boarders who we don't have beds for and they end up staying in that department longer than they need to.

The Linear Accelerator floor is part of the $100 million CMS (Centers for Medicare & Medicaid Services) HRSA (Health Resources and Services Administration) grant that was provided to us several years ago. There are seven vaults to be populated with LINACs (linear accelerator). It takes about six weeks to put a LINAC in and gain acceptance testing from it. We are starting those installations by the end of April. The good news here is we have found a way to take the machines apart and transport them up elevators and not have to take a side off of the building, which was originally planned, and crane them in from the side of the building. We have found a lean way to make this happen quickly and is less expensive.

Finally, our schedule. The dates are important but even more important is that each of these happens in progression. Each of these dates are stacked and delivered to us in multiples each week. We don't have the staff to clean, install IT, commissioning, and other things, and keep the process going. We are very stringent on meeting our schedule going forward.

Mr. Price:

Jay, quick question. You thought you were going to have to take off a side of the building? You figured out a way to dismantle it and take it up?

Mr. Kasey:

Yes.

Mr. Price:

Has anyone else done that? I have not seen that done before.

Mr. Kasey:

We will need to check with Variant. Variant and our engineers worked together on this.

We do have service elevators that are quite large.

Mr. Price:

Ok. I was just curious.

Mr. Kasey:

It is a good thing. It is very helpful and saves us time.

I will stop there Mr. Chairman. Does anyone have any questions?

Mr. Wexner:

Questions? Comments?

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, to discuss personnel matters regarding the appointment, employment and compensation of public officials, and to discuss the acquisition of real property.

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

Mr. Wexner:

Thank you. We are adjourned.

Attest:

Leslie H. Wexner	Heather A. Link
Chairman	Associate Secretary