

THE UNIVERSITY OF TOLEDO
Minutes of the Faculty Senate Meeting of April 8, 2014
FACULTY SENATE

<http://www.utoledo.edu/facsenate>

Approved at FS meeting on 9/16/2014

Summary of Senate Business

Mr. David Cannon, Vice Chancellor, Finance and Data Management, OBOR

Mr. David Morlock, Executive Vice President and Administration, UT

Note: The remarks of the Senators and others are summarized and not verbatim. The taped recording of this meeting is available in the Faculty Senate office or in the University Archives.

President Rouillard: I call this meeting to order. Welcome to the fourteenth Faculty Senate meeting of AY 2013-2014. **Lucy Duhon**, Executive Secretary, called the roll.

I. Roll Call: 2013-2014 Senators:

Present: Anderson (Quinn), Bailey, Black (Barnes), Cappelletty, Cochrane, Denyer, Dowd, Duhon, Edinger, Ellis, Elmer, Federman, Giovannucci, Gunning, Hewitt, Hoblet, Humphrys, Keith, Kistner, Kranz, Lee, LeBlanc, Ligan, Lundquist, Molitor, Monsos, Nigem, Ohlinger, Porter, Regimbal, Rouillard, Sheldon, Springman, Teclehaimanot, Templin, Thompson, Thompson-Casado Van Hoy, Weck-Schwarz, Wedding, White, White, Williams

Excused absences: Brickman, Chiarelott, Cooper, Crist, Duggan, Farrell, Gohara, Hamer, Kennedy, Moore, Quinlan, Randolph, Relue, Srinivasan

Unexcused absences: Frantz, Caruso (Seligman), Gilbert, Hasaan-Elnaby, Moynihan, Plenefisch, Skeel, Willey

III. Approval of Minutes: Minutes from February 11, 2014 and March 11, 2014 Faculty Senate meeting.

Academic Year 2013-2014. I ask that Executive Secretary, Lucy Duhon come to the podium to call the roll.

President Rouillard: Good afternoon Senators. Welcome to the fourteenth Faculty Senate meeting if AY2013-14. Today's agenda is pretty full. We have guest speakers with us today that traveled from Columbus. Our speakers...with the speakers' driving requirements. With your permission we will sort of suspend our normal agenda for right now and move right to the speakers and then we'll do our normal business including the roll call, approval of Minutes, and so forth. So, this afternoon it is my honor to present to you Mr. David Cannon who comes to us from OBOR and he's going to speak with us about the state share of instruction formula. He has also brought with him Ms. Penelope Palmer and they have generously agreed to do a question and answer after their presentation. So if you can, please join me in welcoming our guests.

[Applause]

Mr. Cannon (OBOR): Some of you may have seen me when I was here in May. I'm very excited to be here this afternoon and I just think it's wonderful that your faculty, staff, your council here would invite us up here to do a presentation on the state share of instruction (SSI). As we go around the state and we

talk with different groups we hear from different groups how they only heard a piece of it or they want to know about this particular component of it and we really never get to give a full presentation or go through the whole process with the group, so hopefully this will help you. We do have a very short amount of time and I want to be very aware of your time as well. We do have a lot of information so I'm going to probably go through this pretty quick. The important stuff I'm going to let Penelope do because she's the real expert. She's the one behind the magic in terms of doing the calculations and the funding formula. I just want to give you a little background, an overview as a way of comparison of how the whole process gets started and then I'll let Penelope talk about the particular models. And so to start off with, what we want to talk about is our budget process, how we get to the state share of instruction out of the budget process. We are going to talk about performance funding, kind of the history and background where it was, and where it is now, where you can see some of the changes it's gone through. We will talk about the distribution of the formula if we have time. If we have time we will talk about some of the outstanding issues that are still out there that we can look at possibly addressing. One of the things we put on there is if anybody wants to dig "way down in the weeds" and go through these spreadsheets and see how all the calculations work, Penelope can do that, but based on the limited time, I'm not sure how far we can get to that today. Also, as we go through this, please feel free to ask any questions because I'm going to be going pretty quick.

When we start our budget process the office of Budget Management gives us guidelines and they tell us, "Give us your budget request. If you have 90% of the funding that you had from the previous year, then what would you ask for if you got 100%?" That way they want to see what our priorities are and for us the state share of instruction is always our highest priority. That's the money that we need to be able to send out to the institutions to operate their schools. But what you'll see, when you're such a big part of the budget, it's hard to swing more money into that pot to help the SSI because all the other components don't add up to much compared to the SSI, and I will show you that in a minute. We have to go through and provide that for office of Budget Management. The SSI is such a big share of that pot. The other big piece of that is the debt funding that is put into the Board of Regents budget. That debt funding is what provides all the capital funding. So as you heard, there's a new capital bill coming out and it is allocated for capital projects. What the state does is they go out and borrow more money over a 20-year period to pay for those facilities and those improvements, but they don't pay for that all at once like they do with the SSI -- that's done through a 20-year bond and those bond payments/service payments end up in our budget. Again, that's a BIG part of our budget. During the process The Board of Regents I think did do very well from the governor's budget proposal. We got almost a 2% increase in the SSI, our debt payments are structured to make sure the payments can be met, we saw increases in our financial aid, we saw increases in workforce funding. Unfortunately, we couldn't do as well in the medical school or partnership funding which is a supercomputer in OhioLink and some of those other consortium partners that we work with, but as you can see we were well taken care of. Fortunately, we were one of the state agencies that didn't have any reductions. As I mentioned, our Board of Regents budget is about \$2.3 or 2.4 billion, of that we had a slight decrease in 2014 because of the LEAP payments that were rolling off the books. Over the last several years we had from a 4% increase to a 2% increase. In some of these very tight budgets that the governor had to deal with I think we did as well as could be hoped for. As I mentioned, we had several increases in our BOR budget because I do believe that the governor and the legislature support higher education and they support the institution. In all, we got about 4.8... items for our \$2.3 billion and as I mentioned, the SSI is our largest share of that. About \$1.8 billion is what gets

divided up between institutions for SSI. Our debt service is the next largest and the one I put up there is financial aid, mostly OCOG (Ohio College Opportunity Grant) -- that really takes the majority of the funding for the Board of Regents.

Past-President Dowd: What's the GRF?

Mr. Cannon (OBOR): General Revenue Fund. That is where all the state taxes go and then that's the general operating account. We are like Toledo, if you have designated revenues that have to be used for particular purposes, those are set aside in special revenue funds or internal service funds, but the general revenue of the state is all the other tax funds. So let's start talking about the SSI. You can see in FY14 we had a 2.1% increase that brought the SSI distribution to \$1.7 billion / \$1.8 billion and of that, the community colleges get about \$411,000 and they had their own funding formula. They are not part of the same funding formula as the university. The regionals in FY14 also have a particular distribution amount that was set by statute. So the regional campuses have their own formula and they've got their own pot of money to do that. There was also \$5.4 million that was set aside for bridge funding. For the change in the SSI the legislature didn't want any campuses to receive less than 96% of what they earned in the previous year so they allocated that bridge funding in order to cover till they got to 96%. Unfortunately, by the time we got to the end it was just a little bit less than what was needed, but they got pretty close to 96%. In FY15 the amount goes up another 1.9%, \$34 million over the biennium. You generated another \$74 million in state share of instruction from the legislature. In FY15 we are going to start merging the branch campuses into the same funding formula as the university and we are going to talk about the specifics of that in a little bit. And you can see the change in the SSI over the last several years. The legislature, as I said, I think really appreciates higher education and has been able to come up with some additional funding to increase the SSI.

I wanted to go back quickly and talk about historically for some of you who may not know where the SSI, the state share of instruction, how it started out in terms of performance-based funding. That was kind of designated performance funding 1.0 and as they developed that they didn't rush and put a lot of money into the performance base, they kind of eased into it. And so going back into 2010 and 2011, they set aside 5% of the university's funding for degree completion. You had doctoral set-asides. You had medical, med-1 set-asides. You had med-2 set-asides. You had your Access Challenge funding and then you had 5% in 2010 for degree completion. In 2011 that degree completion component increased to 10% and then the remainder of the university's allocation went to course completion. Back in 2010 and 2011 there were at-risk components and it was based on percentage of the OCOG-eligible students. And stop-loss back then was set at 99% so it wasn't really much risk if a university started dealing with performance funding, because you had stop-loss. The question is, is that really a performance-based system when you're guaranteed 99% no matter what you do? As you can see over the last couple of years that stop-loss has kind of changed. It kind of came down a little bit. In 2014 that stop-loss has gone away to where it is now, all based on performance degrees and course completions. And back then the formula used a 2-year or 5-year average so if things change on the campus and had spikes and decreases in particular course completions or degrees, you can do a look back on 2-years or a 5-year look back and whichever was more beneficial to the institution. We will talk about that, but that's now been changed to a straight 3-year average for all institutions. As we move to 2012 and 2013 as we try to get more into the performance based funding, we still have the set-asides as part of the allocation of the university sector and that's set in statute that those amounts go to the doctoral program and it gets set aside for veterinary

and dental schools in Ohio State which is med-1 and med-2 which is all the medical universities. We set the Access Challenge for those six institutions that qualify as open access institutions and those were: Akron, Cleveland State, Cincinnati, Central State, Cheney, and Youngstown State.

Senator Anderson: But the doctoral program then -- is the allocation of that 12% the same in percentages in degree completion?

Mr. Cannon (OBOR): No. We will talk about that. There was a formula established for the doctoral program which is based on that historical FTE. There's a research component, there's a component for a four-year degree completion, and they had a fourth one for quality metric, but it was never really developed and now that piece has gone away. We can talk about that distribution of the doctoral component here in a second.

One thing I do want to point out, back in 2012 and 2013 -- because I know this has come up at other campuses -- is associate degrees. Back then in those years it wasn't a very big piece of the distribution formula; it was 2.5 million in FY12 for those universities that were able to receive funding for an associate degree. So it was all six of those Access Challenge institutions. However, only four of those were actually awarded associate degrees- Cleveland State and Central State have not and did not award any associate degrees during that time. So those associate degrees were awarded by four of those institutions and you can see how that grew in FY13. Back in FY12 and FY13, again, now we are putting more emphasis on degree completion. The funding for degrees now went from 5% to 10% to 15% in FY12 and will go to 20% for a degree completion. So, as those degrees are awarded and the cost of those courses for a degree increases that now get a share of the pot funding, so more emphasis is placed on degree completion. What was left out of that pot went to course completion. The stop-loss was still in effect and had reduced to 97%. In FY13 it was reduced to 96% and they still had the 2-year and 5-year average. They said they are going to be getting away from that in FY14 to a 3-year average. Here's the answer to your question, sir. For the doctoral for 2012 and 2013- you can see all the changes between 2012 and 2013. What they really are trying to do is get away and reduce the amount that was more on the historical and FTE share of the doctoral funding and put more on the degree-based and the research-based. They also had that allocation between 2012 and 2013 for the quality measures, but those quality measures weren't really developed and eventually got put back and included in the pot with the historical and the FTE-based. So that 62.5% or 55% in FY13 is really FTE-based for the doctoral, and that's really scheduled to kind of go away.

Past-President Dowd: Is the associate received for doctoral students, the amount an institution receives, is that still capped? Is there an absolute upper limit?

Mr. Cannon (OBOR): I don't believe so. There's an upper limit in terms of the amount that is allocated for doctoral programs and it is all disbursed among those campuses that have doctoral programs, but I don't believe any institution is necessarily capped within those four parameters. I think a campus had 85% of your FTE back when it was established and you had to meet that criteria, but I'm not aware of anything for doctoral.

Ms. Palmer (OBOR): No. There's no explicit cap... [*Statement was garbled on recording*]

The FTE part though, the more the enrollment base is in a sense capped because as long as you hit 85% of your historic number you'll get a set percentage and if you go below that you'll get less.

Past-President Dowd: That is what I was thinking.

Ms. Palmer (OBOR): But as far as the degrees and research part, there is no cap.

Past-President Dowd: Thank you.

Mr. Cannon (OBOR): Also part of the FY12 and FY13 distribution -- there was an Access Challenge component that was available. In 2009 an institution received the same amount of money from that Access Challenge [grant]. The University of Toledo was not part of that \$3.9 million piece of the funding. There was also plant, operation, and maintenance in Toledo. I do remember Dave Dabney fought to keep that in the formula at least for this biennium because Toledo received about \$786,000 from that plant, operation, and maintenance which is in the previous funding formula. And that is not a set-aside out of the pot of money; that is based on what was available in 2009 and what schools received in 2009 from their formula for square footage and usable square footage. From what I understand, Toledo benefitted from when they merged the medical school into the university and that helped with their being able to generate funding from the plant, operation, and maintenance. That amount of money comes from other institutions so there isn't a set-aside pot of money for plant, operation, and maintenance. Toledo and Central State had this allocation that they continue to receive it, but that gets reduced from other institutions by the earning. And so, that's just part of what the funding formula was in the past. In 2014 and 2015 that stayed in the formula because as I mentioned, Dave Dabney was very adamant about not seeing that part of the funding formula go away. It is scheduled to go away in 2016. It is also a stop-loss for 2012 and 2013 for which Toledo pays, because schools that didn't generate 96% of their previous year in FY12 and FY13 -- those institutions that received more contributed based on their share of earnings to the campuses that would not generate 96%. We saw that in FY13, Toledo paid \$216,000. So you can see, based on the funding formula that was in 2013, Toledo got about 8.5% of the pot and \$100 million from the funding formula and that being made up of the course completion and 62.2 million within the course completion. There's a risk factor for students. If you have students that are in financial need, those with an EFC (Expected Family Contribution) with less than 2190 will qualify as an at-risk student or academically with an ACT score lower than 17 -- they can generate additional funding for course completion. So if those students would go through and complete a course you will get an add-on for the cost of that course for those students. And then there was an additional...for course completion and that ranged anywhere from 1.0% to 1.8% additional add-on for the statewide cost for the course. Of the 2013 distribution Toledo received \$17.4 million -- about 17.1% from degree detainment and that was when it was at almost 20% of the pot.

Again, there are at-risk factors for EFC, remedial education, ACT score, national heritage, and aid. So if you had students that met those qualifications that went on and earned their degree, again, you can receive additional funding for those students completing their degree based on the at-risk factors that go with those students. Medical Doctoral was a piece of that and we received about 9% of that. So that is kind of where the performance funding came from and what it's been over the last several years. In 2014 the governor felt he had real good success asking the presidents to work together to develop the last capital bill. He thought he would like to see the college presidents also work together on the funding formula. To be honest I was really kind of not very optimistic in terms of trying to get all the presidents to agree on that funding formula. When you talk about a capital bill everybody got a little piece of that pie.

Everybody kind of walked away with something. So it is really not hard to sign up when you know you are getting some piece from the capital project or some high priority. Now, the funding formula is a little bit different because it's one pot of money and many times there are winners and losers. So the presidents worked together so they can accept whatever the formula generates in terms of funding for their institution. I was very surprised, I think, the presidents given their time constraints on putting this together did a remarkable job. I think they were given this in September and had to be done by late November and so I think they did a real economical job. They did that with combating principals of improving graduation rates, the number of graduates, although graduation rates are not part of the formula, but completions are. As students earn their degrees and we look back over that three-year period that's what gets included in the funding formula; it's not a graduation rate and there is no time of completion as far as the funding formula. If we have any data in our system for that student going back to 1999, that funding would count as that student graduates. So there is no time to completion as far as the funding formula. Our goal for setting out for higher participation rates for high school graduates and attracting the best and the brightest in Ohio, that is now in the funding formula as Ms. Palmer will talk about as far as adding an out-of-state component to the formula so that students that are from out of state as long as they work in Ohio or continue their education in Ohio now can generate additional SSI for the institution. So with that, I will let Ms. Palmer talk a little bit about the 2014 and 2015 funding model.

Ms. Palmer (OBOR): Okay. I will try and talk a little bit, but unfortunately, I'll probably end up talking a lot. As Mr. Cannon said, some things have changed since FY14. It is now a formula called 2.0 which is a new and improved funding formula. The doctoral medical set-aside is pretty much still the same, they are a set percentage in the legislation. In FY14 and FY15 the Access Challenge is still there; it is still based on the 2009 amounts. The remaining amount after the amount for degrees comes out is allocated to course completion. But the main change is at the top and you'll see 50% of the total now goes to degree completions. So you saw that it was increasing slowly and I think it got up to 20% in FY13 and now it's 50% in FY14. And as Mr. Cannon said, there is also now a component for out-of-state graduates. So if someone was a non-residential student who spends their entire time here and has not been counted in the funding in the past, now they are counted. In FY14 they are counted and they are weighted at .25, so for every degree granted to a non-resident student the institution gets credit for .25 of that degree. As you saw earlier, \$116 million went to the regional campuses. In FY14, bachelors, masters, and professional degrees of course count. Associate degrees count if and only if they are awarded at a main campus at one of those open access institutions that you saw earlier. We did add STEM weighting for the degrees and that's always been included in the course completion component, but it is now also included in the degree component. You can see the FY13 associate degree earnings on the slide. The plant, operation, and maintenance were still in there in FY14. You can see UT's share in FY14 was \$811,000. Now, there was not a stop-loss in FY14; that was removed and there was some bridge funding added to try to get everybody up to 96%. It didn't quite make it, but everybody was pretty close (95.9%). The doctoral share you can see it on the slide. As Mr. Cannon stated, as you follow this through the years you can see the FTE share is declining and the shares for degrees and research is going up each year. Medical funding hasn't really changed at all. Now, here we have distributions and there's \$1.25 billion for the university main campuses in FY14 and \$130 million went to Toledo; about 8.7% of that came from course completions, including some that were in there because of students completing courses who were at risk and the STEM weighting. About 7.4% of your allocation came from degree attainment and again, that

amount includes taking into account risk factors of the students who graduated and STEM weighting for the appropriate degrees. And then about 9.4% of the doctoral medical allocations went to Toledo.

You might ask and we've been asked, does performance funding work? We are pretty early into this, but we were able to look at some data and see how things looked so far. The first thing we looked at was basically the percentage of courses that were completed. So of the FTE courses that were attempted, what percentage was completed? And you can see the statewide over on the right, those numbers have been fairly steady, maybe rising a little bit. In Toledo they have been relatively steady. We didn't do a statistical analysis on this because it is not a sample, it is the population, so it is what it is. So, that is promising, the course completion rates are going up slightly.

Degrees awarded: You can see the number of degrees awarded to Toledo have been relatively stable. There was a blip for the state in 2012 and that's because of the conversion from semesters for some schools. Then we looked at degrees awarded for FTE. Those are not completed FTE, those are eligible FTE, and you can see that that's been rising pretty nicely. That's a better measure than just general degrees; you can see that it's been rising in Toledo and it's been rising statewide, so that's a very good thing. For FTE, these are some really small numbers for Toledo and they have not been eligible for SSI in the past, but starting in FY15 they are eligible. I'm not sure why you have that drop in 2012, but statewide they've been going up a bit. They are still pretty small at universities; this is just of universities because there's a completely different formula. So that was a quick overview of FY14. Does anybody have any questions about that?

This is now FY15 that we are going to talk about. There are a number of changes between FY14 and FY15. We are still working with 50% of the appropriation going to degrees, but it's 50% of the total appropriation for main campuses and bridge schools because those two are now combined. So it's actually an even bigger number even though it's the same percentage. The risk factors are student-based. In previous versions (for degrees) of the model there was a statewide weight and campus for institutional at-risk index that was used and the statewide weight was a way of looking at the likelihood of graduation of students who were at-risk compared to a likelihood of graduation of students who were not at-risk. This data was developed for using the Fall 2001 and 2002 cohorts and then they were tapped at seven or eight years to see if they had graduated. Then the campus for institutional index was also developed for using the same data and that is basically what an at-risk institution is, it's the number at-risk students and a sort of "at-riskness" for each group so if your institution has a lot of at-risk students, then you will have a higher campus index. Or if your institution had the same number of at-risk students as somebody else, your students were in a higher at-risk category you would have a higher at-risk campus than theirs. But in FY15 now the at-risk factors for degrees are used in a different way. There are four risk factors: academic, minority, financial, and age and those are combined in 16 different categories. Each of those 16 different categories has its own weight and that is what we used in FY15, the number of degrees that were earned and we look at the student to see which of those categories they fall into and the appropriate weight is applied. Thirty percent goes to course completions. So here are the categories that the risk factors are combined. It starts out with no risk factors to all risk factors: over here on the far right you can see the weight; you can see for example case four has a 342% weight which means if you graduate somebody who is in the age at-risk category you're going to get credit for that degree, plus another 3.42 into your reimbursement funds. This is not the same as your SSI. The higher these numbers are, the more credit you're getting for each degree that's awarded to a person. This is to encourage institutions to

successfully graduate at-risk students. Another big difference is that, as they alluded to, now all associate degrees awarded to all campuses are eligible for funding, where it was just at six universities.

Senator Anderson: I don't want you to go back in slides, but the at-risk percentages, is that determined by OBOR or is that determined by some legislative action?

Ms. Palmer (OBOR): What do you mean by at-risk percentages?

Senator Anderson: Age for example.

Past-President Dowd: The 342%

Senator Anderson: Yes, the 342% -- is that the number that OBOR generated?

Ms. Palmer (OBOR): That was based on some analysis that was done before I came to the Board of Regents that looked at Fall 2001 and Fall 2002 entering cohorts and tracked them for seven or eight years and looked at the likelihood of graduation for students in each group compared to the likelihood of graduation for students with no risk factors and developed them based on that.

Senator Anderson: So it probably was just a performance-based number?

Ms. Palmer (OBOR): Yes. We did update that recently, adding a couple more years of cohorts because some of these numbers are pretty small. It changed somewhat, but the pattern was still the same.

Mr. Morlock: Which one is age?

Ms. Palmer (OBOR): Just "age" is case four. Age is also in case 5, 6, 7, 12, 13, and 14, so the really high ones do tend to approve age.

Mr. Morlock: So you said, 2001 and 2002?

Ms. Palmer (OBOR): Yes.

Mr. Morlock: The last time I was down there in a meeting we talked about one of our uppity schools, not us, but a different one had a fairly robust nursing program that they had put in place (I think it was online) that was focused primarily at practicing nurses who were going to complete their degree. And that particular school was getting a big chunk of money and a lot of it grew by the age adjustment. And in fact, when you kind of look at that population of folks while they technically qualify under age the way it is written, they are not "high risk." I mean, they're just not "high risk" like that analysis suggests, so what's going on with stuff like that?

Mr. Cannon (OBOR): Matter of fact, one change was put into the NBR so that they couldn't get the add-on weight for that risk factor for the time they did not spend at that institution.

Mr. Morlock: Right.

Mr. Cannon (OBOR): So it's like you said. The program that that institution has, bringing students from other campuses and now they are going for their bachelor's, so that time they spent at the other campus now no longer counts at that at-risk factor, so they won't get that additional weight. Because the reason

behind that is the school didn't have to cast support cost for that at-risk component because they weren't there at the time so they shouldn't benefit. But, one of the things that we'll get to, is I think that would be up for further discussion: this summer as we look at the implementation of the changes in 2014 and 2015, were there any unintended consequences and are there things that maybe we need to look at to true-up and make fair to everybody the way that the formula is currently awarding?...That school just hit the trifecta. They brought in students that weren't very much at-risk and they graduated those students. It was a high-cost degree and it swung like you said, a bunch of money in the projections. So because of that point, that's really the reason we're not at 15 numbers yet. We had to go back and recalculate these numbers because we didn't feel comfortable with the projections that we had gotten because it was such a swing in the amount of money that schools would generate from the SSI.

Mr. Morlock: I know the other schools weren't comfortable either <laughter>.

Mr. Cannon (OBOR): I can imagine what you're going through <laughter>.

Mr. Morlock: So, the industry kind of changed a bit in the last 15 years; it's more focused on adult learners and that kind of thing. At some point I assume it is on your radar screen to update some of that stuff. I imagine the at-risk profile has changed.

Mr. Cannon (OBOR): It changed partially.

Mr. Morlock: Yes, partially.

Mr. Cannon (OBOR): I think we do need to go back and revisit it. And if a student comes with either an associate's degree or some other degree, should that student be at risk at all because the likelihood that they would graduate is actually pretty high now. I think that is something that really needs to be looked at. We can go through some of the things that we've identified and I know those "shots" at IUC are also putting a list together of those different topics.

Ms. Palmer (OBOR): But this is what's being used for FY15. Are there any other questions about the at-risk? It's a little simpler for course completion: there are just two components, financial and academic preparation. It's just a statewide...campus index ...except what's used for course completions. It's just different for degrees.

But then another formula that was made for FY15 was the change for whole degrees from proportional degrees. So instead of you awarding a degree and you getting credit for that degree, you may or may not get credit for all of that degree. If a student took all of their credits here and no others within the system they will. Let's say it's a \$100,000 degree and they took six \$10,000 worth of classes here and \$40,000 worth of classes at OSU. You will get .6 credits for courses and OSU will get .4 credits from those courses. Now, for example, if a student came in the system with other credits from an out-of-state or community college, if they get \$60,000 worth of classes here and \$40,000 worth of classes at OSU, you each will get .4 for that for the courses, but there is also a .2 sort of hanging around out there because there is still \$100,000 average cost for that degree because it is the cost of the statewide average for that degree. So we add all the courses that students took and came up with an average cost for each degree. So if they took \$40,000 worth of courses at two different universities you've still got that .2 out there and the degree-granting institution will get that as kind of a bonus (We are still using \$100,000 because it's easy to keep up with). Now, that bonus is not included in any at-risk calculations, but it is included. So, you

will end up getting .4 for the courses they took here and .2 for that bonus. If they were an at-risk student, that .4 will be multiplied into the at-risk add-on, but the .2 will not.

Senator Edinger: How do you figure out the AP courses a student will come in with, or credit that they get for investing, do those count as credit earned? I mean they are credit earned for the student, do they figure into this at all?

Ms. Palmer (OBOR): No, they don't really. That is one of the reasons why we have the bonus. Say that it is an average statewide cost of \$100,000 and you get the student through \$80,000 and they took some credits from a community college or they took some credits from AP or something, or you just went really efficient. You will still get \$100,000 worth of credit for that degree because of the bonus. It's also true now that you might get credit for the degrees that you don't award. The same example -- \$100,000 degree -- where somebody went here and went to OSU, but they got the degree from OSU not here, you still are going to get credit for the courses that they took here when they receive that degree from OSU. Does that make sense?

The out-of-state students in FY14 were weighted at 5.25. In FY15 we calculated a rate of stay-in-the-state by looking at the ODJFS data and our data to see if they were employed or in school with the state. If they are, then they get counted as stays, so we have a rate for each school. So each number of degrees awarded to out-of-state students are multiplied by .5 and then multiplied by that rate from the institution. Looking at the slide, here's the different rates. You can see Toledo's rate-of-stay is 28% and that's pretty good. Looking at the slide, this real quick is kind of the breakdown for all this. You can see the 2014 and 2015, 50% of the total went to degrees. You can see the...the stop-loss...stop-loss. This is looking at all of the different changes from 2014 and 2015. The first yellow column is the FY14 formula, but with the FY15 allocation or appropriation. So it's the overall total for FY15, but distributed the same way the money was distributed in the FY14 formula. Then we go across all the different changes and show how that affects each institution. You can see in the first section is when we merged the branches in for their FTE. Toledo got an increase at that point as did most institutions with branch campuses. Institutions with branch campuses didn't do as well in that step. And in that step we added in all associate degrees. If you look at the change from the previous, you can see that Toledo lost a little bit there and that's because we added in more associate degrees and you (University of Toledo) don't award a whole lot of associate degrees so it is was not very helpful to you. Then the proportional degrees changed from previous, .4 so that didn't really affect you very much. The at-risk change from using the campus index and the statewide weight to using the individual factor weights, -1.6 from the previous. Then the out-of-state change hardly affected anybody, only .2%.

Mr. Cannon (OBOR): I apologize for the quality of that slide, but we wanted to show everybody the impact of each of the changes that are coming up in FY15. We did this with the older data. So we kept it data-constant and we increased the appropriation so we can just focus on the change of the model. So as Penelope mentioned, when you integrate branches, Toledo does better because you're not bringing in any more students. Campuses that have a high degree of students at a regional or branch campus don't do as well because now they are splitting that funding with more students that are coming in. I think on this one -- the associate degrees -- you don't do quite as well with that one as compared to other schools. I think Toledo just doesn't issue a lot of associate degrees. One of the things I think we'll see in 2015 when we get ready to run data -- it will be interesting to see how much money actually does go to associate degrees

once we start counting all the institutions that are able to award associate degrees. Again -- budget -- just to give an indication of what the impact of the changes does to each of these institutions.

Mr. Morlock: Fortunately, we are doing budgets.

Mr. Cannon (OBOR): And we need to get some numbers. And that's one of the things that we are working on and I'll explain kind of where we are with that.

Senator LeBlanc: Bottom line, the column at the bottom right, 1.9% at the bottom, is that the increase in the SSI based on your total budget?

Mr. Cannon (OBOR): Right.

Senator LeBlanc: If you did better than the 1.9% then you did better than the average.

Mr. Cannon (OBOR): 1.9% is the increase in the amount of funding [cut off].

Senator LeBlanc: So if the model hadn't change at all we would all go up 1.9% and everything else would stay the same?

Mr. Cannon (OBOR): You could look at it that way. But the performance base, again, I think you'll have to look at, are you performing as well as others so that you can continue to earn the amount of money that you should've got out of that additional funding.

Senator LeBlanc: So, if a school did better than 1.9% then they fared better under the new model than they did under the old model.

Ms. Palmer (OBOR): That's a fair way to look at it. That's using the old data though. But now since we are using this formula a lot of other institutions are going to be upping their efforts since it's a distributive model; to keep up, you're going to also have more course completions and more graduates.

Senator LeBlanc: I know it's hard to see, but did Central State have a 16% increase?

Mr. Cannon (OBOR): Yes.

Senator LeBlanc: So they did really well.

Ms. Palmer (OBOR): Well, they are small too. So of course, starting with smaller numbers it's easier to have a larger percentage increase.

Mr. Cannon (OBOR): Their biggest change is in that at-risk change.

Senator Hoblet: Are you tracking universities? For example, we hear that Kent State is going to be awarding all associate degrees after two-years of course completion, are you watching for this type of maneuvering?

Mr. Cannon (OBOR): Yes, that's been brought to our attention and we don't see really any way that that's going to happen. From what we hear I think what came out of the paper wasn't really... first of all, they can't just award an associate degree to any student.

Senator Hoblet: Right.

Mr. Cannon (OBOR): There has to be a program approved by the Board of Regents in order to be issued an associate degree for that program. Once they are currently authorized by the Board of Regents to award, they can award those and then they will count. But they can't just because a student gets 60 credit hours and say "You get an associate degree." That's not going to happen because they do need the Regents' approval to start that program and we will be very "judicious."

Senator Hoblet: Thank you.

Mr. Cannon (OBOR): Another impact of that is, because of the three-year average that is being used, because they are not going to be getting credit going back, they are going to be going forward and the three-years that's going to be used for the FY15 distributions are 2012, 2013, and 2014 data. And they obviously didn't have those in place in those years, so they're not going to receive that this year and that is going to be one of the discussions about, are there any changes we need to tweak in the formula? Because we don't want to see those kinds of unintended consequences.

Senator Anderson: Is there likely to be positive feedback to the legislatures in the sense that every one of these schools that can prove the at-risk category ought to be getting more money, but they won't because the pot of money is still the same?

Mr. Cannon (OBOR): And that's a great question because we hear that especially on the community college side. I would bet a paycheck that if we see degree completions like we saw for FTE continue to increase and we're seeing the performance metric, I would bet that the governor and legislature would put more money into those institutions because we're getting the desired results and now we're going to have the data to track it just like Ms. Palmer tracked just the last four-years. We will continue to monitor that and see how each institution is performing. That is what the legislature and governor stated they wanted and if we deliver, why shouldn't we get some additional money besides what's being distributed in the formula. Now, like I pointed out, the \$72 million is not a small amount of money, but what point is the balance between continuing to ensure the institutions are funded properly and reward those institutions for doing the job that we are asking them to do.

Ms. Palmer (OBOR): *[statement was garbled on recording]*...

This just looks like the funding for each component and you can see the interest rates in Toledo, 8.8% of the funding is related to at-risk compared to 12% for the state as a whole.

Mr. Cannon (OBOR): I kind of hear some murmuring and we were kind of surprised too that you guys were below the statewide average at-risk funding that you usually receive.

Ms. Palmer (OBOR): I've been thinking of that and I think that all has to do with you have a fairly good amount coming in...and so institutions don't and so I think that is probably a lot of it.

Mr. Cannon (OBOR): And this goes back to your question, kind of where we are now with dual projections and not being able to provide the FY15 number? The way it was set up is we asked the school to do a projection of your FY14. We asked for this back in October when school was kind of just getting started. We saw that wide variance in terms of what other institutions kind of cost so we didn't feel really

comfortable in terms of what those projections showed, because Mrs. Palmer ran some numbers for the institutions based on the historical trend of what we anticipated for 2014. We had two institutions that went in and made changes based on what they thought their numbers would look like. Those institutions were UC and Ohio State. Those are the two biggest institutions and so if they go in and tweak their numbers and nobody else did, we didn't want that to lead to changes in the funding formula later. So we are asking the campuses to provide updates so they all can go in and look at their numbers and see if they can give us better projections so we can do the FY15 number. Again, we were trying to get the projections so tight is because we still had to do the...at the end of the sixth month. The final distribution is based on those actuals that we talked about being the actuals for 2012, 2013, and 2014. And so, what we don't want is a wild swing six months into the fiscal year where you guys may project your numbers well, but Ohio State didn't and now all of a sudden they get more degrees or more course completion funding -- they're going to get a bigger share of the pot and well, that money is coming from somewhere. It is from those institutions that maybe earn more in the projections pay and now will have to give up money in that second six months. I know that's really lousy for the budget people or we are going to have to deal with it six months into the fiscal year and say, "holy cow what happened? I budgeted it on \$7 million and now I'm getting \$105 million" and that's a tough thing to do.

Mr. Morlock: We are setting our budget up in the next few weeks. So the timing on this is [cut off]

Mr. Cannon (OBOR): We have one school we're waiting on and we hope in two weeks we can at least have some numbers out to start sharing with institutions and making sure everything looks reasonable. I think that's kind of the timeframe we're thinking of.

Mr. Morlock: Do you know what is reasonable? The flexible people of Toledo Ohio <laughter>. We are putting our plans together and as things adjust and tweak, we will adjust and tweak as we go along.

Mr. Cannon (OBOR): I don't know if you saw the original projections that were done with the 2012 and 2013 actions and 2013 and 2014 projections. I don't know if you got that data. We will certainly be willing to share it with you, if you want to start with that maybe to set your budget. But we didn't feel real comfortable with that set of numbers and that's why we're asking for those updated projections.

As I said, I think you are going to look at your Summer and your Fall now that we are this far along. Maybe your estimated Spring data, but we're getting pretty far along. Most schools should know now what their Spring enrollments are and what their graduates look like so we are really hoping to fine-tune these projected numbers. Ms. Palmer ran the data two ways. First, we look at historical trends such as how many degrees were offered by each college. We also talked with some of the BFO's and they said "Based on those students who are classified as juniors and seniors based on our history, which ones are likely to graduate?" and so we ran additional data so the schools can take a look at it. What that showed in terms of the number of degrees that could be awarded this year. We just wanted to take out as much swing in that set-up as we possibly can.

Here are other issues: we know based on what we've seen in terms of the new model funding formula, we may see some things we want to address such as associate degrees. What really is the best policy for associate degrees? Should universities be in the associate degree business and then how should that impact funding? I think that would take some additional research and review over the Summer. And then, what level of funding should an associate degree get? In the past the associate degree got the full cost of

the courses for the associate degree and then if that student went on and got their bachelor's they also got the full amount for the bachelor's and that is how it was set up for FY14 and FY15. The question is, should a student that is continuing through get that double count for the associate's degree? I'll tell you when Chancellor Petro was here he was very interested in seeing more associate degrees and being stackable degrees. So I think based on the history and how that was funded, his view in terms of how to try to get more associate degrees and get students out who may not graduate with their bachelor's degree, but spent time here in a program (completing the program) should they get some funding. In my short time in terms of the consultation, that gets the most discussion. What they are trying to do with the at-risk weighting is balance the institutions and the open access institutions, so how do you do that by weighing some of the students that the open access take? We want to re-look at that cost basis. We see more hybrid around online courses. In the past six years go back and get the cost, where is the cost of the courses that then lead into degrees? The question is, is six years too long, especially in the changing model where we've got online courses? Maybe we want to just catch the most recent and put that on a three-year average and maybe we'll see what the cost of the courses will be as we transition to more online or hybrid.

What do we do when a new program comes in? We saw in the funding that it's got a historical piece which is the majority of it based on FTE. There's got to be a fair way to do that and to look at that, but again, that requires discussion, view, analyzing, and debating. One other thing that we're doing, at the Regents, so much more emphasis is put on the completion and the data. Are we really keeping up our review and our HGI audits and our verification? They have not done that since we started. We are getting back into that business of verifying student data in terms of the courses that students took and did they meet all the requirements? We are also going to be more emphasizing those completions so we'll be asking the schools to supply more data on students that graduate. We are not doing that because we don't think we're getting good data in these... when we went back to look at that data we saw that the data was very good. We haven't seen any schools or any institutions from the students' information we received on the transcript where it doesn't match what's in HGI and that's not the reason we're doing it. We've got a lot of money at stake and we also want to see what happened down in Columbus in the high school side. We just want to make sure when we are issuing dollars for completion and funding it's done with verifiable data.

Senator Anderson: And that is transparent so the institution can go back and look at your data?

Mr. Cannon (OBOR): Absolutely. We have to be distinct with what the institution shows.

Senator Regimbal: So you have the six-years versus three-years, are you going to be pushing for people to finish in three?

Mr. Cannon (OBOR): No. The cost basis is how we calculate a course ... and historically it's gone back to a six-year period. We wondered if it was too long and maybe because of...going more to hybrid courses maybe there may be less cost for hybrid courses. I don't know. It's just one of the things we talked about. It's putting that on a three-year average rather than going back six years. It has nothing to do with time and completion.

Senator Keith: I have heard and maybe this is a rumor that part of the funding is based on whether or not you could offer a degree lower than the state average. For example, Engineering. On average it costs \$100,000 and if we deliver it for \$80,000 we would get a bonus based on we were delivering it cheaper.

Mr. Cannon (OBOR): Well, that's true in a sense because I think what that statewide cost does -- it rewards efficiency to institutions that have the lower costs. We're not setting out to tell schools to offer a degree at a lower cost, but since we are coming through a statewide... those who do it less are benefiting. So that's happening just through efficiencies and the cost of the institution. It isn't anything the Board of Regents or the formula is trying to push, it's just the way the cost formulas were in efficiency compared to your program. From the statewide average you can benefit if you were lower.

Senator Keith: So that is not an explicit part of any formula.

President Rouillard: I hate to cut you off.

Mr. Cannon (OBOR): I know. We need to get going.

President Rouillard: I would like to thank you very much for your time.

[Applause]

Senator Anderson: I want to thank you too because that was really good.

President Rouillard: All right, thanks again to David Cannon and Penelope Palmer.

[Applause]

President Rouillard: I want to welcome Mr. Morlock to give us an update and we are very appreciative of your time as well.

Mr. Morlock: Just to give you quick context. I have been in front of this group to provide some financial updates and my view of the financial state of the university. I did the same thing with the Board of Trustees when I was then given the extra duty of being the CEO of the hospital. When Dr. Gold left, they asked me to please provide the same level setting activity around the Medical Center, so that is what this presentation is. President Rouillard happened to be in the audience that day at the Board meeting and she asked if I could come and present it to Senate, so here I am. (disk change)

For those of you who don't pay any attention to the health market here in Toledo, it's really competitive and it's really consolidated. Under any circumstance having market relevance is necessary in my view. By the way, the first statement at the top is stated like it's a fact, but it's actually my opinion. My wife will happily point out that I state my opinion like it's a fact often <laughter>. My opinion is, under any circumstance, market relevance is necessary for long term viability into the future as an entity. From an academic medical center standpoint, we are one of the smallest in the country. The best I can tell, because sometimes it's hard to gather some specific data, I think we are the second smallest. There's a smaller one in Nashville, but we are a very small academic medical center. In a few slides I will talk about some issues around that because our medical school is actually about the 75th percentile in terms of the number of students in class size. So we've got some imbalance in the clinical engine versus the academic engine. This is a view of a physician market in Northwest Ohio in the Toledo area. By physician market these are

our own employed physician practices. There are plenty of independent physician practices that are out there that are not included in the data. If you go to a primary care physician who is one of three doctors in their own independent practice they are not showing up in any of this independent data. The University of Toledo physician practice has 220 doctors, Promedica has 315, Mercy has 188, and the Toledo Clinic has 146. The data is a little dated; I think they are up to about 160 now. Actually from a market position, this is one of the strengths of the clinical enterprise of the University of Toledo, but not so much the hospital as much as the size and integration of our multi-specialty position group.

This is the hospital market share in Toledo. So Promedica is little bit more than half. CHP Mercy, Catholic Health Partners were 11%, and 3% is spread around in Wood County and Fulton County and places like that. This is a view of our patient activity over the last six years. So CMI adjusted discharges are, well, I won't get into all the arithmetic, but if you are admitted to the hospital it's real easy to count, that's "one." What gets difficult is on the outpatient side where you're not admitted to the hospital. One patient might go in for a simple X-ray and another patient goes in for outpatient surgery, those are two vastly different things and it's hard to just call those "one" and "one" because they are not equal. There's a bunch of arithmetic that I think personally is a little bit "pokey," but it's the industry standard approach to this so at least everybody does the same thing. This is actually our own data to our own data over time. The broad point of this is our patient activity is basically really flat over the course of four to six years.

Out migration is a phenomenon of there is care for people that live in Toledo that are in this market that leave this market to have their care. Our market is actually a low amount of outmigration at 3-4% and that's fairly evenly split between Columbus, Cleveland, and Ann Arbor. So roughly 1 to 1.5% goes to each of those three markets. So I tried to frame for the Board other upper Midwest cities with that level of outmigration. You can see we are in line with some of these folks and others are much higher. For example, Champaign and Joliet, they are not far from Chicago, so a lot of outmigration goes to the city of Chicago. The most profound one to me is Lansing, Michigan; I don't know where those people are going. They must be going to Grand Rapids <laughter>.

A few slides ago I talked about market relevance. One view of market relevance is, do you offer unique services that nobody else in the market offers and if so, that creates relevance to insurance companies when they are building network of hospitals and physicians. I apologize for the abbreviations. Those are four things that we do that are unique to this market: 1. ECMO which basically means, your lungs aren't working and we'll suck the blood out of you into a machine and put oxygen into the machine and send the blood back to you. We do that and nobody else offers that here. 2. Transplantation, a kidney transplant etc. LVAD, which is actually something created to help bridge congestive heart failure on the way to a heart transplant and somebody figured out that this bridge is lasting a really long time so let's just leave the patients on this, so we do that. In a slide or two I'll talk about that more. 3. LVAD is another niche or slice where we are absolutely stars in the country. The Joint Commission was here about three-weeks ago to look at our congestive heart failure program and she looked at it and said, "This is the best place in the country for this." 4. And then Robotic lung surgery is another key point. So, the key question around market relevance to me is, can you build an insurance network in Toledo and then offer these services and tell your enrollees, we've got to get that done in Ann Arbor or Cleveland? I don't know if you've heard the phrase, "narrow networks"? It's starting to work its way into discussions in popular media around Obamacare. Narrow network means insurance companies, in terms of trying to save money, will include a few hospitals and doctors and exclude lots of them and then because of that they can negotiate lower

prices in exchange for volume. If we have these unique services then the key question is, can we still get cut out of networks and then an insurance network say -- if you need an organ transplant -- I really don't think it's that bad to drive up 23 for an hour to Ann Arbor and get it done or drive over to Cleveland. There are lots of people in America that live more than an hour away from a transplant center. So I worry that these elements are not enough uniqueness that particularly geographically positions us close to Columbus, Cleveland, and Ann Arbor.

Heart failure and LVAD, this is something I just mentioned a few minutes ago. Readmission rate is a key statistic around that. Basic readmission rate means within 30 days of when you were discharged from the hospital did you get readmitted for the same problem. You are not in great shape if you've got heart failure. Our readmission rate is 16.2%. The best 10 percentile is 20.9, so we are materially better than the negative percentile.

Slightly different topic around market and that is consolidation. So there's lots of consolidation going on around the country such as hospitals are joining hospitals, hospitals are buying physicians, physician practices are coming together, insurance companies are buying each other and being involved with hospitals, IT actors etc. This is a list of recent activity over the last few months in the Northwest Ohio area. In particular Promedica acquired Fremont Hospital not too long ago and it literally is all going to Promedica. So this is a view of the transfer report. These are patients that are admitted at some other hospital and then get transferred to us. You'll see that these are basically small community hospitals: Bellevue- 315, Blanchard Vally-79, Fulton County- 307, Wood County- 101, Monroe Mercy-62, Henry County- 100, Fremont- 118, Fisher-Titus- 120, Firelands- 65, and Williams County- 70. Monroe Mercy has announced they are on the block so they are trying to sell themselves. Fremont just joined Promedica. Henry County has just announced they are on the block. I just heard today that Bellevue is in discussions with the Cleveland Clinic. When I look at a chart like this there's one thing that worries me, Bellevue and Fulton County is 620-plus admissions and that's about 5% of our patient volume. So somebody else buys and fires those hospitals into their system the general expectation will be that you sent patients to the "mother-ship" not to where you've been sending them before and that worries me.

All right, the value proposition -- we are shifting gears again -- the issue of being the low-cost provider and so there are four ways to think about this: One is the cost that we incur in terms of supplies and staffing to provide the care. Two is what we charge folks for the care. Third is what we get paid because healthcare is an odd business and what you charge in the vast majority of cases has very little to do with what you actually get paid for the service. And then a fourth way, it is difficult to get the data analyzed, but eventually this is where the healthcare business model will go in America. I think it's per-capita cost of care per population of people. The expense base to provide care, UTMC is about 15% cheaper than the median of other academic medical centers, meaning we provide care more cheaply in terms of staffing and supplies etc. As somebody that spent a big chunk of my career at the University of Michigan Health System in Ann Arbor, I can assure you we run a much leaner shop in the hospital than a place like University of Michigan. On one hand, this is a good thing that we run a lean and efficient shop. On the other hand, the downside of that is, as reimbursement gets squeezed, payers try to pay less etc. We don't have that lever to pull anymore. So for example, Ann Arbor's got a lot of fat- they've got a lot of room to cut. It's just a matter of will power, do you want to pull the lever or don't you want to pull the lever. We actually don't have the lever anymore; we've pulled the lever in the past. Community hospitals- this statement is a broad statement across America; it is not a statement here in the Toledo market. But across

American community hospitals tend to be 15-20% cheaper than academic medical centers. So when we're 15-20% cheaper than our academic medical center peers we're basically right in line with community hospitals and since we are the second smallest academic medical center in America we're sized like a community hospital so I kind of look at our cross profile and say, "it's okay, but it's not great."

Past-President Dowd: For the top bullet, do you have an idea of how we raise 15% median for academic medical centers? How are the...for competition?

Mr. Morlock: I don't have the data readily available yet. I think I can get it, just sorting through the internet, but I haven't done that math yet.

Okay, this is another view. This is what we charge versus the market. It's sort of the list price/the sticker price. I took 10 high-volume inpatient type cases and 15 high-volume outpatient type cases and then compared us to Toledo Hospital or St. Vincent's and then I just looked at it and said, "Who charges the highest? Who is in the middle? And who is the lowest?" So the broad conclusion of the list of what we actually charge is lower than the other players in the market and I would generally view that as a positive. Another view is what we get paid versus the market. It is a little tougher to get this kind of data, so this is a view of some data that's a couple years old and it came from Anthem, the BlueCross plant around this part of the country. I did the same kind of approach, but I had a small data set to look at - on the left is the types of data sets we looked at: knee replacement, colon screening, and all those other things that are different forms of imaging scans where they look at your brain or your bones etc. I did the same kind of thing, high, medium, and low, and basically what you see is we are generally paid the lowest in the market. In my view that is driven primarily by physicians in the market. When you've got 11% of the market share you've got less clout and "arm twisting" in negotiations. Or, if you don't have that many unique services then you've got less clout. This is another view of what Medicare pays rather than BlueShield/BlueCross. One particular type set of cases are major joint replacements. The broad point is, all of the dots on the graph are local hospitals. I circled Toledo, UTMC, and St. V's. And then this chart in yellow is the data points. It is what we charge and what we get paid. We charge less than the other two, but actually Medicare pays us the most for major joint replacements compared to Toledo Hospital or St. Vincent's. That's because being an academic medical center we've got some add-on stuff because it's theoretically more expensive to provide care in a teaching environment.

Senator Hoblet: This can be a real "rub" for us, especially when Medicare goes forward with patient satisfaction, correct?

Mr. Morlock: When you say, "...goes forward with patient satisfaction?"

Senator Hoblet: As far as a report card and releasing reimbursement for quality service.

Mr. Morlock: Yes. Medicare has a program in place called, Value Base Purchasing. It takes a bunch of metrics in the data in the first few slides that I talked about and they pull back 1% of the total money they made (all hospitals), put the money in a pot, and then they took all the hospitals' scores and said, "Okay, the best scores -- you get the share of that 1% and the others are "losers" basically in this arithmetic. So about 90% of the hospitals in the country lose money on value based purchasing and 10% make money on value based purchasing. Our hit last year in round numbers was about \$75,000. No knock on a government program, but when I look at our quality and satisfaction scores which didn't look so "hot" to

me and somehow with all of this stuff there's a \$75,000 payment and I don't want to peddle away \$75,000, but in the grand scheme of things that is not driving the market anywhere.

Senator Anderson: I'm not anywhere near the medical profession, except a user, but why is the charge 3X's the payment?

Mr. Morlock: That is a virtually standard promo. I'll just say this, if you were designing a healthcare system from scratch you would not design the system or the reimbursement mechanism the way it exists today.

Senator Anderson: But this is also just for Medicare, it's not for insurance paid by employers?

Mr. Morlock: That is correct. A similar profile exists from Medicaid and BlueCross. There are very, very few patients where that charge number is actually valid. Although, there's plenty of stuff that will hit the media like "they charge me \$9.00 for a Tylenol." Those kinds of things look great in the media but what they never get to is, it is actually irrelevant to what is generally being paid; which is another perverse way of looking at it, why would you charge \$9.00 for a Tylenol? And I don't have any idea what we charge for a Tylenol so don't ask <laughter>.

So this is a per capita look. This is just a point view of SS, per capita spent on healthcare. Why access is life expectancy in years and all of the dots are countries in a developed world. This is where the U.S. is. So we spend a lot more per capita than anybody else and we don't have a lot to show for it in terms of life expectancy. There's a lot of lifestyle stuff. You begin to drive more miles in this country and more McDonalds etc. We have a lot of stuff that impacts some of the data. The broad point is that it is problematic from a long-term sustainability perspective. In the Toledo area our market is 7% higher than the rest of the U.S. Medicare data. So, U.S. is "bad" and Toledo is "worse." Not only are we 7% higher than the median, but we are actually 25% higher than the best performing markets in this country. A healthcare economist talks about the balances in supply and demand. In healthcare there's a lot of evidence that suggests that the supply of healthcare assets actually creates the demand for healthcare which then drives up per capita cost, especially since the purchasing decisions are divorced from their wallets. Just a quick story: I've been having conversations around helicopters in this area. There are eight medical helicopters in Toledo. It is "nuts" that a town this size has eight helicopters. We started talking about where our helicopters transport (that list of transports) from other hospitals. You may have seen an article in *The Blade* a couple of weeks ago about the life flight helicopter thing which is actually about helicopter trips from scenes, so things like that. We haven't lost any of that hospital-to-hospital stuff in the cancellation of that contract. By the way, Promedica called me the next day after the *Blade* article and said, "We'll do a deal with you" and so we're in conversations. I heard the other day about a helicopter transport of a patient from Blanchard Valley which is down in Findlay. It was a hip fracture. Somebody fell in the nursing home and broke their hip. They couldn't take care of it there and so they sent them up here because our orthopedic programs are pretty good up here. I was like, "Was this person in danger of dying from a broken hip?" They were like, "No, we got him stabilized and they put him in a helicopter." Now, if there was no helicopter they would have just put him in a ground vehicle and driven him up here and the patient would have not been any worse. It probably would have taken 20 minutes longer to drive than to fly low. That is an example of "somebody's paying for it, so let's just get more helicopters." This is the market for commercial insurance. The broad take-away is this is a very fragmented market. There are markets in the country where one payer dominates the market, nobody dominates here.

Unknown Speaker: Mr. Morlock, is that a positive or a negative?

Mr. Morlock: I view it as a positive because you can claim each other off and work on alignment. So, when I was up in Michigan, BlueCross owned 80% of the commercial market in the entire state. Because of our position the University of Michigan could beat “the snot” out of BlueCross. Unfortunately, no one else in the state could and in fact, BlueCross beat everybody else up. I view it as a positive action.

Financial position: This is the last two-years of actual data and one-year of what I’m actually projecting for this year. Double A and Single A -rated medians are just financial metrics for a couple national financial hospitals that we can compare to, then Promedica and Catholic Health Partners. In this look it’s not Toledo Hospital or St. Vincent’s but the entirety of Promedica and the entirety of CHP. So days of cash-on-hand, that’s a measure of the amount of money you have in the bank, the higher the days, the more money you have and so you can see we’re a little light on cash. We are not on the brink of bankruptcy, but we lack the industry medians and Promedica has more checks to cash. Debt to Capital, a sort of a non-finance way to think about it is the size of your mortgage to the value of your house. So the higher the percentage the more debt you have. So we are a bit ahead of the industry and Promedica does not have much debt. So, from a finance geek’s look at things, Promedica’s got a really strong balance sheet, lots of cash and not much debt. Cash flow margin, this is profitability and it’s before depreciation and those kinds of things. We’re actually reasonably strong. We’re in the 9 to 10% range. We are in line with the industry and we are in line with at least Promedica. As a problem, you may look at it and say, if we’re reasonably profitable, how come our debt and cash position doesn’t look as strong as our hospital? There are two drivers. One, we are sort of small. So even though we’re roughly making a 10% cash-flow margin, 10% on a topline revenue number still isn’t a whole lot of cash. So when you’re buying IT and things like that, that stuff scales really well on a big enterprise and it doesn’t scale so well on a smaller enterprise. And number two, UTMC transfers a big chunk of its cash-flow to the College of Medicine. So it’s a funding of the academic mission. But the downside is you then don’t have that cash to put in the bank or to invest in fixed assets. In terms of investing in fixed assets these two metrics speak to that average age of those assets, so you want to have a lower age and capital expenditure as a percent of depreciation. These two years show a pretty significant capital spend in the hospital. The university borrowed money to spruce up the hospital back in 2011 and that’s the spend that occurred from that borrowing. We’re projecting to be under level of depreciation here and I’m worried that we’re going to be significantly under for the next several years in depreciation without a lot of cash in the bank to tap into, or a capacity to go out and borrow more money. So, this is why we’re trying to study our strategic options of what to do with the hospital and should we be partnering with other systems because we are in a structural financial issue that is not a great position. So in round numbers our topline of revenue is \$280 million and 10% cash-flow means \$28 million and \$12 million of that \$28 million is transferred to the medical school so that leaves \$16 million and roughly half of that is then used to pay the mortgage payments, so that leaves about \$8 million per capital depreciation of about \$16 million. In a ballpark, we are going to be about 50% for the next few years which means, “You can’t keep up with the Joneses” basically in a competitive environment.

Senator Hoblet: With this sort of balance sheet, why would anybody want to partner with us?

Mr. Morlock: There are three reasons to partner with us. One, we bring 220 doctors that are organized and work well together, that’s huge. Number two, we are the pipeline for physicians, nurses, occupational

therapists, physical therapists, pharmacists etc. in Northwest Ohio. And number three, this isn't so bad, that level of profitability that you can add into the portfolio especially since if somebody big acquires us they can improve that because of certain scale economies on supply chain purchasing running an IT shop etc. So, I frame that as somebody purchasing us. I don't know if we want to go down the road of actually selling. And I don't know if we can actually sell to anybody in the Toledo area because of Federal Trade Commission issues. You may read articles in the paper about Promedica and St. Luke and that sort of thing, we will have the same issues. So maybe partnering is not "let's sell the hospital." Partnering may be setting out an affiliation relation agreement and let them run the hospital and take advantage of the scale, but we still own the hospital.

Senator Edinger: So what does that mean for the academic venture if you have another entity coming in, do you lose control over funding your academic side?

Mr. Morlock: That would be part of any negotiation that you would enter into. I don't want to get the cart too far ahead of the horse, but we're not in these conversations with anybody at this level yet. But part of that discussion would have to be assurances around all the necessary training, a lot for our learners. I have a slot on where our learners are located right now, whether they are in medical school, nursing school, or any of those health science campuses.' And right now, this hospital is throwing off "X" per year to fund the academic mission and "X" plus some percentage has to continue going forward into the future. All of that has to be "rock-solid" in contracts. That being said, this type of transaction is not that uncommon. If we headed down that path it is not like we will be breaking new ground in the United States of America. This is a view of net assets. So net assets, think of equity in the place. Bottom-bottom line, after transfers to the medical school etc., it is down to basically 0%. The last few bullets on margin issues to me create concerns. We make money on commercial payers etc. and we lose money on Medicare and Medicaid. That is a very common profile. More and more businesses in America are shifting to government-paid which is problematic, so that worries me about our profitability, one. Two, much of our profitability is concentrated in the hands of a few key services: orthopedics and cardiovascular care etc. That kind of margin concentration is incredibly risky. Number three, we don't have a big benchmark? in a lot of areas. For example, ear, nose, and throat, we have one practicing ear, nose, and throat surgeon. He has a medical condition right now that actually prohibits him from performing surgeries. Well, there's no benchmark and that's a problem. That's a margin concern that I have. All of those things add up to two words, "grey hair" <laughter>. I had no grey hair until the hospital <laughter>.

This is a question that speaks to distribution of our learners. So what we took here were residents, med. students and their clerkships, nursing students, occupational therapy students, pharmacy, all Health Science Campus students to go somewhere to have some clinical exposure. I have about 45% to 30% because it changes semester to semester and year to year, but the numbers are reasonably steady. UTMC, we provide just under half of our own material, 30% to Promedica and about 15% is spread all over little hospitals and nursing homes etc. The end of the 45% that we do here is strength. The other day one of our cardiovascular surgeons was telling me the story that over time some of these procedures have shifted to minimally invasive surgery which means they don't crack your chest. They make a small incision with one little camera. He was like, "Dave, I got this little incision with this little thing. I got six students trailing behind me and everybody's trying to look in the little 2 inch incision." And I said "Well, why don't I get you a camera and we will stick it on your forehead and when you are looking in an incision it.

will shoot it up on a screen so students can look at, is that all right?” That was creative thinking, but, however, there’s still some straining in doing 45% of our own work here. We can easily reduce that number and spread it out. Was the presentation helpful?

Group of Senators: Yes.

Mr. Morlock: Are there any questions?

Senator Lee: From your time so far, how do you think we are or not capitalizing on using advanced practice nurses and the whole picture of UTMC?

Mr. Morlock: I’m not sure I can answer the question. I don’t think I have a great opinion on that. So I’ll speak to potentially the broad category of physician extenders. So, would you put an advanced practice nurse in an extender category or would you not think of it like that?

Senator Lee: I wouldn’t think of it like that. But I understand where you are at; you’re thinking physician assistants and support for the physician services, that’s okay.

Mr. Morlock: I don’t think we are optimally running in the outpatient arena. I don’t think we are optimally running our clinics in terms of patient flow, in terms of eve of registration and those kinds of things, in terms of physician flow within the clinics, and in terms of use of extenders in those clinics. We’re working to tackle that issue. It’s a mix of old history, and the practice, and cultural things and all that stuff.

Senator Lee: Because we do have a large nurse practitioner program and so I was just planting that seed for the floor. Thank you.

Mr. Morlock: Yes. Thank you.

Senator Edinger: I don’t know how to ask this nicely. But, if you were negotiating for insurance benefits for your employees, where would you want them to go?

Mr. Morlock: If I was an employer negotiating it, I would want to try to negotiate a broad network. So I would actually want my employees to go to anywhere they want in this town and whatever position they want to see in this town. If I was an employer and I had a patient with congestive heart failure I would actually want to come right here. If I had someone who needed neural intervention for stroke issues and blood clots in the brain I would want them right here. In fact, for that one, I would want them right here instead of the Cleveland Clinic or the University of Michigan. We are awfully good in orthopedic care. Promedica is also awfully good in orthopedic care with that new Wildwood facility on Central Avenue. But, the short answer to your question, I would want to create as much access as I could for my employees. I can tell you this, I can take off my shoe and sock and let you see the scar on my foot that I had surgery here a couple months ago. I had a very good experience. I got at least a first couple of visits in the clinics before somebody tipped them off who I was. I could do secret shopper for a bit <laughter>.

Senator Edinger: I would say I’ve had very good experience here too, but your number “scares” me.

Mr. Morlock: We’ve been ringing our hands over this over the last few weeks in the Leadership meeting in the hospital. So interestingly enough, we’ve got some physicians who practice here and practice at

other hospitals so it's a clinical material issue and they've got to spread their practice around. We have doctors with patient satisfaction scores here and at the Toledo Hospital, it's the same doctor with materially different scores and higher scores over there. Now, maybe it's our nurses, I don't know. Maybe our nurses aren't nice and theirs are nice. Maybe the valet parking is better there than it is here. I don't know. Some people are telling me that at least part of it is just a lot of old history. They look at me and say, "You are not a native Toledoan, are you?" "No, I am not" and they proceed to launch into some 30-year old history about an old county hospital and this is where people go to die. It's like this ancient history that still casts a pall on things.

Senator Anderson: It sounds like *U.S. News and World Report*.

Mr. Morlock: Perhaps. This is data, *U.S. News and World Report* for rating hospitals is the same thing, it's a lot of reputational stuff. We actually received an award from *U.S. News and World Report* and that's on the flip side, so that's a positive. We're working hard to try and figure it out. As you all probably saw in the *Toledo Blade*, Dr. Jacobs was a patient here in our hospital. I stopped by to visit him and he's looking around going, "I can't figure out why our H-caps aren't higher." He said "The place is shiny and beautiful and people are treating me really nice." And I said, "You might want to discount "the people are treating me really nice""<laughter>. If somebody doesn't treat you nice, particularly, point it out because they should be fired for being "not smart"<laughter>. But the point he was making was, he had a recent grandbaby born three or four weeks ago at a hospital in another state (up in Michigan) and he was telling me how appalled he was by the dirty floors in the waiting room and stuff like that. And we actually don't have that situation in our waiting rooms. We actually have a nice physical plant. Our environment is pretty nice. We are working hard to tackle the issue.

Senator Anderson: My wife was actually taking care of her boss in...and she said the service...it is a premium institution...they don't understand the bacterial infection....

Mr. Morlock: Wow. I talked about the strategic looks we are doing to potentially partner our hospital with somebody else and that might not work out, all right. In my view I can't just stand by and underperform. So we're busting out rear ends to improve which will only make us more attractive I think.

Past-President Dowd: If we are a very small hospital, how many dollars would it take to dramatically change our environment? What are we looking at?

Mr. Morlock: I would approximately say doubling so we are doubling the size of the hospital and rebuilding the clinics and we will be in the magnitude of \$100 million.

Past-President Dowd: It is something that should be considered to a certain extent. You could magnify certain areas.

Mr. Morlock: We are looking at all those things; we are doing it. We can't go down the road unless we do it. We actually had a strategic conundrum that was actually set up literally 50 years ago at the founding of the Medical College of Ohio and the building of the hospital, which was one of the smallest clinical engines in the country for an academic medical center versus a reasonably decent-sized medical school. We will increase the size of the medical school over the next couple of years, but not hugely. But that was a strategic mistake like right out of the gates, that once you get 30 years, 40 years, 50 years in, it's hard to undo that.

Senator Regimbal: So where does the Sim Center fit into this mechanism?

Mr. Morlock: In all of this the Sim Center is actually probably part of the academic enterprise. It's not in any of this picture although the Simulation Center, at least one of the floors of the Simulation Center, relates to clinical training. So there are training opportunities that would be created for folks in the Simulation Center. Perhaps that can help alleviate some of the future training issues where I'm showing more than half of our trainees are going to other organizations and perhaps some of that can be retained in a simulation setting, at least for some of their in training. And so that can help alleviate some of it. I know Dr. Jacobs has at least in his mind that the Simulation Center is not just a healthcare thing; it's a much bigger thing.

Senator Ohlinger: I would encourage you to then look at some of the staffing and resources that are being allocated to the Sim Center. It is an amazing facility and we already utilize it for our college. But for the facility that it is and what it could be, unless the people increase, we are not going to be able to utilize it nearly to its potential.

Mr. Morlock: I agree. The question to that is, can you make a business model of the Sim Center? There's outside revenue to begin with: one of the areas you want to focus on is actually training opportunities that they can sell to the United States Army. And I think there are actually some legitimate opportunities around that.

Senator Ohlinger: And I think that might take some up-front investment in terms of looking, if one person is looking at possible outside contracts.

Mr. Morlock: Yes. There's some investment and some revenue stream there. It's hard for me to envision the Sim Center being like a rocket engine. You would generate revenue and offset some cost.

Senator Anderson: So, we are investing a lot of money....personal interest...do you have any statistics...

Mr. Morlock: Patient growth is a reasonable statistic. It's the patient base of that sector of our business growing and the answer to that is, yes, it is. I would love and we're in a variety of conversations to try to figure out a way to get our college approved, and get cancer doctors from the Cleveland Clinic to partner with our cancer doctors and that would be extraordinary robust; that would be the premier cancer center in the area for sure. So there's a lot of possibility here. I know that some of the broad gestalt of this is like "uh," I got that, but there's some wonderful pockets of great performing areas and opportunity and I am working hard to try to make "uh" better too.

Senator Lee: Because we do have the offset of the university, are there opportunities for what we've been hearing about in healthcare? Thirty-eight years I've been a nurse for health promotion and wellness as opposed to competing with the market that is oriented to disease treatment.

Mr. Morlock: Yes. The business model of American healthcare right now is not what is called real healthcare.

Senator Lee: I know and that's the problem.

Mr. Morlock: It's medical care and insurance required. We make a lot more money when you fall over from a heart attack as opposed to when we give you salad and a treadmill.

Senator Lee: It's just a dream that I have.

Mr. Morlock: Eventually, if I say ACO, Accountable Care Organization is a pilot funding mechanism that was created in Obamacare and that is actually a mechanism that tries to turn the healthcare business model upside down which is, you make money the less you have to take care of the patient; but keep the patient healthy. So the clinically ill person, it's a lot better to send a social worker to their house and make sure they are getting their diabetic exams on their feet and their eyes. Making sure they are keeping track of their diet and taking their medication and paying to send a cab to pick them up and take them to the doctors' appointment instead of skipping their doctors' appointment and keeping them out of the hospital. Then that becomes a money-making patient as opposed to, we make money when you show up sick. Until recently -- the last three or four years -- hospitals actually made money if they did things like, if you got an infection. You are in for this simple surgery and you got an infection and got really sick they just made a lot more profit out of you and that's a really perverse mechanism, right? I mean that's incredibly perverse. That is now being fixed and eventually I think the model will move towards what we are talking about. Unfortunately, politics in America has a way of into turning cliffs into slopes.

President Rouillard: We are very appreciative of your time and I hope you join me thanking him.

[Applause]

Mr. Morlock: Thank you.

President Rouillard: Obviously, it's too late this afternoon to work on curriculum which means our final meeting in two weeks is going to be very busy. And that means the first thing we will take care of is these curricular issues. The elections close on the 16th of April, so our other order of business will be seating officers at that last meeting. Any final announcements before we adjourn? Meeting adjourned at 6:07 p.m.

IV. Meeting adjourned at 6:07 p.m.

Respectfully Submitted by:

Lucy Duhon
Faculty Senate Executive Committee

Tape Summary: Quinetta Hubbard
Faculty Senate Administrative Secretary

