

The Regents of the University of California

**COMMITTEE ON HEALTH SERVICES**

January 19, 2005

The Committee on Health Services met on the above date at UCSF–Laurel Heights, San Francisco.

Members present: Regents Dynes, Johnson, Kozberg, Lansing, Lee, Marcus, Pattiz, and Preuss; Advisory member Brunk

In attendance: Regents Anderson and Connerly, Regent-designate Rominger, Secretary Trivette, General Counsel Holst, Senior Vice Presidents Darling and Mullinix, Vice President Gurtner, Chancellors Bishop, Carnesale, and Vanderhoef, and Recording Secretary Bryan

The meeting convened at 4:10 p.m. with Committee Chair Marcus presiding.

1. **APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of October 12, 2004 were approved.

2. **UPDATE ON MEDICAL CENTER, LOS ANGELES CAMPUS**

Chancellor Carnesale recalled that The Hunter Group had developed a broad strategy to help the UCLA Medical Center rebound from financial losses. Part of the strategy was to reshape the management team. He reported that 2004 had been highlighted by the transition of senior enterprise leadership from the Navigant consulting group, previously known as The Hunter Group, to a newly recruited senior management team for UCLA Healthcare. In July, UCLA Healthcare welcomed a new hospital CEO and a new president for the UCLA Medical Group. Dr. David Callender was appointed Associate Vice Chancellor, UCLA Hospital System, while Dr. Thomas Sibert was named as Associate Vice Chancellor, UCLA Faculty Practice Group. In September, Mr. Mitchell Creem started his tenure as Associate Vice Chancellor and Medical Sciences Chief Financial Officer. In this position, Mr. Creem provides oversight for the financial systems of the UCLA Hospital System and Medical Sciences entities, including the Faculty Practice Group and Medical School. In September, Mr. Jay Kasey, a Navigant employee, was named interim Chief Operating Officer (COO) for the UCLA Medical Center in Westwood and the Santa Monica–UCLA Medical Center. Mr. Kasey will serve in the interim system COO role until a new COO for Westwood and a new chief administrative officer for Santa Monica are recruited. Both of the recruitments should be completed by June 30.

Associate Vice Chancellor Callender provided an update on the medical center, the hospital construction project, the financial performance, and an action plan for the UCLA Hospital System.

***Fiscal Year 2005 Financial Performance***

Associate Vice Chancellor Callender recalled that in FY 2004, the UCLA Hospital System posted \$11.7 million of income before other changes in net assets – an \$18.3 million shortfall from the \$30 million that was originally budgeted. The difference between budget and actual was due to higher labor and purchased medical services costs.

With regard to fiscal year 2004 revenue variances, total operating revenue exceeded budget by \$14.5 million, despite a negative budget variance of \$4.2 million for the category of “Other Operating Revenue”; however, the FY 2004 total operating revenue was not sufficient to offset the costs related to patient acuity that was higher than budget forecasts and significantly unfavorable changes in payor mix, patient days, and admissions. During this period, patient days associated with higher-paying contracts and private payers fell short of budgeted targets. Additionally, patient days with low or no reimbursement, including those attributable to Medi-Cal and non-sponsored charity care patients, grew. Also, Medicare admissions were 655 below the fiscal year 2004 budget forecast. Analysis reveals that the reasons for declines in favorable patient admissions are multiple and complex, including the declining volume of patients for profitable surgery subspecialties, most likely due to improved capabilities of local competitors; a shift in referrals to competitors with lower rate structures for some profitable services; and the influx of Medi-Cal and non-sponsored charity care patients through the emergency department and transfer mechanisms, due mostly to hospital service level changes in Los Angeles and surrounding counties. Another factor that contributed to less-than-optimal revenue performance was the failure to achieve the budgeted conversion of capitation contracts to more profitable per diem arrangements. Finally, the category of “Other Operating Revenue” fell short of budget targets due to a reduction in State-supported Clinical Teaching Support funds and reductions in various other revenue streams that are used to support patient care.

On the expense side of the net income equation, the UCLA Hospital System was substantially over budget, resulting in an unfavorable variance of \$43.5 million during FY 2004. Expenses in the “Salaries and Benefits” and “Supplies” categories were responsible for unfavorable variances of \$14.0 million and \$18.7 million, respectively. These expense overruns were attributed to total patient days and patient acuity levels considerably in excess of budget forecasts. High patient days and acuity levels contributed to staffing costs in excess of budgeted levels. Patient volumes and acuity also contributed to the higher than expected demand for surgically implantable devices and pharmaceuticals. Costs for devices and drugs also rose dramatically, related to inflation. Finally, expenses in the “Purchased Services” category exceeded budget by \$11.2 million, due mainly to volume increases in purchased medical services for dialysis and organ acquisitions, and to maintenance costs related to the operation of aging facilities.

***Fiscal 2005 Year-to-Date Financial Performance through October 2004***

Dr. Callender reported that trends contributing to the UCLA Hospital System’s financial performance during the last half of FY 2004 continued through the first four months of

the current fiscal year. As of October 31, 2004, income before other changes in net assets for the hospital system was \$2.7 million below budgeted projections. Net Patient Service Revenue was slightly below budget projections, with a negative \$0.4 million variance. The problems with an adverse payor mix continued, with Medicare and favorable managed care contract business below budget targets, and Medi-Cal and non-sponsored charity care business exceeding budget targets. Likewise, total operating expenses were \$5.7 million in excess of the budget target through October. Higher "Salaries and Benefits" costs accounted for \$2 million of this operating expense variance. These higher personnel costs were associated with nurse orientation expenses, a retroactive union-negotiated salary expense, and temporary staffing. Purchased and Professional Services accounted for another \$1.8 million in unfavorable expense variances, again related to medical services such as dialysis and transplant. Outside provider costs associated with capitated patients were \$1 million over budget. Lower than budgeted transition costs, related to the delayed occupancy of new facilities, created a favorable categorical expense variance through October.

### ***Fiscal Year 2005 Financial Outlook and Action Plan***

With the weak financial performance during the first four months of FY 2005 and continued unfavorable market trends, projected year-end financial performance will likely range between break even and a modest, positive net income. Cash projection will range between \$32 million with a break even scenario, and \$52 million if a small, positive net income is achieved. If the hospital system remains on its current financial trajectory, management believes that the health system can achieve break-even performance. If current and planned revenue-enhancement and cost-savings interventions are fully implemented, a net income of \$10 million is achievable. Full implementation of the interventions will result in significant improvements in management of payor mix, length of stay, revenue cycle, and service volumes. Additionally, costs associated with supplies, personnel, outside providers, and purchased services will decrease. The interventions are included as part of a three-phase business improvement plan, with Phase I currently under way. Phase I includes adjustment of the hospital system's operating cost structure to help match the revenue streams associated with a more adverse payer mix. Phase I includes introduction of new management tools and controls to improve the management of costs and new efforts to improve revenue cycle performance. Phase II, which begins at the mid-point of the current fiscal year with efforts to prepare the operating budget for FY 2006, will focus on improving business planning and development. Phase II includes the introduction of a service-line approach to planning and management and a more thorough analysis of contracting performance and strategies. Phase III will begin in early FY 2006 and includes a market assessment and development of a long-range strategic planning process.

### ***New Hospital Construction Update***

Associate Vice Chancellor Callender reported that construction work continues toward completion of UCLA's new hospital facilities in Westwood and Santa Monica. In summer 2004, the Office of Statewide Health Planning and Development (OSHPD)

issued a stop work order related to a number of outstanding inspection and documentation issues related to both sites. Relevant work resumed at both sites as the inspection and documentation issues were addressed, but the pace of activity at the Westwood site has not yet returned to previous levels. The UCLA Capital Programs hospital project team is working with the general contractor, subcontractors, and OSHPD to remediate outstanding inspection and documentation issues and to establish a revised Westwood construction schedule aimed at completion in December 2005 and occupancy in mid-2006. Construction of the Santa Monica facility is in the shell and core stage, and completion is anticipated to be achieved in three phases, the first scheduled for late 2005 with occupancy in mid-2006. Completion of construction and occupancy of the remaining phases will occur over the following two years, with final demolition of the vacated facilities anticipated to occur in spring 2008.

Dr. Callender commented that, in summary, the UCLA Hospital System is faced with major financial and market challenges that force significant changes in operational practices and plans. Additionally, a new strategic assessment and plan are necessary to position the hospital system best as an ongoing, contributing member of the UCLA Healthcare enterprise. Implementation of the business improvement plan will make it possible to address these challenges and plan for the future. It is expected that the hospital system's financial performance will be restored so that it meets the needs of its UCLA Healthcare peers and the expectations of the University, its financial partners, and its bond insurers.

Regent Marcus asked whether milestones had been met since the new management team had been in place. He emphasized the importance of setting short-term goals. Provost Levey responded that changes are happening in all areas. Chancellor Carnesale expressed confidence in the accuracy of the financial projections. He noted that UCLA's hospitals could be profitable easily if research and education were not part of their mission; however, the campus will not sacrifice the quality of these aspects in order to correct problems in the business aspect of the enterprise.

Regent Johnson asked whether the payor mix was affected by problems at King-Drew Hospital. Provost Levey reported that, although the level of trauma patients may have increased slightly, that was likely based on systemwide changes and not on problems at Drew. The greatest problem that the possible demise of Drew would cause is that it could threaten the existence of Charles R. Drew University of Medicine and Science, which the campus oversees. Regent Johnson requested that a discussion about the University's relationship with Drew Hospital be scheduled for a future meeting.

Regent Pattiz stressed the importance of maintaining the quality of the UCLA Medical Center in order to continue attracting donors. Associate Vice Chancellor Callender agreed that across-the-board cuts in personnel who deliver care would not be appropriate. Instead, the administration is focusing on the scope and direction of programs.

Regent Marcus commented that the planned occupancy of the major hospital facility is about 18 months away. Dr. Callender reported that planning for the move is ongoing.

Transition plans are ready. He noted that moving hospital patients is a complex undertaking that has to be completed in a single day. To prepare the hospital to receive the patients will take about six months and will engender substantial cost.

### 3. **REPORT OF THE CLINICAL POLICY REVIEW TEAM 2003-04**

Dr. David Taylor, Executive Director of Medical Services, recalled that the Clinical Policy Review (CPR) Team was established in 1996, at the request of President Atkinson, under the leadership of Vice President Gurtner and the Office of General Counsel, to analyze current practices at the University's medical centers and to recommend a methodology for establishing an ongoing internal review process to assure that each medical center is in compliance with existing federal and State laws and regulations, and with University policies. Areas of focus have included contract review, human subject research, quality improvement, medical staff governance, and risk management.

Dr. Taylor reported that by the time the initial cycle of reviews was completed in 2000, the University's academic medical centers had inaugurated a series of substantive improvements in staffing and organization. These changes, many of which resulted from the advice of the Clinical Policy Review Team, have included most prominently the creation of a role for active chief medical officers at each medical center. In addition, the position of Executive Director, Medical Services at the University of California Office of the President was created in 2000. The Executive Director is responsible for oversight of patient care issues at the University and coordinates the work of the UC medical directors systemwide. The Executive Director, his staff, and representatives from the Offices of Research, Health Affairs, Risk Management, and General Counsel conduct clinical policy review.

#### ***Development of 2003-2004 Work Plan***

The UC medical directors meet regularly as a systemwide group to shape hospital policies and procedures in medical staff affairs, accreditation, risk management, performance improvement, peer review, patient safety, and clinical resource management. The actions and contributions of the medical directors in these areas have helped to shape the work of the CPR Team. A member of the medical directors' group joins the CPR Team for each medical center visit. A campus Institutional Review Board director participates in the review of human subject protection programs at sister campuses. In the ongoing review cycle, the team, in consultation with the systemwide medical directors group and others, selected the following topics for review:

- Interface between risk and quality functions at the medical center;
- Joint Commission National Patient Safety Standards;
- Resident supervision and resident competencies;
- Clinical service agreements; and

- Human subject protection programs.

These topics are a refinement of the original charter of the CPR and reflect the current environment in this new decade. This list of topics continues to expand into closely related areas such as medical staff, hospital governance, and clinical service agreements between the University and external healthcare entities.

Since CPR was established, there has been a great deal of focus nationally on patient safety, and the UC medical directors have been particularly visible on this issue. Institute of Medicine reports in 1999 and 2001 have permanently shaped the national debate on medical errors, and the University is responding in a variety of ways.

The interface between risk and the quality of functions at a medical center is a crucial measure of whether risk reduction efforts are effective. The incorporation and implementation of new processes and safeguards based on lessons learned from major adverse events, suboptimal outcomes, and legal claims depend almost entirely on regular communication between the risk and quality functions. In addition, at an academic medical center there is the added complexity of the relationship between the clinical departments of the school of medicine and the hospital. The need for reliable communication between the medical staff and the department chairs is essential.

Resident physicians, who train in the various clinical departments, care for patients in the hospital and its clinics. A key risk issue at academic medical centers is the delineation of roles, responsibilities, and requirements for house staff, the attending physicians who supervise them, and the nurses who interact with both groups.

Human subject protection programs are an area of burgeoning complexity and regulation. The University remains committed to ensuring that human subjects in clinical research are treated with dignity and respect and that they are exposed to minimal risks. The management of state-of-the-art human subject protection programs involves institutional review boards (IRBs), grants and contracts departments, conflict of interest sections, post-approval monitoring, and compliance activities. This is a potentially vulnerable system due to its inherent complexity and the enormous burden of work required to assure compliance with all relevant federal regulations. The CPR Team has taken as its focus that portion of human subject research which takes place at the academic medical centers, where the majority of subjects are also registered patients.

### *Visits*

Each initial visit lasts two days and includes meetings with approximately 50 individuals at each campus. At each visit there is an exit interview with campus leadership including the chancellor or designee, school of medicine dean, hospital CEO, chief medical officer, chief nursing officer, and IRB director. Following the visit, a report outlining recommendations is submitted to the campus for comment before the final version is endorsed. In addition, a corrective action plan with timetable is returned to the campus for completion within three months. Within nine to twelve months, a followup visit is

arranged at each campus to review corrective actions taken. Reports for all five campuses have been completed, and all corrective action plans have been returned. Followup visits have been completed at Irvine and San Diego, with plans to complete the remaining three campus visits in late summer and fall.

### ***2003-2004 Visit Schedule***

- April 2003-UC Irvine initial visit
- August 2003-UC San Diego initial visit
- September 2003-UC San Francisco initial visit
- November 2003-UC Davis initial visit
- December 2003-UC Los Angeles initial visit
- January 2004-UCLA Human Subject Research initial visit
- March 2004-UCD Human Subject Research followup visit
- March 2004-Willed Body Program Survey: UCD, UCI, UCLA, UCSD, UCSF
- March 2004-UC Irvine followup visit
- May 2004-Langley Porter/UCSF initial visit
- June 2004-UC San Diego followup visit
- November 2004-UC Irvine Internal Joint Commission site visit
- December 2004-UC Davis Bariatric Surgery survey visit
- December 2004-UC Irvine Bariatric Surgery survey visit
- December 2004-UC San Francisco Bariatric Surgery survey visit

### ***Findings***

Role of chief medical officers:

- Positions are well integrated into medical center administration
- Similar roles exist across five medical centers
- Succession planning should be encouraged

Risk management programs:

- Risk managers work well with medical staff and are active participants in every phase of incident management
- Development of proactive educational activities is continuing
- Root cause analyses and intensive case reviews are managed collaboratively with leadership

Quality Improvement activities:

- Development of clinical pathways is impressive
- Professional, creative and energetic staff provide structure and support to programs
- Physician involvement in quality improvement activities is increasing

Compliance with Joint Commission National Patient Safety Standards:

- Thorough and comprehensive approach systemwide

- Positively received by Joint Commission on Healthcare Organization (JCAHO) surveyors during visits at four medical centers in 2004
- Audit standards continue to improve

Resident supervision and resident procedural competencies:

- Policies for attending physician supervision vary by department and campus and are becoming more uniform
- Information provided to medical center staff regarding resident competencies is available to hospital staff electronically at most sites

Clinical service agreements:

- Procedures for centralized review of these agreements in place at most campuses
- Communication between individual faculty, departments, and administration is increasing
- Legal review of contracts is intensified

Human subject protection programs:

- As research volume grows and specialization intensifies the demand for IRBs grows with a consequent need for increased faculty and staff participation in review and oversight
- Human subject protection programs continue to require higher staffing levels, particularly in the areas of compliance, serious adverse event monitoring, and reporting
- Data sharing between human subject protection programs and medical centers and other relevant campus units needs improvement

### ***Projects for 2004-2005***

Corrective action plan followup:

- Will follow up with three medical centers not yet reviewed in 2004

Internal JCAHO consulting:

- Collaborative inter campus reviews and site visits by JCAHO coordinators to share best practices; visits planned to UCLA, UCSD, UCSF



Bariatric surgery programs:

- Visits completed to UCD, UCI, UCSF; UCLA and UCSF planned for early 2005

Human subject protection programs:

- Plan to develop focused objectives for 2005 visits
- March 2005 UCSF corrective action plan visit

Willed body programs oversight :

- Continue to work with consultants, former Governor George Deukmejian and Vice President for Health Affairs, Michael Drake, on improvements

Develop work plan for return campus visits in 2005-2006

Discussion of this item took place following Item 4.

#### 4. **SYSTEMWIDE HEALTHCARE QUALITY PRIORITIES 2005**

Executive Director Taylor discussed the healthcare environment and trends, reviewed the University's commitment to provide safe, effective, evidence-based care to patients, and described the steps being taken to ensure that UC makes consistent progress in healthcare quality.

Dr. Taylor recalled that six years ago the Institute of Medicine issued its landmark report on medical errors which estimated that 98,000 Americans die each year due to medical mistakes. This marked the beginning of heightened awareness in the medical community and in the government that, despite enormous successes and advances in health care, there were very serious issues with how care is provided to the public. Funds were made available to study ways to improve patient safety, and many researchers at UC have been involved in this important work. There was a realization among the large corporate and governmental purchasers of healthcare services that this lack of safety and quality could be measured in terms of waste, inefficiency, and poor services. There has been a growing demand for accountability and transparency on behalf of healthcare providers by consumers of healthcare and regulatory agencies. Public report cards rating physicians, hospitals, and clinics have proliferated, each with varying methodologies and validity. The focus on quality unsurprisingly follows the drastic reductions in healthcare reimbursement which led to leaner hospital staffing, the worst excesses of managed health care, and shorter hospital stays in the 1990s. A nationwide shortage of nurses and even the important reductions in resident physician work hours have exacerbated the situation. It seems reasonable that when forced to do more with fewer resources, health care, like any other system, would become strained to the point of breaking down.

#### ***Current Activities***

An effort is under way, led by the UC systemwide medical directors group, to continue improving the quality of care at the University's hospitals and to promote effective patient safety activities. Focus is being brought to the analysis of deficiencies. Routine

comparison of adverse events across the system encourages the adoption of best practices and the creation of policies that will prevent future medical errors. Systemwide benchmarking data sets have been developed for adverse events, and there is routine analysis of this shared information. There is also comparison of the data that is reported to the federal government, the Joint Commission on Accreditation of Healthcare Organizations, the Leapfrog Group, and other indicators of patient safety. The medical centers are periodically reviewed by the Clinical Policy Review team.

In the past year, the five CEOs of the UC medical centers along with their chief medical officers determined that the hospitals needed to push further in order to become premier institutions nationally in the drive for safer health care. A two-day retreat was held in Oakland during October 2004 for sixty of UC's health system leaders. Prominent figures in the national healthcare quality movement were invited to lead the participants in an examination of their systems. The presenters included Dr. Don Berwick, Harvard pediatrician and CEO of the Institute for Healthcare Improvement; Dr. David Brailer, the first National Health Information Technology Coordinator; Dr. Karen Feinstein, co-founder with former Treasury Secretary Paul O'Neill of the Pittsburgh Regional Health Initiative; Dr. Richard Davis, Director of the Center for Innovation in Quality Patient Care at the Johns Hopkins University School of Medicine; and Dr. John Kenagy, a proponent of grafting the best of Toyota's production system into health care. The participants were educated intensively about how the organization of health care at every level must be challenged in order to improve the quality of care provided to patients today. An important message transmitted during the retreat was to have a zero tolerance for errors of any type – in other words, to move beyond the health care industry's preoccupation with benchmarking and anticipate a future in which the only target that matters is zero errors.

### ***Priorities***

Following the retreat, principles and goals were drafted for the UC health enterprise that aim for more efficient, safer, and stronger hospitals and clinics. These principles strongly emphasize the role of the most senior leaders at the University. Experiences in other industries suggest that until the leadership becomes visibly and meaningfully committed to change and improvement in quality, there is not likely to be any significant institutional transformation. At Johns Hopkins, the President of the University, a radiologist, regularly visits a hospital unit to learn what steps are being taken to improve the quality of care. The goals also emphasize the importance of establishing and nourishing a culture of safety. There are successful examples for this type of work environment in high reliability industries such as aviation and nuclear power. Lastly, and most importantly, the UC health systems are accepting the challenge to reduce to zero the likelihood that any patient will develop an infection during hospitalization at UC. Hospital acquired infections will take years to eliminate. It will require a tremendous effort, but it is so important that management is concentrating on this above and beyond the energies already devoted to the achievement of high-quality outcomes in other areas such as the reduction of medication errors; better outcomes for patients who suffer from heart attacks, heart failure, and diabetes; or those who undergo surgical procedures in the University's

facilities. Another retreat will be held in October 2005 to review progress and plan for continued efforts.

Vice President Gurtner emphasized the extent of the effort to encourage the campuses to collaborate in order to implement best practices.

Regent Pattiz commented on the effort to stamp out secondary infections in the University's hospitals. Dr. Taylor emphasized the positive impact of enforcing even the simplest practices in the interest of safety.

5. **ESTABLISHMENT OF HEALTH SERVICES ADVISORY GROUP, OFFICE OF THE PRESIDENT**

Vice President Gurtner recalled that the five academic medical centers of the University of California function within an increasingly complex environment. Because of the growing costs of providing health care, the budgetary constraints at both the State and federal levels, and the growing ranks of the uninsured, the future of healthcare delivery is under intense debate.

Each of the University's academic medical centers is engaged in the strategic process of determining its role within this changing environment. The University of California has been fortunate to have the services of many individuals willing to volunteer their time and expertise. Each of the medical centers relies upon advisory groups made up of just such local individuals to develop their strategic plans.

An advisory group drawn from the ranks of existing advisory groups, as well as others throughout the State who would be willing to lend their expertise, could be invaluable in providing the Committee on Health Services with advice and consultation as the future of healthcare delivery evolves.

A Health Services Advisory Group is contemplated, with seven to ten individuals appointed by the President and the Chair of the Committee on Health Services and to be staffed by the Office of Clinical Services. The Group would meet quarterly and report to the Committee on Health Services periodically.

Regent Preuss noted that each medical school has in place an active advisory body. Mr. Gurtner commented that these advisory bodies, members of which are familiar with the local environment, may contain candidates for service on the Health Services Advisory Group.

**6. UPDATE ON STATUS OF MEDI-CAL REFORM**

Vice President Gurtner reported that the 2005-06 Governor's Budget was released just prior to the meeting. He provided an update on the continuing discussions between the State of California and the federal government regarding the renewal of the waiver under which State medical expenditures are matched with federal dollars.

Mr. Gurtner commented that three issues are under discussion. The first is the Governor's budget, in which the anticipated impact on Medi-Cal in California has been modified substantially and will have a relatively modest effect the first year. It will become more important in the future, however. In that proposal are some noteworthy elements. One is the movement of the aged, blind, and disabled under Medi-Cal from traditional fee-for-service to managed care. This population represents over half of the Medi-Cal patients treated at some of the University's medical centers. If approved by the Legislature, the plan will be different in each county. The University is working with the State to determine how the plan will work at the University's medical facilities. He believed that over the next several years the University's medical centers will need to restructure the way in which Medi-Cal patients are handled.

The second issue is the waiver. The Medi-Cal program in California functions on a 50-50 split between the State and federal governments. That agreement is under negotiation and represents a significant change in the way in which the University has been paid historically in that it moves the University from a negotiated level of payment to a cost-based level of payment. The University is supportive of the State's efforts, but there is concern about the outcome. If the negotiation is successful, as defined by the State, the University will be left in a relatively good position. The issue will take many more months to resolve.

Mr. Gurtner explained that the third issue is one between the University, the State, and the federal government relative to the way in which Medi-Cal costs are calculated, or the Upper Payment Limit. The University cannot receive matched dollars for expenses it does not have. When the last waiver was written, the State made an error by not calculating UCSF Medical Center for a full year, because of the merger with Stanford. The University, in working with the federal government to get that number changed, subsequently received approval representing a distribution to the University's three disproportionate share hospitals in excess of \$30 million.

The meeting adjourned at 5:20 p.m.

Attest:

Secretary