

THE GOVERNOR'S COMMISSION ON RATIONALIZING HEALTH CARE RESOURCES

Testimony of Gary Carter, *President and CEO*

117-member New Jersey Hospital Association

April 30, 2007

Professor Reinhardt, Michele Guhl and members of the Commission. I'm Gary Carter, president and CEO of the 116-member New Jersey Hospital Association. I thank you for the opportunity to testify before the Commission on critical issues that will shape the future of healthcare delivery in New Jersey for decades to come.

This testimony highlights my personal observations as well as concerns and recommendations of the NJHA Board of Trustees. It also provides detailed answers to questions that have been posed to NJHA in advance of me appearing here today.

I think I bring a unique perspective to this hearing in that I have worked at hospitals in San Antonio, Chicago and Salt Lake City, and served as CEO of the New Hampshire Hospital Association prior to becoming CEO of the New Jersey Hospital Association 13 years ago. As an association, we have not shied away from addressing the issues that face our industry, and in fact, you might be aware that we recently embraced pricing and quality transparency with two new publicly available Web sites, www.njhospitalpricecompare.com and www.njhospitalcarecompare.com. Some of you may even remember my arrival at NJHA 13 years ago, when I surprised many by saying that I thought New Jersey had 25 too many hospitals.

Part of my intent before you today is to use this testimony as a springboard for discussion. In that light, I encourage your questions along the way. I don't want this to be a monologue, but rather a candid dialogue that will best contribute to your eventual conclusions and recommendations.

A confluence of factors has contributed to where we find ourselves today. Much of the media focus regarding the Commission's charge has emphasized hospital closures and capacity issues. Of course you will be addressing these issues, but we think it needs to be undertaken with a broader perspective on the issues that are straining the system.

You've already read the consultant's reports, seen the data, and I'm sure scanned the headlines that paint a bleak financial and operational picture for New Jersey's 81 acute care and 35 specialty hospitals. I'm here, in part, today to tell you that that portrayal is an accurate and realistic one.

In fact if you look at just one indicator of our system under siege: the difference between the amount of charity care our hospitals have provided during the last 14 years and what the state has reimbursed, the amount of the shortfall is more than a staggering \$6 billion.

Fifty-one percent of New Jersey's acute care hospitals are operating in the red, a rate that is more than double the national average. And while not-for-profit hospitals in other states are finding

some relative “breathing room” with operating margins averaging around 3.5 percent, our most recent data shows our New Jersey average margin hovering around a negative 0.5 percent.

In addition, the growing and staggering gap in charity care funding, uninsured numbers that have surpassed 1 million, chronic governmental payer shortfalls, the nation’s highest insurance premiums, competition posed by new niche provider facilities and a healthcare planning process in dire need of reform have all combined to push our healthcare delivery system to the brink of collapse.

To begin with, let me briefly summarize the four major areas that our membership and NJHA Board of Trustees would like me to address with you. I will also comment in further detail on each of these in response to your questions as provided later in this testimony. These areas are:

- Increased competition from non-hospital providers;
- The state’s unique charity care obligation which requires hospitals to treat all patients in all settings, regardless of their ability to pay.
- The real problem of over-utilization set forth in the Dartmouth Atlas;
- An examination of the policies and rates paid by all payers.

INCREASED COMPETITION FROM NON-HOSPITAL PROVIDERS

It’s no secret that the dramatic increase in competition from freestanding ambulatory care and surgical centers has been a drain on hospital revenues. As our Accenture Report points out, New Jersey’s number of these niche providers per 100,000 population is markedly greater than that of surrounding states. In fact, New Jersey has more ambulatory care centers than New York and Pennsylvania combined. Not subject to Certificate of Need as they are in other states, the surgicenter explosion here has seen a diversion of better paying patients and less complicated cases away from hospitals. It has also raised questions about these facilities not maintaining the same reporting and quality standards that hospitals must adhere to.

NJHA has repeatedly called for a “level playing field” between acute care hospitals and these freestanding centers. Recommendations that would accomplish this include: Holding these centers to the same regulatory mandate as hospitals in treating all patients regardless of their ability to pay; enforcing existing laws against physician self-referral; and requiring these centers to comply with the same reporting and quality requirements as hospitals do.

THE CHARITY CARE CRISIS

If I had to isolate the one issue that needs most immediate attention and remedy, it would be the growing number of uninsured and the charity care crisis our hospitals face. Charity care was instituted in New Jersey when the system was deregulated in 1993. At the time it was felt market forces would make the system more effective and the state would not have to pay for bad debts. Unfortunately, the state underestimated the cost and impact of the program.

First, the state put in place guidelines (*Refer to Appendix A*) that define who qualifies for charity care and those guidelines really allow for more charity care than was anticipated by legislators. An attached chart dramatically illustrates this charity care shortfall. Strikingly, the data shows in detail what I mentioned earlier. Since 1993, the cumulative shortfall in charity care payments to hospitals, when comparing the documented amount of charity care provided by them to funding from the state, exceeds \$6 billion. (*Refer to Appendix B*)

With \$6 billion taken out of the system it is no wonder that hospitals are closing or declaring bankruptcy. The economic model where market forces work requires that there be adequate resources for the system to work, and because New Jersey has consistently under-funded charity care and Medicaid, we have a program of starvation with no clearly designed outcome.

The program becomes even more troublesome because the regulators have taken a very broad approach as to what qualifies for charity care. Here's a good recent example. It concerns a 450-pound charity care patient who wanted bariatric surgery. This surgery is a high risk procedure and entails a long period of follow-up care that requires post-operative lifestyle changes by the patient. Because of the patient's non-compliance history and risk factors, doctors were unwilling to perform the surgery. The man appealed to the state, and in a meeting I attended with the hospital, regulators told the hospital that they had to provide the service.

It didn't matter that no surgeon was willing to perform the surgery because of the man's prior history and accompanying risk factors. The state regulator stated that whatever services you provide to insured patients must also be provided to charity care patients. I left the meeting thinking that we already have health insurance for all in New Jersey, the only thing is that it was implemented by regulators, not the state Legislature.

I don't have to remind you of the numbers related to charity care: a staggering \$1.6 billion in care, (*Refer to Appendix C*) valued at hospitals' costs, provided yearly to a growing number of uninsured estimated to be 1.4 million New Jerseyans. And that figure does not include bad debt. The state currently subsidizes \$583 million of these costs, but that number has remained frozen now for three budget cycles while the demand to provide charity care to the uninsured grows. In addition, the state provides no charity care payments for physician services. Interestingly, this puts added strain on our hospitals as physicians then approach us for payment to care for these individuals.

Beyond charity care, a new, related challenge has quickly emerged over the past few years. We estimate that our hospitals provide anywhere from \$275 million to \$300 million in un-reimbursed care yearly to undocumented immigrants. There is little source of payment for this care, so covering these costs comes directly from a hospital's bottom line. Yet, we remain obligated by law and our mission to care for all, regardless of whom they are or their ability to pay.

The most obvious long-term answer to easing the charity care crisis would be to increase the number of insured. This will take time, but we applaud the efforts of state legislators like Sen. Vitale and Assemblyman Greenwald in laying the groundwork for universal healthcare insurance proposals where the cost of healthcare is shared by all payers, providers, the business community and

citizens alike. On a most immediate front, it is imperative that the state funds charity care at reasonable amounts and distributes this money equitably. Without added funding our delivery system will continue to splinter and hospitals will continue to fail.

Even the most recent State Commission of Investigation's report acknowledges the potential impact of continued charity care under-funding to hospitals. The report concludes that "acute care hospitals across the state now provide more than \$1 billion worth of care in this realm, and the cost continues to spiral even as the state, buffeted by its own serious fiscal problems, is struggling merely to maintain the status quo on subsidy payments."

UTILIZATION OF HOSPITALS AND SERVICES

I'll explore this issue in much more detail in answering one of the questions you posed to me on essential hospitals, hospitals services and health planning, but briefly I'd like to set the stage with some observations about capacity.

There's been much talk recently about New Jersey hospitals being over-bedded and underutilized. According to the Accenture Report and NJHA's own recent data, a case can be made to counter the idea of over-bedding and underutilization. Most recent state hospital licensure data shows that New Jersey's hospitals house 24,390 licensed beds and 20,209 maintained beds. (*Refer to Appendix D*)

In many respects, you can't simply look at bed numbers without looking at occupancy rates. Our statewide occupancy rate is actually higher than the national average. Year-end 2006 NJHA data shows statewide occupancy based on licensed beds at 59.8 percent. But that number includes beds that aren't staffed and maintained at the ready to receive patients. Looking at staffed or maintained beds alone shows a higher occupancy rate of 75.3 percent. This compares to a national average occupancy rate of 65 percent.

In total, we have about 4,000 un-staffed beds in the state. That's about 17 percent of the state's total bed compliment that in essence can be held in reserve as surge capacity in response to incidents like an outbreak of pandemic flu, a natural disaster, another terrorist attack or the ever-increasing demand for care from an aging population, including a baby-boomer generation that is poised to place enormous requirements on care delivery.

Another key element of concern is the practice patterns of New Jersey's physicians. According to data from the Dartmouth Atlas and reinforced by our own Accenture report, on a per-capita basis New Jersey has a high number of licensed physicians relative to other states, represented by a large percentage of specialists and foreign trained doctors.

As data from the Dartmouth Atlas clearly shows, physician-ordered utilization of hospital services runs high in comparison to other parts of the U.S. Using a number of metrics, including such things as physician visits per patient and medical specialist visits per patient, New Jersey has the highest utilization of all states in caring for chronic care patients during the last six months of life.

ONGOING PAYMENT SHORTFALLS

The last of the four major areas I'd like to touch on is the reimbursement policies and rates paid to hospitals by both governmental payers and private insurers alike. (*Refer to Appendix E*)

Medicare and Medicaid reimbursement have failed to keep pace with the cost of delivering care to the elderly and poor. The federal Medicare program pays hospitals 85 cents for each dollar of care they provide, while Medicaid rates in New Jersey cover just 73 percent of hospitals' costs. Since both Medicare and Medicaid combined account for nearly half of all hospital revenues, any further erosion of this payer base will continue to have a negative impact on finances, but also services provided to these vulnerable patients. According to the Kaiser Foundation, New Jersey ranks 50th – second lowest in the nation – in terms of healthcare expenditures for hospitals. Nationwide the average state expenditure for hospitals is 36.5 percent of total healthcare spending, while New Jersey spends just 32.5 percent. Another report by the watchdog group Public Citizen ranked New Jersey's Medicaid program 39th out of the 50 states, earning low marks for its poor reimbursement to providers. New Jersey's Medicaid program ranked dead last in the reimbursement category. This also means that Medicaid is not adequately paying for mental health services and these patients continue to show up in our emergency rooms.

With regard to the state's Medicaid population, let me isolate another problem. Although Medicaid recipients have insurance, we firmly believe that this population is underserved, exacerbated by an inefficient and often ineffective bureaucracy. The Medicaid HMO network, as it's constructed and operates in New Jersey, is a phantom network, meaning that the HMO may maintain a roster of providers on paper, but when contacted, the provider is either no longer participating with the plan or is not accepting any new patients.

NJHA has requested public record information from Medicaid regarding the numbers and types of physicians in each Medicaid HMO network, along with patient encounter data. We have yet to receive the basic information regarding which doctors are in the network, and we were more than a little surprised to find that encounter data is not presently tracked. This is the only means by which access to participating physicians can be evaluated.

Regarding private, commercial insurers, our concern begins with the fact that a relatively high concentration of market share by a small number of major health insurers has tilted the balance of power in negotiating fair market rates with providers. In addition, ongoing slow payments to hospitals and denial of claims by managed care companies remains a constant. Add to this the fact that New Jersey has the highest health insurance premiums in the nation. It's indeed a paradox that while hospitals continue to experience operating losses, health insurers in the state are enjoying some of their best financial returns in years. (*Refer to Appendix F*)

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At this point let me answer in detail the specific questions that were forwarded to me in advance. I'll address them in order.

WHAT CRITERIA SHOULD THE STATE USE TO DEFINE AN “ESSENTIAL” HOSPITAL?

This is a good first question because it leads to other questions like “essential for whom?” For the patient, for the community or for the hospital? For years I believe that policymakers in New Jersey have indicated that certain communities need a hospital and have placed services in that hospital in an effort to ensure the community’s survivability.

This of course is not a healthcare policy issue but rather a community infrastructure issue. I also wish that this type of planning were done strictly on a policy basis, but I have seen too many decisions about services made for political reasons. I also think we labor under a misguided impression that people in the suburbs will migrate into these communities for these services, but they often don’t.

Further the state’s policymakers have the belief that urban patients won’t or can’t leave these communities to get services, but an examination of the patient referral patterns once a hospital closes indicates that patients can and do in fact leave their communities for healthcare services. This is all well and good, except the patients in these “essential” hospitals are primarily Medicaid and charity care patients and both of these programs don’t reimburse at appropriate levels, further straining an already fragile essential hospital.

I would also like to add that I have lived in some very rural states where it was hours between hospitals, and some of those hospitals only had “essential services” and I thought the system was very effective in providing adequate and accessible care from a quality and cost standpoint.

In addition, when defining what is essential and what is not, rather than looking at hospitals alone, it is necessary to look at other facilities to see if they offer services to those persons in need, particularly the uninsured. In short, NJHA believes that it is a mistake to only examine the state’s acute care hospitals. The current system of charity care drives patients to hospitals for care that is free to them. In turn, hospitals are under-reimbursed, which constrains them. Surrounding providers are free to pick and choose among paying patients, leaving hospitals scrapping for survival. But hospitals are only one component of this broken health delivery system. It’s also best to look at volume of services provided in a given town, city or region to ensure quality of care is being maintained.

All of this leads me to the Certificate of Need program, or as I have often called it, the “Certificate of Want” program. In many ways the management of this program is at the heart of the problem. When planning was first instituted the idea was rational planning. Here in New Jersey health planning has become fundamentally flawed and driven by a community “home rule” mindset and politics. In addition, we have deregulated so much from the original CN requirements that the system no longer works.

I can remember sitting in a meeting in a Chicago hospital where we were developing a plan for the Lincoln Park area. We had two 500-plus bed hospitals within a couple hundred yards of each other, and neither hospital was doing many births and in fact had very few pediatric patients. We

I can remember sitting in a meeting in a Chicago hospital where we were developing a plan for the Lincoln Park area. We had two 500-plus bed hospitals within a couple hundred yards of each other, and neither hospital was doing many births and in fact had very few pediatric patients. We decided in that meeting that it was in the best interest of the patients for one of us to do OB and the other pediatrics.

New Jersey has no long or short-term strategic health plan. I can remember vividly when a former commissioner of health put out a call for cath labs. He told me that he thought there would only be five applicants. I told him I thought he was way off the mark because he had not assured the provider community that there would be a subsequent call. As a result hospitals would have no choice but to submit applications. Needless to say the state received 35 applicants. When, at a later date, one hospital demonstrated a need for such a service in their community, they were denied a CN because no further calls were being issued.

I think the real issue should be a matter of defining “essential services” rather than “essential hospitals.” This would mean that we would have to determine what the needs of the community are and then ensure that those services are available. These criteria must also accommodate room for the unpredictable and the unknown — things like the prospect of a pandemic flu outbreak, a natural or man-made emergency or the care demands of an aging baby-boomer generation must all be considered to ensure that proper “surge” capacity is maintained.

Regarding Certificate of Need moving forward, the process must be revamped and expedited so that changes, mergers and even facility closures do not get mired in a costly, time-consuming bureaucratic quagmire that more often than not is politicized. Rather than looking at hospitals alone, it is necessary to look at them in the context of a larger healthcare delivery system, where there may be a scarcity of some services and an excess of others. Consideration must be given to other facilities to see if they offer services to those persons in need, particularly the uninsured. In short, NJHA believes that it is a mistake to only examine the state’s acute care hospitals.

As hospitals we are caught in this paradox of being a major employer and purchaser of services in our communities, so when a hospital closes there is considerable outcry from the political leaders about jobs and the impact on the economy. But we need to look beyond this and examine these issues of access, quality and patient safety.

The issue of access to services applies to post-acute as well, and here again the state continues to make poor decisions. In 2004, a post-acute care provider approached the state about providing home health services to the residents of its retirement community. According to public record, DHSS “encouraged” the provider to pursue the idea. They used the CN provision that says an application for services that normally fall under full review can be considered under expedited review if there is either a health emergency, or the service proposed will not have an adverse impact on the healthcare system as a whole. DHSS took the applicant’s word that there would be no adverse impact on the health system, without soliciting any public input or doing any of their own due diligence. Needless to say, other providers were not happy because there *is* an adverse impact on the healthcare system. Not surprisingly, the matter is now in court.

provider appealed that limitation, and DHSS lifted it. Now the provider can serve any of its more than 3,500 residents who qualify for Medicare-funded home care services under its CN award. This is just one of many examples where there is a process in place for determining need, but it is consistently ignore.

DO YOU BELIEVE THE STATE IS OVER-BEDDED?

This is another good question with a complex answer. Our Accenture report says “no.” Most recent state hospital licensure data from 2006 shows that there are 24,390 licensed beds in New Jersey and 20,209 staffed, “ready for service” maintained beds. But, it is too simplistic to just look at bed numbers.

You need to consider occupancy rates, which are continually higher than national averages. Looking at NJHA’s year-end 2006 FAST report data, occupancy based on licensed beds is 59.8 percent. However, based on staffed or maintained beds the statewide occupancy rate climbs to 75.3 percent. The math tells us that we have about 4,000 un-staffed beds in the state, or about 17 percent of total bed capacity.

Is that 17 percent enough of a cushion or reserve when facing the prospect of a pandemic flu outbreak that many consider “inevitable,” as well as the enormous increase in demand for services that will arise as the “baby-boom” generation seeks care? Noted futurist Ken Dykwald says that between the years 2010 and 2025, a tidal wave of more than 76 million “baby boomers” will put enormous strain on every aspect of society, especially healthcare delivery.

Even with efforts at health reform over the past few years, all this plays out as the number of uninsured keeps rising, the amount of charity care keeps growing, and our emergency rooms are still full, despite significant investments in expanding our federally qualified health centers.

Thirty years ago in health policy graduate schools, the planning perspective centered around slightly more than two beds per thousand. New Jersey has some counties around that number, but others are considerably higher. (*Refer to Appendix G*) Of course much has changed in the practice of medicine in those 30 years, and I would think the need would be less than two beds-per thousand today. The state’s average is higher than two beds-per thousand and there are many states with fewer beds per thousand than us.

This also leads into the discussion about utilization of services. The Dartmouth Atlas suggests that this is a major concern for New Jersey. About 10 years ago the leadership of the Robert Wood Johnson Foundation invited the then-Commissioner of Health and Senior Services and me to meet with Dr. Elliot Fisher to discuss New Jersey’s results as they appeared in the Dartmouth Atlas.

Coming here from New Hampshire, I was very familiar with the Atlas and had used it extensively to change practice patterns there. But for some reason, New Jersey never saw fit to use this information in developing state health policy. The data called into question the care in some of our inner cities and raised the point that some of our hospitals and physicians, in fact, were pos-

sibly providing too much care. What I see in parts of New Jersey is a length of stay that is too long when compared to other parts of the country. This length of stay problem then complicates the review of the need for beds and occupancy levels. It would seem to me that once length of stay was reduced to mirror national averages, our occupancy levels would fall even further. I am still of the opinion that there is too much capacity in the system.

I have discussed much of these data with the Medical Society of New Jersey's Board. It appears that because New Jersey is not a state with large multi-specialty group practices, it's harder to reshape practice patterns. In addition, since 52 percent of New Jersey physicians are foreign trained there are cultural matters that add to the complexity of the issue.

Mainly as a result of free-market forces, 17 New Jersey hospitals have ceased operating as full service hospitals during the last 20 years. In the past 14 months, three hospitals have filed for bankruptcy, and another has filed a CN to close. Some of these facilities have shut their doors completely, while others have been transformed or consolidated into satellite emergency centers, outpatient clinics or alternative care settings. Given the market forces that continue to play out, more hospitals are likely to follow this pattern.

Contemplating the closure of any hospital brings to mind an enormous array of complex implications and consequences. Among them: access to care and patient safety issues; the increased demand for services on neighboring hospitals; and the potential loss of community-based wellness and support services, to name a few.

In addition there's the overriding question of whom or what will absorb the "stranded costs" of closing a facility. These include such things as unpaid debt; the economic impact on a given town or region in terms of lost jobs and purchases; pension benefits, severance pay; bond obligations as well as the impact on vendors and suppliers.

As I mentioned earlier, while you proceed with your specific recommendations it's imperative to look at such things as utilization, occupancy, bed numbers and the prospect of closures not so much on a hospital-specific basis as much as from a regional planning perspective based on "essential services."

HOW SHOULD THE COMMISSION ASSESS THE AVAILABILITY OF SERVICES TO THE PEOPLE OF NEW JERSEY, INCLUDING SERVICES OFTEN REGARDED AS NECESSARILY PROVIDED IN THE NEAR VICINITY (SUCH AS OB/GYN) AS OPPOSED TO SERVICES THAT MAY BE APPROPRIATELY LOCATED MORE REGIONALLY (SUCH AS TRANSPLANT)?

I am not sure if I understand this question. If the intent is to merely assess the availability of services then a simple survey instrument would accomplish this. However, if the desire is to assess the needs of the community, then I think we are once again getting involved in the issue of a dynamic health plan. Of course planning that is never updated, modified or reviewed, like New Jersey's lack of a cohesive plan, will not provide long-term, workable solutions.

There is no question that with demographic changes different services are needed. Think of the communities where children were born, attended school and then left to start their own families. Their parents remained, but suddenly there is an influx of younger families moving in and completely changing the dynamics and population mix of the community. Any statewide plan must take these issues into consideration.

In assessing the availability of services, you should first recognize that managed care companies will not contract with hospitals unless the hospital provides certain services. Second, the CN rules must be enforced in terms of volume requirements, and in terms of not politicizing who gets what and who gets denied. Thirdly, DHSS needs to consistently issue calls for certificate of need. The industry relies upon them, yet DHSS routinely misses deadlines or cancels scheduled calls. You must also look at various physician shortages that may impede access to care, and we understand the Department of Banking and Insurance has some information in this regard.

It's no secret that the Medicaid population, while having insurance, is underserved. Medicaid is a financial boon to New Jersey. Prior to Medicaid managed care the state was never sure how much would be expended, and there were times that payment for Medicaid was suspended near the end of the fiscal year. Hospitals were then paid for those services in the next fiscal year. To ensure that the Medicaid patients are cared for, the Medicaid managed care company has to verify an active network of providers. In this respect, we firmly believe that the Medicaid network is a phantom network. This means that HMOs state that their networks contain the required complement of providers, but when contacted, the provider is either no longer participating within the plan or is not accepting any new patients. NJHA has used the Open Public Records Act in an attempt to gain information from Medicaid regarding the numbers and types of physicians in each Medicaid HMO network, along with physician-patient encounter data.

We have yet to receive even basic information regarding who is in the network. We were more than a little surprised to find that encounter data is not presently tracked. That means that the state is paying hundreds of millions of dollars to Medicaid HMOs and we have absolutely no idea of what care is being provided to whom. These same Medicaid patients are finding their way into our emergency rooms when the contracted physicians can't or won't see them.

It's interesting to note that in the FY08 budget proposal for the Department of Human Services, there is an \$88 million increase for the Medicaid HMOs over last year's amount. We question this increase given the state's inability to track care provided. All this plays out around the fact that our Medicaid program pays providers the lowest rates in the nation.

GIVEN THE OFT-CITED NEGATIVE FINANCIAL IMPACT OF AMBULATORY CARE/SURGICAL CENTERS ON HOSPITALS, WHAT SHOULD BE DONE TO DEAL WITH THIS PERCEIVED PROBLEM?

In part, the answer's quite simple: Enforce the Codey law (NJSA 45:9-22.5) against physician self-referral. The law establishes a clear prohibition against referrals by physicians to entities in which they have a financial interest. But the BME's interpretation of the law softens its intent. Under the law, if the service is provided at the physician's medical office for which the patient is

billed directly by, and in, the practitioner's name, there is no violation. I have attached for your review a solicitation offer (*Refer to IDC Overview, attached*) that would seem to violate the intent of the law, but the state has done nothing to investigate or even prevent these practices.

This loophole needs to be examined in the context of the current healthcare environment. Perhaps the BME should be re-examined as the enforcing authority given the poor job they have done in overseeing this self-referral issue.

Once begun, deregulation is difficult to reverse. However, we recommend that, in addition to enforcement of the Codey law, the state seek to level the regulatory playing field for ambulatory care and surgical centers by:

1. Having DHSS routinely inspect these centers for quality and patient safety. We understand DHSS presently lacks the resources to do this with any frequency, if at all. This is untenable given the number of patients treated at these facilities, the complexity of certain procedures and the administration of anesthesia.
2. Requiring ambulatory care centers to comply with the same reporting and quality requirements as hospitals. For example, require freestanding centers to issue a uniform bill (UB92) for all patients so volumes can be tracked.
3. Revealing physician-specific admission data so physicians' admitting patterns can be tracked and evaluated.
4. Examining the Board of Medical Examiner rules at N.J.A.C. 13:35-4A.1 regarding surgical services performed in an office. "Office" is defined as a location at which medical, surgical or podiatric services are rendered and contains only one operating room. This allows for self-referral by way of the fact that single room ORs are not subject to the jurisdiction and licensure requirements of DHSS. This added loophole needs to be examined in terms of quality of care provided and the types of surgeries performed.

HOW CAN FQHCs BEST WORK WITH ACUTE CARE HOSPITALS TO ENSURE ACCESS FOR OUR CITIZENS?

In 2006, NJHA, in conjunction with the New Jersey Primary Care Association (NJPCA) secured the introduction of S-2376, which establishes a three-year Cooperative Health Care Utilization Pilot Program in DHSS. This program is designed to reduce the incidence of medically underserved patients seeking primary care in hospital emergency rooms and instead assist them in obtaining primary care in the more appropriate setting of FQHCs.

Under this program, a participating hospital and FQHC would designate a common service area and establish a system to provide transportation services between facilities and pool staff and other resources. Professional staff would educate and counsel patients, enhance the coordination of care and make and track referral appointments between the participating hospital and FQHC.

NJHA and NJPCA are currently working with the Division of Medical Assistance and Health Services to submit an application to the Centers for Medicare and Medicaid Services for grant money made available under the Deficit Reduction Act of 2005 to carry out this program for Medicaid beneficiaries.

While FQHCs play an important role in New Jersey's healthcare system, they are not a panacea. FQHCs are not open at night and in the early morning when patients make inappropriate emergency room visits. It has been hospitals' experience that FQHCs have done little to stem the tide of these visits.

Furthermore, FQHCs do not provide their patients with access to specialists other than a visit for which they pay \$95. This fee is paid out of the \$40 million FQHCs receive from the 0.53 percent assessment on hospitals' gross revenues. FQHCs charge on a sliding scale, while ERs don't. That may be impacting where the patient chooses to go, along with the fact that at the hospital it is one-stop shopping, meaning patients have access to a full array of primary, specialty and acute care services through the emergency department.

HOW SPECIFICALLY CAN HOSPITALS ASSIST WITH INCREASING THE NUMBER OF PEOPLE WITH HEALTH INSURANCE, PARTICULARLY WITH ENROLLMENT INTO MEDICAID AND FAMILYCARE?

There's a common misconception that hospitals possess the ability to directly enroll eligible patients into the Medicaid and FamilyCare programs. With respect to Medicaid, federal law does not allow hospitals to determine eligibility. This restriction does not exist for FamilyCare, a state-run program that is administered separately from Medicaid and managed at a county level. However, only a state-designated vendor can determine eligibility for FamilyCare. Hospital admission staff can assist patients in filling out these applications, but the applications and all documentation are required to be sent to the state vendor.

On the other hand, Medicaid enrollment must be completed by the county Board of Social Services. Obstacles arise at initial screening because our hospitals are unable to determine if the patient is enrolled in a medical assistance program as a result of the state vendor or the local Board's refusal to disclose this information. Moreover, hospital staff that assist with patient applications face difficulties in tracking those applications to completion.

There's also another roadblock to efficiency. Federal regulation (42 C.F.R. 435.904) requires that Medicaid outstation workers be present in hospitals. Pursuant to N.J.S.A.30:4D-7a, the Commissioner of Human Services shall require a county board of social services to provide adequate employees to determine Medicaid eligibility at hospitals. However, according to a 2006 survey, only 14 of the 18 county boards of social services that participated in the survey reported having outstation workers in hospitals, and the services they provided in hospitals varied by county. The state and the counties need to do a better job of out-stationing these workers, and they have to work beyond the 9 a.m. to 5 p.m. workday.

Despite all these obstacles, hospitals use many methods to inform patients about the availability of financial assistance. Hospitals host enrollment fairs, go out into the community to discuss the availability of programs and post signs throughout the hospital to inform patients about these programs.

Our hospitals have also hired health educators and financial representatives to screen and assist families with applications. They have also invested in training and technological enhancements to aid in financial counseling at registration and established an Incentives Bonus Program to reward staff who refer or help families with NJ FamilyCare applications. In addition, many hospitals have placed promotional bilingual messages on telephone hotlines, radio, cable stations and in church bulletins.

Finally, we believe that the state needs to do more to promote these programs. Neighboring New York and Pennsylvania have multimedia campaigns, including TV commercials. Relying on hospitals alone to do enrollment is a flawed methodology.

HOW CAN HOSPITALS WORK MORE EFFECTIVELY WITH PHYSICIAN GROUPS TO ENHANCE EFFICIENCY, INCLUDING LENGTH OF STAY, AND QUALITY?

This has been and continues to be a major focus of NJHA and our member hospitals. We have long been an advocate of aligning hospital and physician economic incentives as a method of improving efficiency and quality of care. What currently exists is a system of unaligned incentives for physicians and hospitals. Doctors are reimbursed for each day that a patient is hospitalized. Physicians do not have incentives to discharge patients, because they know they will get paid. To the contrary, hospitals are paid a negotiated rate, or in the case of Medicare patients, a flat rate based on diagnosis.

NJHA and its members are now attempting to better align incentives with our proposed federal Medicare Gain Sharing Project. New Jersey's pilot, awaiting CMS approval to move forward, includes NJHA and a consortium of 12 hospitals and medical staffs. Under the program, hospitals and physicians will cooperate to maintain strict quality standards while employing strategies to move patients through their stays more efficiently, holding down costs and allowing hospitals and participating physicians to share in any savings.

On the quality front, and in cooperation with medical staffs throughout the state, last year NJHA completed a two-year initiative to improve the quality of care in the intensive care units at 18 hospitals. Under the banner of our Quality Institute's ICU Collaborative, these hospitals shared best practices and followed specific protocols in an effort to improve care.

The results were dramatic. The incidence of blood-stream infections in intensive care patients dropped by 73 percent. The occurrence of ventilator-associated pneumonia fell 55 percent. Avoiding these ICU risks not only improved patient care, it also saved more than \$11 million that would have been spent dealing with these complications. Our hospitals are now working together with physicians and bedside caregivers to tackle other challenges through the collaborative model, including reducing the incidence of pressure ulcers and establishing rapid response teams to anticipate cardiac arrests before they occur.

Finally, our hospitals and physicians have been working together to improve patient outcomes where data is being monitored by various state, federal and independent agencies. Most recently, quality data released last month by the Joint Commission shows New Jersey hospitals ranking above national averages in 19 different measures for treating heart attack, heart failure and pneumonia patients.

What we have shown through our collaboratives is that when hospitals are given data and established best practices, performance improves. It's our opinion that there has to be a way that the reporting of performance is sanctioned. Our Web site, www.njhospitalcarecompare.com begins this process, but there is still much to be done and it would best be accomplished in a partnership.

WHAT ARE THE PRINCIPAL ISSUES HOSPITALS HAVE WITH INSURANCE CARRIERS, INCLUDING CONTRACT NEGOTIATIONS AND PAYMENT PROBLEMS?

Regarding private, commercial insurers, a host of concerns come to mind ranging from payers making unilateral contract changes to the SNFing phenomenon. But our overriding concern focuses on the fact that a relatively high concentration of market share by a small number of major health insurers continues to tilt the balance of power in favor of payers when negotiating adequate rates. Add to this the fact that major payers continue to engage in slow payment practices and the denial of claims.

Specifically, I'd like to highlight some of the chronic problems encountered with commercial insurers in dealing with such issues as contracting, administrative hurdles, claims processing and payment, inadequate post-acute networks and level-of-care issues.

Contracting problems are numerous and troublesome. With the growing consolidation of payers in New Jersey, hospitals' ability to negotiate adequate contracts with payers has all but diminished. The current approach to contracting is weighed in the payer's favor, with payers presenting completed contracts to providers and allowing little room for hospital-initiated changes to what essentially is a payer's contract.

Plans also often make unilateral amendments to hospital contracts absent mutual agreement on those changes. Once a contract is agreed to, the sheer size of these plans allows them to impose unilateral contract changes without the consent of providers. This imbalance appears to be unique to healthcare, as most other industries follow the premise that a contract is a mutual agreement between two parties, rather than an edict given from one party to another. To date, the only recourse that hospitals have is to terminate their contracts, which is used as a last resort when all offers for negotiation have been met with resistance. Also, payers often circumvent key components of the contracting process by changing key policies and procedures at the payer's "sole discretion."

On the administrative hurdles front, plans continue to not respond to hospital payment and denial appeals within regulated time frames. In another tactic, payers often update their computerized systems with little or no advance notice to hospitals. Hospitals then bear the consequences of adjusting to new systems that HMOs implement without adequate testing. The result is often a

large volume of unpaid claims, inappropriately paid claims or an outright inability to track claims.

Another practice, commonly known as “SNFing,” has led to numerous problems for our hospitals. HMOs often deny approval for hospital care and instead approve services at a lower level of care. However, the HMOs then fail to take responsibility for managing the care of their member, such as identifying a network provider that can and will accept the patient. This often happens because the HMO hasn’t secured an adequate number of such providers. Instead, the payer leaves the patient in the hospital, but inappropriately pays the acute care hospital at a less-than-acute care rate.

Add to these problems the woes of HMOs sharing their hospital rate data with other payers; the inappropriate denial of claims; inaccurate payments and paying a physician for a date of service while denying the hospitals claim for the same patients, and our frustrations with managed care continue to mount.

All this plays out at a time when New Jersey’s health insurance premiums are among the highest in the nation, insurers themselves are enjoying some of their best financial returns in years, and hospitals continue to experience operating losses.

###

Let me conclude my testimony with an observation about where we go from here. As I said to you at the onset, the issues that you’re deliberating and the recommendations you’ll make will help shape the future of healthcare delivery in New Jersey for decades to come.

But I firmly believe that the ultimate solutions to the challenges we discussed today, as well as others, will be contingent on how well a variety of stakeholders, not just hospitals, are willing to change and adapt. These include state and federal government, the business community, organized labor, physicians, other healthcare providers and the public at large.

It’s clear to me that the future of healthcare delivery needs to be anchored in change, and that change needs to be driven by cooperation and collaboration. I can assure you that hospitals will continue to be a willing partner in that dialogue. But without good, enforceable state planning, adequate reimbursement, fair funding for charity care, a reduction in the number of uninsured and a level playing field for competition, I question the prospect of a delivery system that is strong enough to fulfill its mission.

Again, I remind you of the charity care shortfall as just one dramatic symptom that threatens the very viability of healthcare delivery. The fact that hospitals have been able to sustain the impact of more than \$6 billion worth of state payment shortfalls during the last 14 years and still managed to function, begs the question: “For how much longer?”

From our hospitals’ perspective, by law and by design, we are always there to provide care to all New Jerseyans regardless of who they are or their ability to pay, whether it be in the emergency room or outpatient clinic, at the intensive care unit or in trauma surgery. Someone is always there to heal the sick and fix the broken. Without the right solutions, will we still be there for all New Jerseyans tomorrow?

APPENDIX A

Emergency Room Charity Care Eligibility Documentation

Hospitals must comply with the requirements set forth in N.J.A.C.10:52-11.16 when writing off charity care provided in the emergency room. This document contains a few of the requirements with which hospitals must comply. As such, it is not a complete list.

What Hospitals Must Ask

If a patient's medical condition permits, a hospital must ask the patient, prior to being discharged, a number of questions. The hospital must ask the patient for his or her name, address, telephone number, whether he or she intends to remain a New Jersey resident (assuming the patient is a resident of New Jersey), if the patient is employed and, if so, the employer's name and address, the patient's best estimate of his or her annual income, and if the patient has a bank account and, if so, the name and location of the bank.

Verifying a Patient's Address

Hospitals are required to verify by telephone or visit that the patient can be contacted at the address provided.

Determining a Patient's Income

Hospitals are required to contact the patient's employer regarding income. If the patient does not identify an employer or if the employer refuses to disclose how much the patient makes, the hospital is required to go by the patient's best estimate of his or her annual income.

Hospitals are required to assume that the patient's family consists only of the patient and to apply the federal poverty guidelines accordingly.

Determining a Patient's Assets

Hospitals are required to assume that the patient's bank account deposits constitute the only assets relevant to the patient's charity care eligibility. If the patient does not identify a bank for the hospital to contact or if the bank refuses to disclose how much the patient has in his or her account, the hospital is required to consider the patient as having no assets.

Charity Care Application

N.J.A.C.10:52-11.12 provides that the Department of Health and Senior Services shall specify the elements to be included in the application. Hospitals cannot omit or add elements.

APPENDIX B

STATEWIDE CHARITY CARE 1994 THROUGH 2007 (\$ MILLIONS)

CALENDAR YEAR	CHARITY CARE DOCUMENTED AT MEDICAID RATES	CHARITY CARE FUNDING	COST (A)	SHORTFALL (B)
1994	\$327	\$383	\$447	(\$64)
1995	\$327	\$400	\$447	(\$47)
1996	\$403	\$310	\$552	(\$242)
1997	\$407	\$300	\$557	(\$257)
1998	\$463	\$320	\$634	(\$314)
1999	\$483	\$320	\$661	(\$341)
2000	\$520	\$320	\$712	(\$382)
2001	\$603	\$356	\$826	(\$470)
2002	\$624	\$381	\$851	(\$470)
2003	\$578	\$381	\$791	(\$410)
2004	\$778	\$381	\$1,065	(\$684)
2005*	\$869	\$583	\$1,190	(\$607)
2006*	\$1,056	\$583	\$1,446	(\$863)
2007*	\$1,140	\$583	\$1,561	(\$978)
TOTAL	\$8,578	\$5,601	\$11,740	(\$6,129)

(A) Cost equals charity care documented at Medicare rates divided by 73%, this percentage represents an average of the last six years

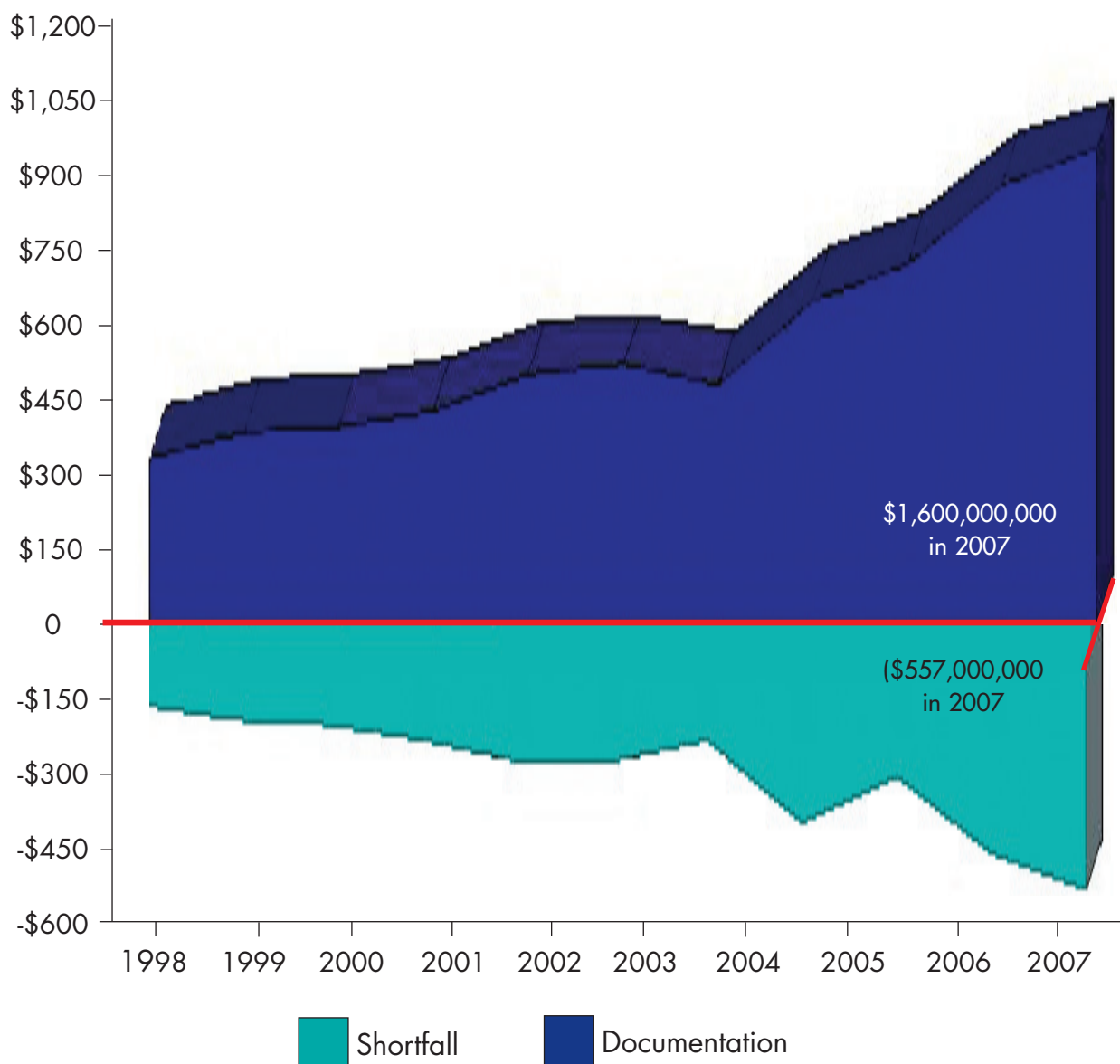
(B) Shortfall equals charity care funding minus cost.

Note: the Charity Care Subsidy began in 1993. The initial subsidy was set at \$500 million. The level of documented services was not collected until 1994.

* FY 2005, 2006 and 2007 Charity Care documentation represents NJHA's best estimate. Final audited data has not been released by DHSS for these years.

APPENDIX C

STATE CHARITY CARE FUNDING, DOCUMENTATION AND SHORTFALL SFY 1998-2007



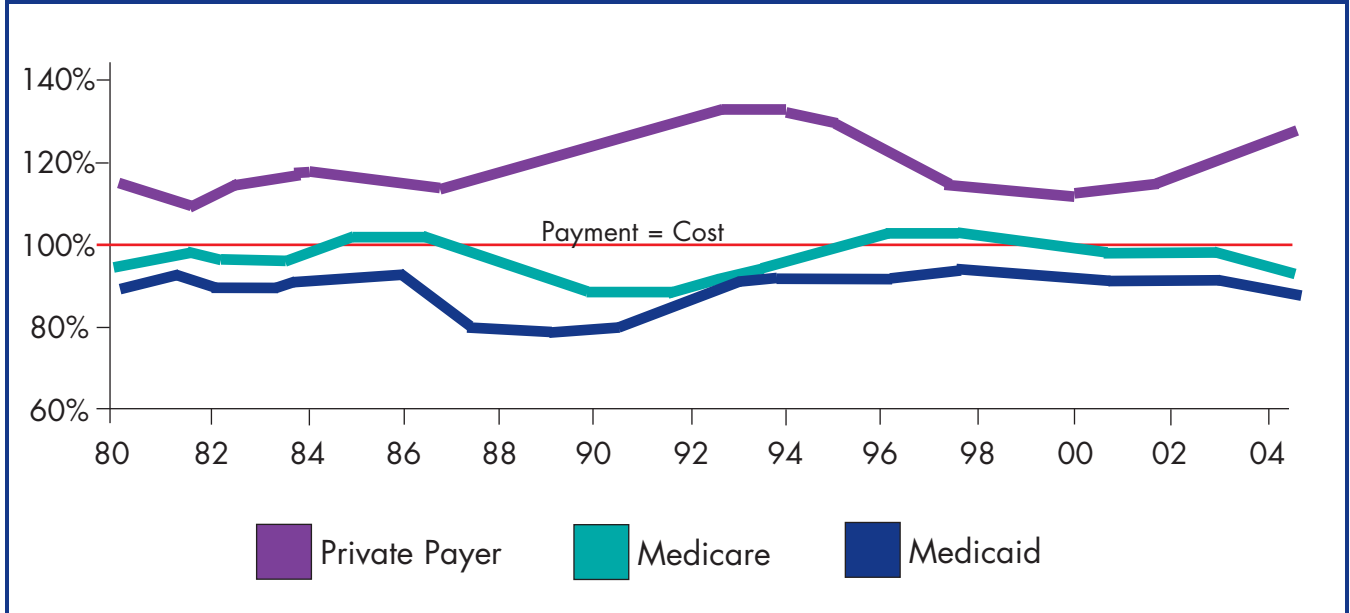
APPENDIX D

NJHA 2006 LICENSED BEDS PER 1,000 POPULATION (ESTIMATED)

COUNTY	HOSPITALS	2005 EST. POPULATION	2006 EST. LICENSED BEDS	RATIO
Essex	9	791,057	3,379	4.3
Camden	4 (7)	518,249	2,021	3.9
Mercer	5	366,256	1,399	3.8
Atlantic	3 (4)	271,015	984	3.6
Salem	2	66,346	239	3.6
Union	5	531,457	1,673	3.1
Bergen	6	902,561	2,749	3.0
Monmouth	5	635,952	1,925	3.0
Hudson	7	603,521	1,752	2.9
Warren	2	110,376	305	2.8
Passaic	4	499,060	1,266	2.5
Cape May	1	99,286	242	2.4
Middlesex	4 (5)	789,516	1,863	2.4
Morris	3 (4)	490,593	1,154	2.4
Ocean	4	558,341	1,277	2.3
Cumberland	1	153,252	299	2.0
Burlington	3	450,743	781	1.7
Sussex	2	153,130	244	1.6
Hunterdon	1	130,404	178	1.4
Somerset	1	319,900	355	1.1
Gloucester	1 (2)	276,910	305	1.1
STATEWIDE	73 (80)	8,717,925	24,390	2.8

APPENDIX E

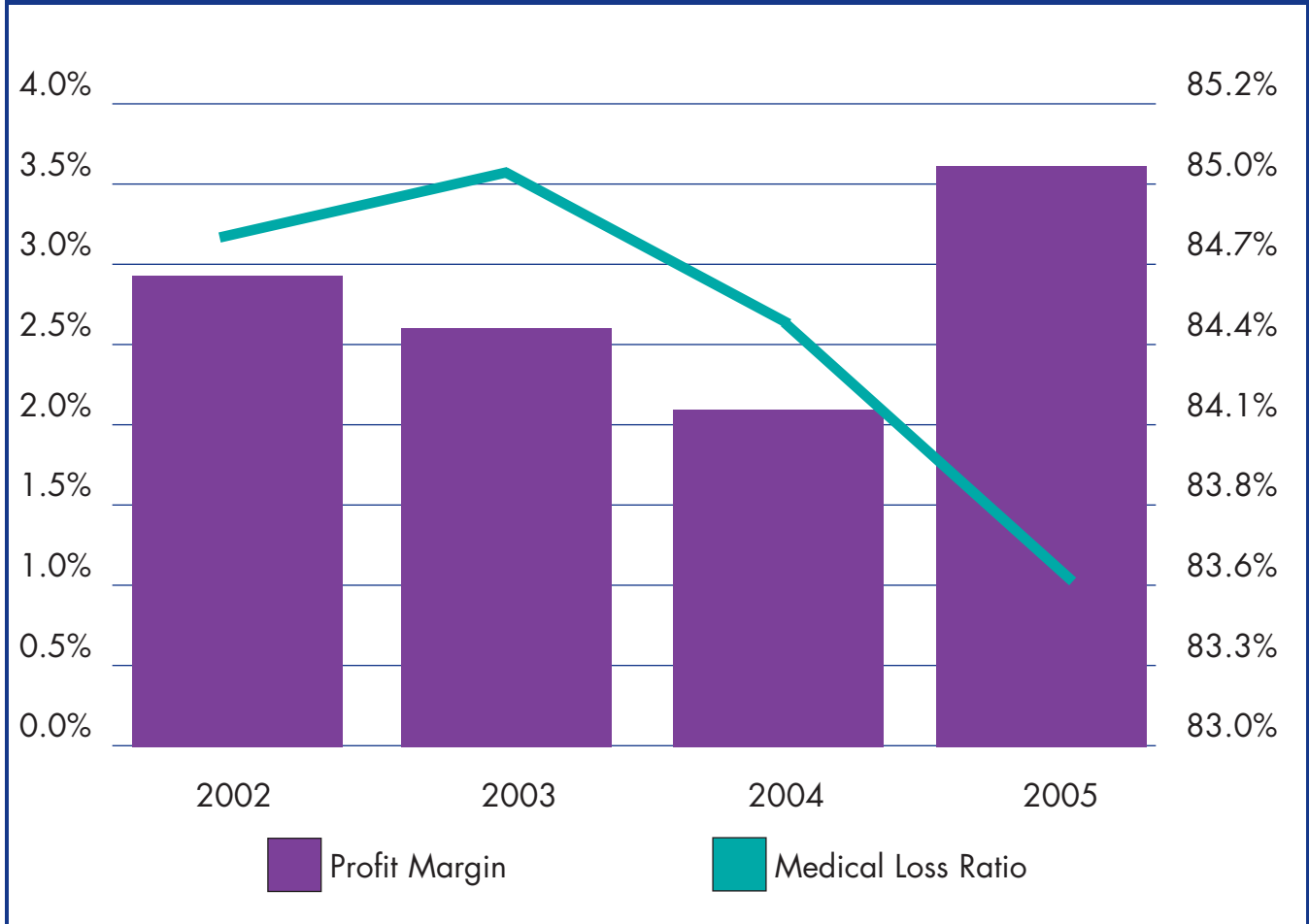
AGGREGATE HOSPITAL PAYMENT-TO-COST-RATIOS FOR PRIVATE PAYERS, MEDICARE & MEDICAID 1980-2004



Source: AHA Survey

APPENDIX F

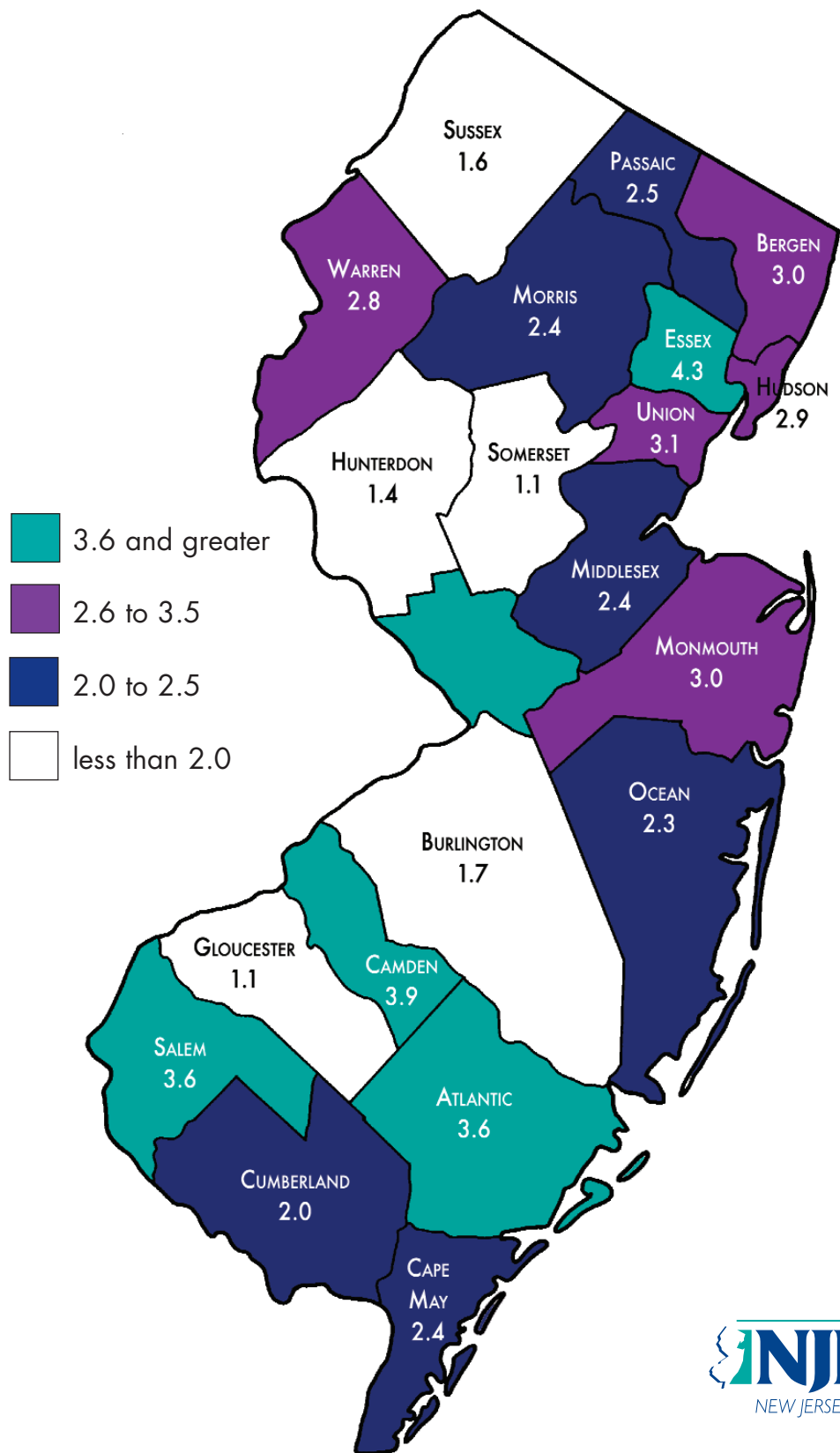
NEW JERSEY HMOs PROFIT MARGIN AND MEDICAL LOSS RATIO, 2002-2005



Source: NJHA's Payer Information Reference System, utilizing HMO Annual Statements and Annual Supplements, as reported by HMOs to the New Jersey Department of Banking and Insurance.

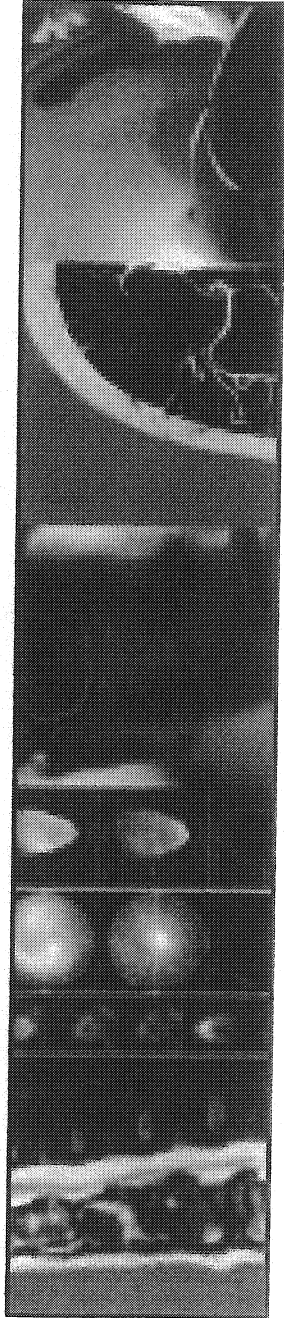
APPENDIX G

NJHA ESTIMATED 2006 LICENSED BEDS PER 1,000 POPULATION



IDC OVERVIEW

Integrated Diagnostic Centers



March 6, 2007



Agenda

Overview of IDC

- Model
- Company background



IDC Credentials

Experienced, well-funded team

- Based in Houston
- Backed by Galen Partners, GE Healthcare
- Background for IDC's development of the "leasing model"

Current operations and plans

- Active in several major markets
- Nearly 1,000 physicians leasing from IDC nationally



The Opportunity

Allows physician practices to internalize imaging services as part of their office practice via an outsourcing model

- IDC physician customers bill and collect for imaging services provided to their patients
- IDC physician customers internalize imaging services via a turnkey time lease and management services agreement with IDC
- IDC customers pay a monthly rent to IDC based on a predetermined amount of time/services purchased from IDC
- The IDC customers' amount of time is typically not pre-determined daily blocks, but is based on a total amount of hours which is "chipped away" as services are utilized



Business Summary

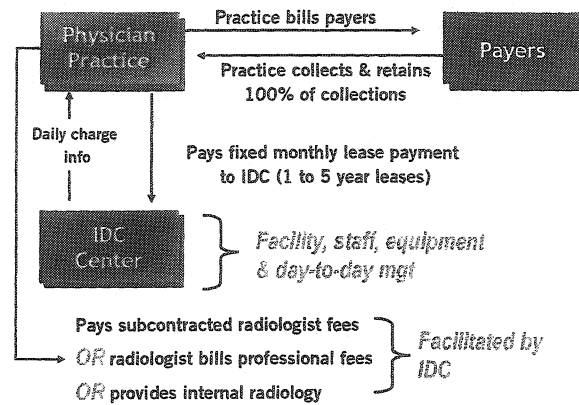
- IDC time-share leases individual modalities within the facility to multiple physician groups on 1-5 year part-time lease terms
- Leasing physician groups bill and collect for imaging services provided to their patients during their leased time
- IDC receives a monthly rental payment from leasing groups; amounts based on pre-determined lease term and time required
- Services include: MRI, CT, Cath Labs, Nuclear, Ultrasound, PET & Pain Management
- Groups lease only those services applicable to them, and can lease individual services simultaneously (*lease includes space, equipment, clinical staff and administrative staff*)
- IDC is NOT a provider and operates exclusively as a leased-site entity



General Economic Flow

Physician Value:

- Physician income independent of other groups
- No up-front capital
- Turnkey operation
- IDC funds all operating expenses & costs
- No debt burden on leasing physicians
- Predetermined lease cost is maximum cost burden to group
- Guaranteed performance by clinical staff

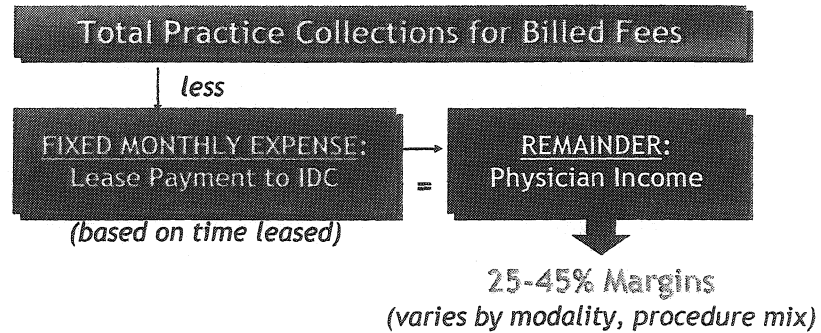


"Expanding Your Practice"

Page 6 of 16



Physician Group Economics



Current Reimbursement Patterns
Average overall collections for leasing practices:
110-130% of Medicare equivalent rates

"Expanding Your Practice"

Page 7 of 16



Lease Structure Specifics

- Each lease signed for specific number of hours by modality
- Annual leases minimum to meet regulatory requirements (range: 1-5 years)
 - Hours prorated by month
 - Pre-determined blocks each week or as scheduled patient by patient
 - No time charge for “no shows” or cancellations
- Lease cost components:
 - Base monthly rent for each modality
 - Supply kit “add-on” only for MRI w/contrast proc's
 - NO other costs

NO operating cost responsibility for group

NO management fees

NO billing fees

NO physician debt on equipment or other capital costs

“Expanding Your Practice”

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Estimated Procedural Mix for Orthopedics

Code	Procedure	Avg Time (Min's)	Relative Mix	Est'd Proc's Annual	(TECH ONLY) Approx Medicare			
					Allowable	@ 110%	@ 130%	@ 150%
72141	MRI neck spine w/o dye	30	4%	88	\$ 447	\$ 491	\$ 581	\$ 670
72148	MRI lumbar spine w/o dye	35	32%	704	\$ 496	\$ 545	\$ 644	\$ 744
72158	MRI lumbar spine w/&w/o dye	45	4%	88	\$ 993	\$ 1,092	\$ 1,290	\$ 1,489
73221	MRI joint upr extrem w/o dye	35	23%	506	\$ 439	\$ 483	\$ 571	\$ 659
73721	MRI joint lwr extrem w/o dye	30	27%	594	\$ 439	\$ 483	\$ 571	\$ 659
73718	MRI lwr extrem w/o dye	30	2%	44	\$ 439	\$ 483	\$ 571	\$ 659
72146	MRI chest spine w/o dye	30	4%	88	\$ 496	\$ 545	\$ 644	\$ 744
73720	MRI joint lwr extrem w/&w/o dye	45	4%	88	\$ 975	\$ 1,072	\$ 1,267	\$ 1,462
Weighted Totals		34	100%	2200	\$ 503	\$ 554	\$ 654	\$ 755

- (1. Mix based on IDC's significant experience with orthopedic physician groups)
- (2. Time based on high field magnet, but IDC will maintain group's cost integrity regardless)

“Expanding Your Practice”

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Operational Flow

- Trained practice staff faxes order and basic pt info to centralized IDC staff
- IDC performs pre-cert and scheduling services
- Scans performed at leased location
- Same day, charge capture info faxed to practice's billing staff
- IDC center staff coordinate films/images and rad reports to physician
- IDC trains billing and front office staffs of leasing practices
- IDC reviews initial billings and collections for accuracy
- IDC reviews practice's collections quarterly to insure ongoing accuracy



Proposal Summary: Standard New Center Terms

- 75% of hours in base lease; 25% of hours in "pool" to draw from as needed
- Monthly rent due at the beginning of the month
- Pool hours used billed at month-end paid within 15 days
- Rent deferments



Financial Summaries

Analysis Process

- Capture group's specific utilization data
- Apply IDC procedure times to group's specific procedure mix to determine "time share" needs
- Apply payer mix and reimbursement experience to procedure mix to project group's collections for technical billings
- Apply IDC pricing to group's time requirements to determine time-share cost
- Prepare a financial proforma for the group



Data Assumptions: Typical Process

Utilization data by procedure code by modality

- Provided or gathered by CUSTOMER and IDC
- Typically based on actual utilization for a 4 week sample period

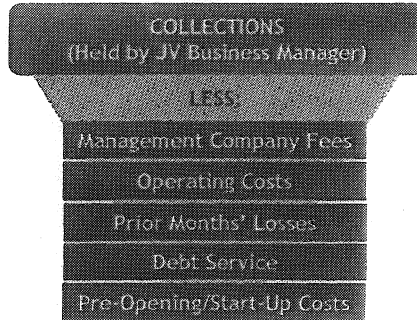
Reimbursement projections based on your group's actual payers

- Result: overall average %'s of Medicare rates for market:
- EXAMPLE:
 - MRI: 115%
 - NUC: 128%
 - CT: 127%
 - US: 128%



Flow of Funds Comparison

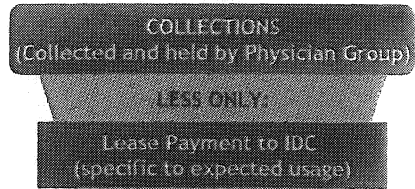
Joint Venture



If funds remain...

Profits distributed based on ownership percentage, regardless of size of physician's patient base or procedures ordered

IDC



NO REDUCTIONS FOR:

- Management Fees
- Operating Costs
- Facility Losses or Debt Service
- Pre-Opening or Start-Up Costs

PROFITS retained by Physician Group -- NO sharing with other groups or IDC



Internal Medicine

	<u>Payor Mix</u>	<u>Reimb.</u> <u>% Medicare</u>
Non Portable - Aetna	5%	
Capitated	0%	90%
HMO	35%	95%
PPO/POS	35%	105%
Medicare	25%	100%
Self Pay	0%	115%
WC	0%	125%
Total	100%	
Estimated % Portable	70%	



Estimated Average Technical Reimbursement

Payor Mix		25%	0%	35%	35%	0%	0%	Portable
Portable Payor Mix		0%	0%	50%	50%	0%	0%	Weighted
		<u>Medicare</u>	<u>Capitated</u>	<u>HMO</u>	<u>PPO/POS</u>	<u>Self Pay</u>	<u>WC</u>	<u>Average</u>
MRI	70543 Mri orbt/fac/nck w/o&w dye	5%	1005.91	905.32	955.61	1,056.21	1,156.80	1,005.91
MRI	70553 Mri brain w/o&w dye	35%	1015.33	913.80	964.56	1,066.10	1,167.63	1,015.33
MRI	72156 Mri neck spine w/o&w dye	8%	1011.93	910.74	961.33	1,062.53	1,163.72	1,011.93
MRI Contrast Procedures		48%						1,013.78
MRI	70544 Mr angiography head w/o dye	5%	534.19	480.77	507.48	560.90	614.32	534.19
MRI	70551 Mri brain w/o dye	7%	519.75	467.78	493.76	545.74	597.71	519.75
MRI	72141 Mri neck spine w/o dye	10%	499.36	449.42	474.39	524.33	574.26	499.36
MRI	72148 Mri lumbar spine w/o dye	20%	540.68	486.61	513.65	567.71	621.78	540.68
MRI	73221 Mri joint upr extrem w/o dye	5%	504.84	454.36	479.60	530.08	580.57	504.84
MRI	73721 Mri joint of lwr extre w/o d	5%	507.81	457.03	482.42	533.20	583.98	507.81
MRI Non-Contrast Procedures		52%						522.69
Total MRI Weighted Average		100%	758.41	682.57	720.49	796.33	872.17	758.41



Internal Medicine

VARIED PORTABILITY MRI Only

	100%	Non Portable	Portable
REIMBURSEMENT ESTIMATES			
Number of Procedures	1,200	(360)	840
Technical Revenue Per Procedure			\$ 758
Lease Cost Per Procedure			\$ 474
Hourly Lease Rate			\$ 750
Procedures Per Hour			1.58
Annual Hours Leased			531
Contrast Costs / Procedure			\$ 200
Estimated Contrast Procedures	48%		403

ANNUAL SUMMARY

Revenue:

Technical \$ 637,066

Costs:

IDC Lease 398,475
 Estimated Contrast Costs 80,600
 Total Costs 479,075

Profitability:

Technical \$ 157,991
 Profit Margin 25%

OVER 3 YEARS

\$ 473,973