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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Glades General Hospital

P.O. Box 8002 • 1201 South Main Street
Belle Glade, Florida 33430-8002

Phone (407) 996-6571
Fax (407) 996-2898

NEIL WHIPKEY
ADMINISTRATOR

FAX TRANSMITTAL FROM OFFICE OF ADMINISTRATION

DATE: 10-9-95 TIME: 4:30 PM/EDT

TRANSMITTING TO: Marilyn Yeager

FIRM NAME: White House Office Public Liason

FAX NUMBER: 1-202 456 6218

REGARDING: Requested Info per our phone conversation

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Charlie Pierce sends his regards.

Glades General Hospital

P.O. BOX 8002 • 1201 SOUTH MAIN STREET
BELLE GLADE, FLORIDA 33430-8002

PHONE 407 996-6571
FAX 407-996-1109

NEIL WHIPKEY
ADMINISTRATOR

October 9, 1995

Marilyn Yeager
c/o White House
Washington, D.C.

VIA FAX

Ms. Yeager:

It was a pleasure speaking with you this morning. To be asked to participate in a conference call with the President is an honor which I happily accept.

I am providing some general information about Glades General Hospital (GGH) which is routine material we have available. I also wanted to take the opportunity to expound on some facts. GGH was originally built in the early 1940s as a direct result of a visit to the area by then first lady Eleanor Roosevelt. Initially the hospital was built for the migrant labor population and it was staffed by military physicians. Several years later the community took over the operation and funding of the facility and supported it with local ad valorem taxes.

Currently we are the only public hospital (out of 15) in Palm Beach County. We are in a rural area with an extremely disproportionate number of people below the federal poverty guidelines. Our population is about 60% African American and 30% Hispanic. We also have the youngest population in Palm Beach County, unlike the coastal areas which have a high medicare population. Our medicare population is steady at about 25%. Teen pregnancy, lack of prenatal care, low birth weight babies, high infant mortality rate, T.B., infectious disease, and aids are all chronic problems here. This is despite the outstanding efforts of ourselves and the local public health unit.

Despite public support to the tune of about 3.7 million dollars we will still have a negative balance sheet for the fiscal year just ended, of about 3 million dollars. In the past year we have reduced expenses 3 million from the previous year; i.e. reduced staff by almost 20%, renegotiated vendor and provider contracts, enacted other cost saving initiatives which under normal circumstances would be quite satisfactory. These are not normal times. Our patient activity has declined significantly and the result is that net revenues are down nearly 3 million dollars from the previous year. Hence, we are running faster and faster just to

try to stay even. Managed care is for many people really managed "non care" and in south Florida many HMOs have been less than scrupulous in taking advantage of the poor, illiterate, non English speaking, and the elderly. The HMOs, of which some are respectable, for the most part are a pox upon society and they would not recognize a scruple if it hit them between the eyes. In too many cases it is a matter of no pay and hospitals such as ours eat the loss. For those of us across rural America, who are marginal, we can fold up the tent and close shop if the current medicare and medicaid budgets, as proposed in the present House and Senate bills, are enacted into legislation.

Our reality is that we are now in a precarious position. Nevertheless, I find myself supporting a balanced budget and the truth is that hospital administrators should be advocating for appropriate changes in both the medicare and medicaid programs. A bankrupt medicare or medicaid is useless yet, we seem unable to support the necessary changes required to ensure the survival of both programs. For the record I support the position of the American Hospital Association and I compliment their leadership for having the integrity to support needed change. For GGH it may be too late; I am not certain if we do everything right that the outcome will still leave us as a viable entity. The fact is that all across America, especially in Florida, there are entirely too many hospital beds and the fact that every little community feels that they are entitled to a hospital is an idea which we can no longer afford. Of course, there are way too many beds in urban areas as well. We, the providers (both hospitals and physicians), are responsible for "killing the goose that laid the golden egg" and we have only ourselves to blame for the current state of the market place. In the words of Pogo, "We have met the enemy and they is us."

With regard to the current state of affairs as concerns proposed legislation I ask the President to do the following; get the House and Senate conference committees to draw their time frame out to ten years. I would be willing to support such a plan, although we could still easily be one of the facilities to fall by the wayside. If that is the case then so be it! I favor a balanced budget, as previously stated, if it happens in ten years rather than seven I do not believe that is a big deal. Barring some give on the congressional level, I hope the President will take out his veto pen and strike a blow for fairness.

A final piece of unsolicited advice. Lets keep the dialogue civil. I find it quite sad when all of the hype is made about damage to this group or that group. More often than not the "sound bites" are attempts at emotional blackmail and it is just so much garbage that simply clouds the real issues. Remember the issues; a balanced budget and a fiscally sound medicare/medicaid program(s).

Please pardon my taking advantage of the fact that you called and gave me your fax number. I am certain that I probably have given you more than you want to bother with and I apologize for having done so. On the other hand it is not every day that you get to talk with someone in the White House.

With regard to a personal bio I am enclosing a resume which certainly gives an overview of my career. In addition I have included a listing of my activities both community related and professionally. If you need more information please let me know and feel free to give me a call. It is my hope that the proposed conference call comes to past. It will be both a thrill and an honor for me.

I have sent letters to both the President and the First Lady on items related to health care and on each occasion I invited them to come and visit GGH any time the opportunity might present itself. The invitation still stands, but you'd better hurry because we are one of the marginal institutions who in all probability will not survive if the aforementioned congressional cuts (reduced payments) do go through.

Sincerely,

Neil Whipkey

Neil Whipkey
Administrator

enclosure

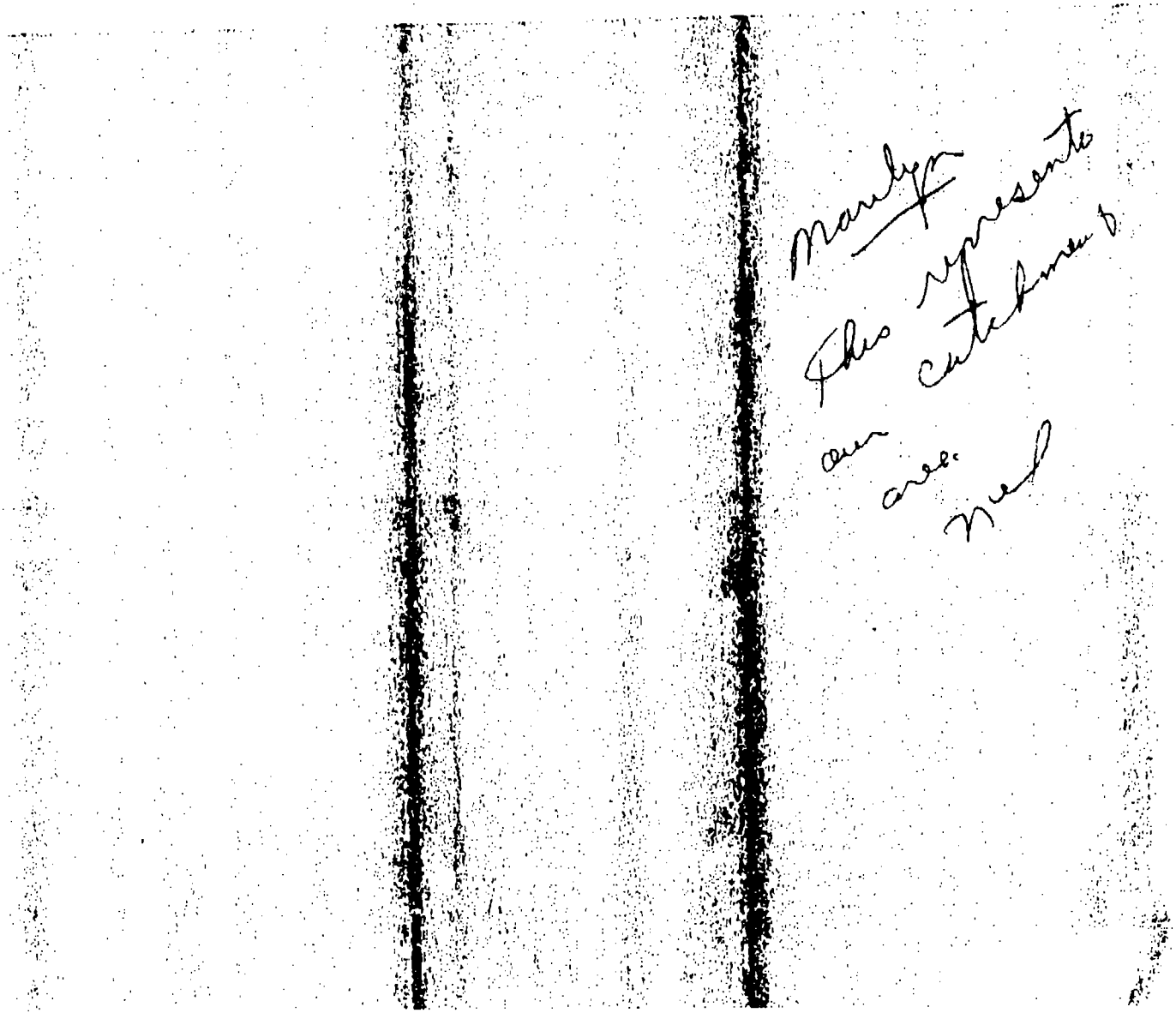
cc: file

1993 POPULATION BY RACE - BELLE GLADE, PAHOKEE, SOUTH BAY

City	White	Black	American Indian	Asian	Other	Total Pop	Hispanic*
Belle Glade	5,510	9,915	100	36	1,687	17,249	3,844
Pahokee	2,403	3,811	10	35	607	6,866	1,867
South Bay	925	2,458	0	6	675	4,064	1,256

* Note: Hispanics may be of any race

Source: UF BEBR and Palm Beach County Health Care District



Marilyn
This represents
our catchment
area.
Neal

GLADES GENERAL HOSPITAL

1201 S. MAIN STREET * (407) 996-6571 * BELLE GLADE, FL. 33430

Glades General Hospital is a full - service acute care facility serving all the residents of the south Lake Okeechobee area. Glades General has been in operation at the same location for over 50 years and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Glades General is equipped and staffed to provide care for a wide variety of cases. Our Level 3 emergency room provides 24-hour, physician staffed care with access to the Trauma Hawk just steps away. Our Critical Care Unit is fully equipped to provide quality care for cardiac, renal and other serious medical problems. We also offer both inpatient and same day surgical services.

The newest addition to Glades General's menu of services is Maternity and OB services. Now, expectant mothers can obtain the complete range of Maternity services from pre-natal care to delivery right here at Glades General Hospital. Our Radiology Department is also undergoing a complete renovation that, when completed, will enable Glades General to provide diagnostic imaging procedures that until now were not available in the Glades area.

Glades General Hospital has a full range of outpatient services as well including our Clinical Laboratory, Physical, Occupational and Respiratory Therapy, Mammography, and the only on-site MRI service in the Glades area.

The highly qualified physicians on our medical staff provide a wide range of services including Emergency Medicine, General and Vascular Surgery, Family Medicine, Pediatrics, Cardiology, Gynecology, Orthopedics, Nephrology and Pulmonology. The Hospital also provides a free physician referral service by calling (407) 996-6571, extension 446 to help you select a Physician.

On behalf of the employees and management of Glades General Hospital, we invite you to come and visit our facility and experience our unique combination of caring and compassion that makes our Hospital special.

GLADES GENERAL HOSPITAL - THE CARING PLACE

Glades General Hospital

1201 S. Main Street • (407) 996-6571 • Belle Glade, FL 33430

Glades General Hospital is a non-profit 73-bed, full service acute care facility serving the residents of Western Palm Beach, Hendry and Glades counties. GGH is accredited by the Joint Commission on Accreditation of Healthcare Organizations and is committed to quality care by caring professionals.

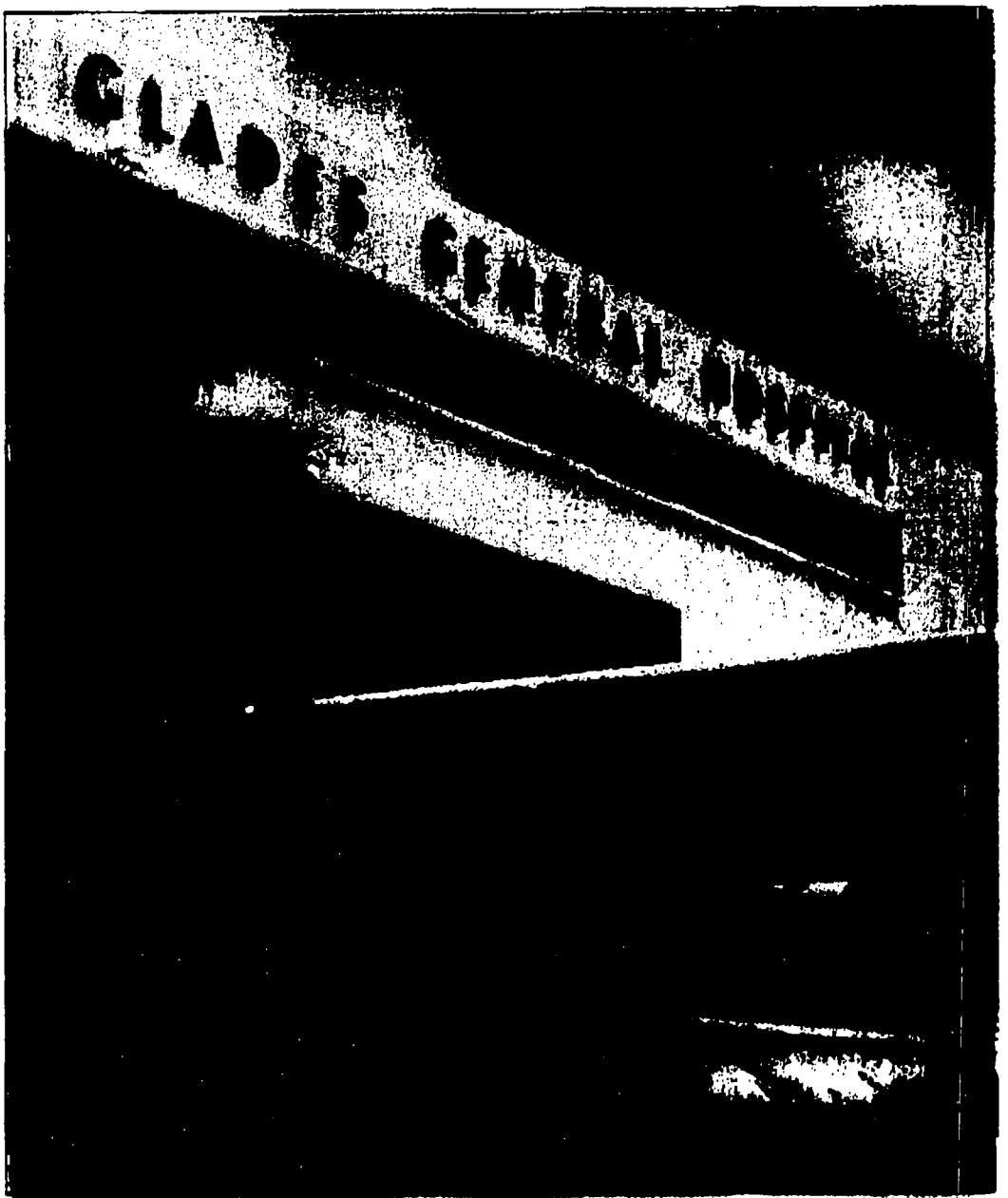
Our facility is equipped to handle a wide variety of cases. We provide 24-hour, physician staffed emergency room care complimented by a fully equipped Critical Care Unit. Our Outpatient services include Radiology, Laboratory, Physical Therapy, Respiratory Therapy, a Breast Diagnostic Center, and a Renal Care Center. Our facilities also include both inpatient and same day surgical suites with laser surgery soon to be available.

The strength of our hospital lies in the committment and dedication of every member of our staff. The highly qualified physicians on our medical staff provide a wide range of services including Emergency Medicine, Urology, Ear, Nose & Throat, Physiatry, Infectious Disease, General Medicine, Gastroenterology, Internal Medicine, Ophthamology, Pediatrics, General and Vascular Surgery, Cardiology, Psychiatry, Family Practice, and Nephrology. Our nursing and professional support service staff are also dedicated to providing healthcare excellence. Those without a personal physician can take advantage of the hospital's free physician referral service by calling (407) 996-6571 ext. 446. The service is available 8 a.m. to 4 p.m., Monday through Friday.

Glades General Hospital continues to promote the health of the communities it serves. Towards this goal, GGH is now offering a series of health education screenings. These screenings will be hosted by physicians and will address specific healthcare topics in which the physician specializes. Through these efforts, Glades General hopes to identify those with potential health risks through education and testing. For more information on this series, please call 407-996-6571 ext. 445.

WESTERN PALM BEACH COUNTY

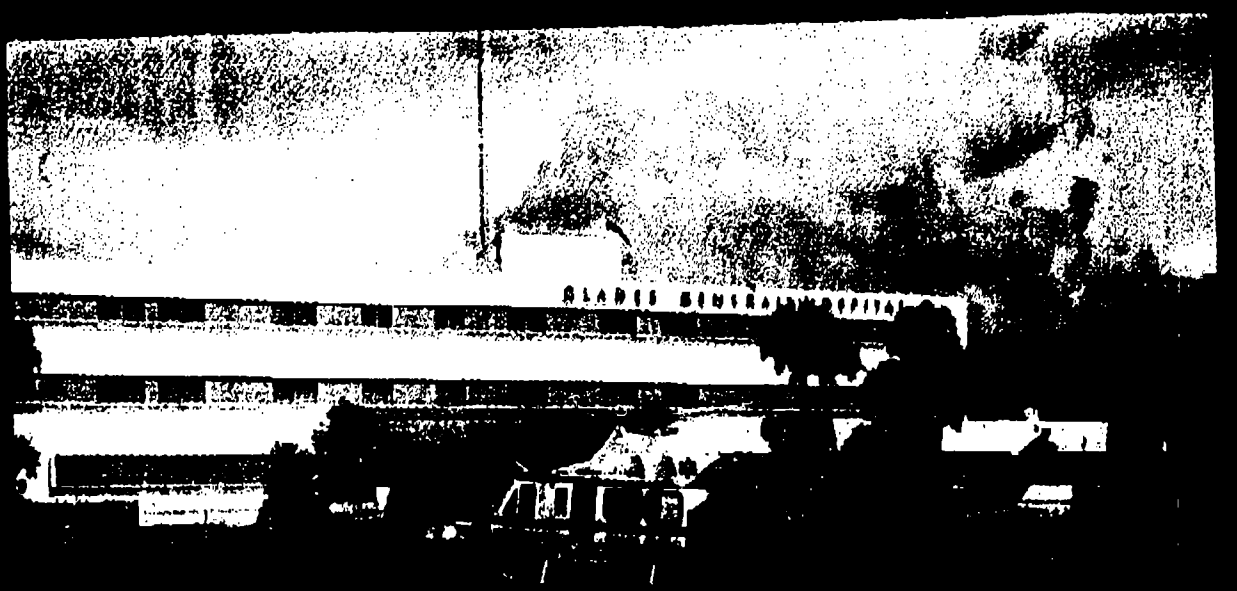
Medical Directory



Glades General Hospital

"Count on Us To Care"

1201 S. Main Street • (407) 996-6571 • Belle Glade, FL 33430



RESUME

NEIL WHIPKEY
P.O.BOX 1345
STUART, FL. 34995

HOME PHONE (407) 996 6568
WORK PHONE (407) 996 6571

RESUME CAPSULE
OVER 20 YEARS MANAGEMENT EXPERIENCE IN HEALTH CARE

EMPLOYMENT:

2/90 TO PRESENT-ADMINISTRATOR, GLADES GENERAL HOSPITAL 1201 S.MAIN ST. BOX 8002, BELLE GLADE, FL. 33430. RESPONSIBLE FOR OPERATION OF 73 BED ACUTE CARE HOSPITAL. GROSS REVENUES UP 40%. RECENTLY OVERSAW A MAJOR REDUCTION IN WORK FORCE. RETURNED OB SERVICES TO HOSPITAL. ADDED NEW SERVICES; CARDIAC REHAB, INVASIVE RADIOLOGY, MRI, LASER SURGERY, COMMUNITY EDUCATION PROGRAM, 2 SUCCESSFUL JCAHO SITE SURVEYS. COMMUNICATION SKILLS AND COMMUNITY INVOLVEMENT A PLUS.

6/87 TO 2/90 HEALTH SERVICES ADMINISTRATOR, MARTIN CORRECTIONAL INSTITUTION 1150 S.W. ALLAPATTAH ROAD, INDIANTOWN, FL. 34956. OVERSAW OPERATION OF A 9 BED INFIRMARY AND CLINIC THAT PROVIDED HEALTH CARE TO 1300 INMATES AT A CLOSE CUSTODY STATE FACILITY. SUPERVISED STAFF OF OVER 30. DEPARTMENT ALSO PROVIDED DENTAL AND PSYCHOLOGICAL SERVICES.

5/82 TO 5/87 MARTIN MEMORIAL HOSPITAL P.O. BIN 9010, STUART, FL. 34995. VARIOUS POSITIONS, I.E. ASSISTANT DIRECTOR NURSING, DIRECTOR OUTPATIENT SURGERY, DIRECTOR BUDGET AND SPECIAL PROJECTS, OPERATIONS OFFICER FOR COASTAL HEALTH A SUBSIDIARY OF HOSPITALS' PARENT CORPORATION. DEVELOPED WALK IN MEDICAL TREATMENT CENTERS, ALS AMBULANCE SERVICE, AND PARTICIPATED IN DEVELOPING A 40,000 SQUARE FOOT AMBULATORY SURGICAL CENTER/PHYSICIAN OFFICE BUILDING.

8/72 TO 7/81 DIRECTOR INTERMEDIATE CARE PROGRAM, SOUTHWEST COMMUNITY MENTAL HEALTH SERVICES 99 S. CENTRAL AVENUE, COLUMBUS, OHIO 43223, DEVELOPED MODEL DAY CARE PROGRAM WITH OPEN ADMISSIONS POLICY. CREATED UNIQUE MEDICAL RECORDS CHARTING SYSTEM.

EDUCATION:

M.ED. XAVIER UNIVERSITY, CINCINNATI, OHIO
B.A. DAVIS AND ELKINS COLLEGE, ELKINS, WEST VIRGINIA

ADDITIONAL STUDIES

WESTERN MICHIGAN UNIVERSITY, KALAMAZOO, MICHIGAN
CHARLESTON UNIVERSITY, CHARLESTON, WEST VIRGINIA
OHIO STATE UNIVERSITY, COLUMBUS, OHIO

Community Activities

Rotary Club
Chamber of Commerce
Lake Okeechobee Area Rural Health Network
Dolly Hand Cultural Arts Center Advisory Board
Leadership Glades
Zora Neal Hurston Rooftop Garden Museum
Lakeside Legacy
Black Gold Jubilee
Cancer Society, Celebrity "bagger"
Career Day Participant, sponsored by local schools and public health unit.
Family Forums, annual day long event sponsored by area health providers.
Glades Area Development Corporation

Professional Activities

American Hospital Association (AHA)
Florida Hospital Association (FHA):
various committees-Strategic Planning, Cooperation and Collaboration, Federal Relations. Leading Small Institution Contributor FHA Political Action Committee.
State of Florida Advisory Committees:
Rural Hospital Professional Licensing Flexibility Advisory Committee, and Rural Health Network Advisory Committee.
Planned Approach To Community Health (PATCH): area Board that coordinates local health care provider services.
Glades Interagency Network (GIN): Agency to streamline services to area residents; i.e. reduce duplication and increase cost efficiencies.

FAX TRANSMISSION

Grinnell Regional Medical Center
210 Fourth Avenue
Grinnell, Iowa 50112
(515) 236-7511

Fax Number: (515) 236-4048 — Hospital
(515) 236-6844 — South Campus

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Date: 10-9-95

Time: 9:45 am

This fax is directed to: Marilyn

From: Todd C. Linden

FAX number: 202/456-6218

This transmission contains 9 pages (including this cover letter).

_____ Please call

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_✓_ For your information

_____ Your comments please

Remarks: _____

FORM #490569

Week in healthcare: *Government settles PHO antitrust cases* *GOP Medicare plan to trim teaching payments*

Modern Healthcare®

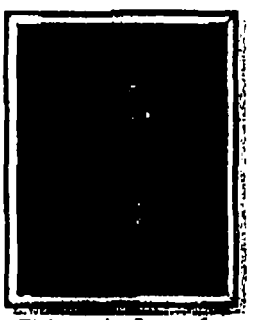
Sept. 18, 1995

WEEKLY BUSINESS NEWS


Elizabeth Alhand


Sue G. Brody


Arthur Ginsberg


Tibisay A. Guzmán


Shelley A. Horwitz


Peter Lawson


Todd Linden


Gary Mendoza

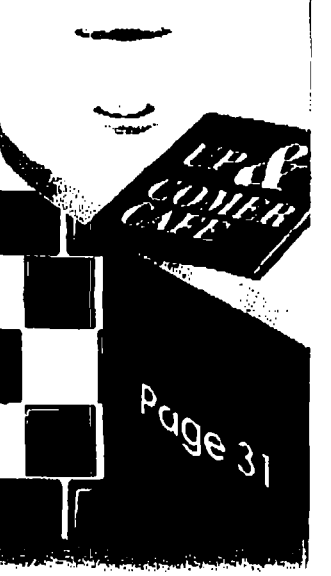

Donald R. Smithburg


Thomas P. Sokola


David Strand


Britt Travis

1995 UP & COMERS



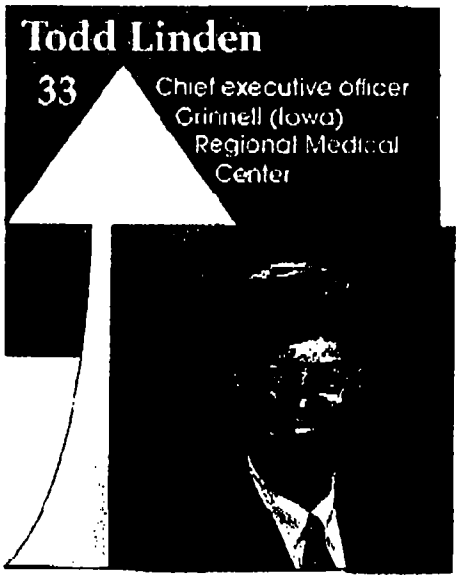
Page 31

Cover story

UP COMERS 1995

THEY REFUSE TO BE CONSTRAINED by the ways of the past. They're working to improve the quality of medical care, expand access to healthcare and formulate a cost-efficient delivery system best suited to the needs of the 21st century.

They're *Modern Healthcare's* 1995 Up & Comers, a group of healthcare professionals all 40 years old and younger nominated by the magazine staff and its readers as examples of the best healthcare has to offer. Here is our annual roster of healthcare's rising young stars.



Todd Linden's healthcare roots run deep.

The son of a hospital executive, Linden started working odd jobs at hospitals as a teen-ager in Boone, Iowa. He became familiar with all facets of hospital work and loved each one, including his first task as a 14-year-old groundskeeper at 57-bed Boone County Hospital.

"He worked in a lot of different departments, like the billing clerk's office and with the maintenance engineer, and then he would come home and ask, 'Dad, do you think there is a better way to do that?'" said Chuck Linden, a longtime chief executive officer of Boone County Hospital. Chuck Linden now serves as president of regional health services at Iowa Health System in Des Moines. "He was always interested in finding out how everything worked."

It's that inquisitive nature that has led 33-year-old Todd Linden to be a leader on several important Iowa healthcare issues.

At his first professional job as an administrator at Greene County Medical Center in Jefferson from 1988 to 1993, he came across a few men tearing up some newly seeded lawn at the hospital campus.

"They told me they were laying fiber-optic cable across the state," said Linden, now the president and chief executive officer of 81-bed Grinnell (Iowa) Regional Medical Center. "I wondered what was going on, so I started making some calls."

Linden discovered the state was going to use the fiber-optic telephone cable to link all 99 Iowa counties in a network. The cable allows the transmission of digital images from computer to computer. Schools and colleges were to be the original benefactors of the network.

But Linden figured the state's investment also could benefit healthcare.

So he continued to study the fiber optic system after coming to Grinnell in January 1994. His curiosity caught the attention of Iowa Gov. Terry Branstad, who appointed Linden chairman of the Iowa Telemedicine Advisory Council in February of that year. Among his duties, Linden helped lobby the state Legislature to have hospitals included in the $182 million network.

By the end of the 1994 spring legislative session, the state's 120 hospitals were given approval to tap the system for telemedicine uses as well as other medical, educational and information applications.

"Todd's interest in legislative issues really helps us," said Steve Brenton, president of the Association of Iowa Hospitals and Health Systems. "He's active on the cutting-edge issues."

Linden's also been at the forefront of many questions affecting rural hospitals. During congressional healthcare reform debates in 1993, Linden testified before the House Ways and Means health subcommittee on the importance of hospitals to rural communities.

During his 5½-year tenure at 53-bed Greene County Medical Center, Linden spearheaded an $8 million development project that featured a 33-unit retirement facility owned by the hospital. The development incorporates acute care, skilled care, a nursing home, home healthcare and public health all under one organization. Those services are key to Iowa towns like Jefferson with many elderly residents among its 4,300 population.

Those accomplishments drew the attention of a recruiter in late 1993. Although Linden wasn't looking for a job, he was floated an attractive offer at Grinnell.

Midway between Iowa's capital city, Des Moines, and Iowa City, home of Linden's alma mater, the University of Iowa, Grinnell offered several opportunities.

In addition to his hospital duties, he teaches part-time as an adjunct faculty member at the University of Iowa's hospital and health administration program. He has a similar role at the University of Osteopathic Medicine and Health Sciences in Des Moines.

"Teaching is very educational for me and helps me to stay sharp," Linden said. "It's a lot of fun and a nice diversion."

Linden is also working on ways students at Grinnell College, a prominent liberal arts college, can work healthcare internships into their undergraduate studies.

Under Linden's leadership, Grinnell Regional Medical Center is coming off the most profitable year in its 27-year history. The hospital reported net income of nearly $1.9 million on net revenues of $17 million in 1994, according to HCIA, a Baltimore-based healthcare information company.

But when it comes to giving credit where credit is due, Linden points to the people around him.

"I have truly been at the right place at the right time, and fortunate to be surrounded by great boards, physicians and staffs," Linden said.

He credits his father and mother, Judith, with influencing his career choice.

"My father was a fabulous healthcare administrator who could keep the balance between professional life and family life," Linden said. He and his wife have three children. "I may come back in and work until midnight or later but only after the kids go to bed," he said.

—Bruce Japsen

Senator Harkin Medicare Press Conference
September 20, 1995

When you spend your energies about what you are against it weakens you. When you spend you energies FOR something it empowers you!

Mother Teresa

I am here today to spend some energies for the people that depend on Grinnell Regional Medical Center.

Medicare is a very important program for millions of Americans. Put quite simply, people depend on it. Hospitals across this country are concerned about the magnitude of the proposed reductions in payment growth. The proposed rate of growth in payments is less than the amount needed to cover new enrollment and general inflation. Access and quality could suffer and suffer substantially in rural areas.

We realize there will be cuts, but we must ensure that the reductions are achieved in the most responsible manner possible.

The system must be reformed.

There is no way so much money can be taken out of the system without real reductions in patient care quality and access. It will mean loss of jobs, which would also be economically damaging for many rural communities. The magnitude of proposed reductions is just too much, too soon.

I am as concerned about reducing the national debt for the benefit of my children as are most other Americans. But I m also concerned about the potential damages to our ability to

meet the needs of out patients. A substantial portion of the proposed tax cuts could be used to offset Medicare spending reductions. This would reduce burden on providers and seniors while dampening partisan rhetoric surrounding the tax cut issue.

Congress will pursue Medicare reform strategies which will involve the voluntary movement of millions of seniors into health plans and HMOs, it is equally clear that the existing underlying payment methodology (AAPCC) for managed care plans is so seriously flawed as to virtually undermine any chance of success in low cost, rural states like Iowa.

As that great American philosopher Yogi Berra said, You can see a lot by looking!

So lets take a look at some of the concerns:
A health plan under the proposed HMO for Medicare in Greene County Iowa would get $266 per month per covered member compared to Dade County Florida which would receive $615 per month. That s 172% difference, yet the covered seniors paid exactly the same amount into the Medicare program!! There is a serious fairness issue here!

The conservative practice of medicine in the upper mid west has placed Iowa and other rural states at a tremendous disadvantage in the reimbursement process. In other words, if you are an efficient provider of quality care, you are at a disadvantage.

I would support an independent commission to help take Medicare out of the partisan political process. Hard choices are going to need to be made, and this commission could help keep the politics out of it.

Another example of reform would be to let hospitals and doctors directly contract with Medicare to provide managed care services to seniors.

WW II parachute packers had an unacceptable record: nineteen out of twenty parachutes opened. The manager discovered that by allowing the packers the pleasure of testing their parachutes by jumping form a plane, quality rose to 100%.....I suggest members of congress put there feet in the shoes of seniors and providers and put efforts toward reforming the Medicare system before they push us out of the airplane.

Todd C. Linden
President and CEO
Grinnell Regional Medical Center
Grinnell, Iowa 50112
515-236-2301

GRINNELL REGIONAL

Health Care for Life

Grinnell Regional Medical Center In Brief

Grinnell Regional Medical Center is a modern 81 bed licensed facility accredited by the JCAHO (Joint Commission on Accreditation of Healthcare Organizations). The hospital was established in 1968 following the merger of Grinnell Community and St. Francis Hospitals. The name was changed from Grinnell General Hospital in 1994 to better denote the broad range of services available at the hospital and the expanded geographical area being served.

GRMC serves approximately 30,000 residents in a five county area in east central Iowa.

GRMC employs approximately 350 staff members, 52% of whom do not live in Grinnell, and is the area's sixth largest employer.

An active 25 member medical staff services the hospital. The staff consists of: 4 surgeons; 2 internists; 2 radiologists; 2 anesthesiologists; 1 orthopedic surgeon; 1 ear, nose and throat surgeon; 1 urologist; 1 pathologist; and 11 family practitioners. The hospital continues to actively recruit new physicians and has received a commitment from two new internists for 1996.

Grinnell Regional Medical Center continues to show increasing patient activity and growth. In 1994 the hospital recorded: 2,371 inpatient admissions, 31,459 outpatient visits, 123,257 outpatient procedures, 18,188 home health visits, and 232 births.

The strong patient activity has meant equally strong financial growth, making Grinnell Regional Medical Center a successful health care institution and an important contributor to the area economy.

1994 financial brief:

- Gross revenue.....$21,200,000
- Medicare discount.....$5,000,000
- Total payroll.....$6,800,000

In compiling the 1994 community benefits study for a statewide survey conducted by Drake University, it was determined that GRMC had a significant economic impact on the greater Grinnell community through subsidized services, health promotions, civic involvement, health education and community funding. Through these services almost 6,000 individuals were directly served by the hospital. Additionally, Grinnell Regional Medical Center provided care but did not receive payment for services in the amount of $354,686.

Grinnell Regional Medical Center is striving to become the benchmark for rural health care and is dedicated to meet the essential health care needs of the residents of the area. This bold vision for the future is based on strong tradition and a commitment to responsive, efficient and effective health care. This vision ensures a bright future for GRMC and the families, friends and neighbors we serve.

210 Fourth Avenue • Grinnell, Iowa 50112 • Phone: 515-236-7511 Fax: 515-236-4048

TODD C. LINDEN

Todd Linden is president and CEO of Grinnell Regional Medical Center, an 81 bed private, non-profit hospital in Grinnell, Iowa. Prior to this position he served five years as the administrator of Greene County Medical Center in Jefferson, Iowa.

Linden received his Master of Arts in Health Administration degree in 1987 and a Bachelor of Arts degree in 1984, both from the University of Iowa. He then completed a Fellowship at Iowa Methodist Medical Center in Des Moines, Iowa before joining Greene County Medical Center in 1988. In January of 1994 he was appointed to his current position in Grinnell.

In 1990 Linden received the Iowa Hospital Association's "James B. Seaman, II Young Administrator's Achievement Award". In 1992 he was named one of 24 young business leaders for the state by the Des Moines Register, and received the Iowa Jaycee's "Top Ten Outstanding Young Iowans" award in 1994. Linden served as Chair of the Iowa Hospital Association's Committee on Small and Public Hospitals from 1992 to 1994 and is currently serving on the association's board of directors. In 1995 Linden was recognized by Modern Healthcare as one of their twelve up and comers for the year.

Linden is an adjunct faculty member in the health care administration program at the University of Iowa in Iowa City and the University of Osteopathic Medicine and Health Sciences (UOMHS) in Des Moines. At UOMHS he was chosen to receive the "Student Choice Award" two of the past three years.

In June of 1993, Linden testified to the United States House of Representatives' Ways and Means Subcommittee on Health for a hearing on healthcare reform.

Linden currently is an alternate at large delegate to the American Hospital Association's (AHA) House of Delegates; a governing council member for AHA's Section on Aging and Long Term Care; an officer on the Healthcare Cooperative of Iowa board of directors; is chair of the Iowa Telemedicine Advisory Council; and is a diplomat of the American College of Healthcare Executives.

Locally, Linden serves on the Grinnell 2000 board, Poweshiek Area Development board, and the Greater Poweshiek Community Foundation board.

Linden is married to Kellie, and they have three children, Davis 10, Courtney 6, and Grant 2.

NMC
NORTHWESTERN MEDICAL CENTER

FACSIMILE TRASMISSION COVER SHEET

DATE OF TRANSMISSION: Oct. 6, 1995

ATTENTION: Marilyn Yager

COMPANY: White House, Wash. D.C.

FAX #: 202 - 456 - 6218

FROM: Peter A. Hofstetter

 # OF PAGES(including this page): 13

MESSAGE: Per our conversation I have enclosed A variety of information on our Hospital. Please let me know if you need anything additional. I look fowrd to hearing from you.

Peter

FAX MACHINE NUMBER:

NORTHWESTERN MEDICAL CENTER - (802) 524-1238

FAIRFIELD STREET
POST OFFICE BOX 1370
SAINT ALBANS, VT 05478

NMC: 802-524-5911
TOLL FREE IN VT:
800-696-0321

PETER A. HOFSTETTER, FACHE
37 Smith Street
St. Albans, vt 05478
(802) 527-2815

EDUCATION:

B.A., The American University, May 1974; Biology/Business Major - Hospital Administration

M.P.A., The American University, May 1977; Public Administration in Health Care

WORK EXPERIENCE

April 1994 - Present — Quorum Health Resources, Nashville, TN
CEO, Northwestern Medical Center, St.Albans, VT
70 Bed, JCAHO accredited facility, managed by Quorum

November 1988 to April 1994 — Quorum Health Resources, Nashville, TN
CEO, J. C. Blair Memorial Hospital, Huntingdon, PA
104 Bed, JCAHO accredited facility, managed by Quorum

May 1984 to November 1988 — Hospital Corporation of America/HMC, Nashville, TN
Administrator/CEO, Notre Dame Hospital, Central Falls, RI
45 bed, JCAHO accredited facility, managed by HCA.

March 1981 to May 1984 — Springfield Hospital, Springfield, VT
Director of Support Services/Acting Administrator
72 bed, acute care community hospital
Number two position, responsible in absence of Administrator

August 1979 to March 1981 — Temporary Nurses, Lyme NH
President/Owner
Business to assist area hospitals, nursing homes and private duty needs with staffing problems. TNI is a pool of nurses, available around the clock to supplement nursing shortages throughout the health system.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	DOB (Partial) (1 page)	ca. 1995	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Jennifer Klein
OA/Box Number: 10854

FOLDER TITLE:
Rural [2]

2014-0209-S
ms740

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[001]

December 1978 — October 1980
Dartmouth Medical School, Dept of Community and Family Medicine.
Facility, Field Activities Coordinator for the North Country Emergency Medical Services (EMS) Project; Liaison with the region's eight hospitals, physicians and nurses, development of evaluation strategies; coordination of regional planning and training activities; and assist with teaching of emergency medicine courses for Dartmouth medical students.

October 1977 to December 1978
Arthur Young & Company, Washington, D.C.
Health Care Consultant
Member, Health Care Management Consulting Staff. Assigned to Emergency Medical Services and Burn Demonstration projects. Responsible for securing continued research through government and private grant funding.

October 1973 — October 1977
Suburban Hospital, Bethesda, MD
Administrative Assistant - Emergency Department
350 bed community hospital, responsible for management of emergency Department's personnel, capital and operational budgets, development of physician referral system and establishment of Hospital as trauma center as part of the State of Maryland system.

Other positions held at Suburban Hospital include: Materials Management, Central Supply, Transportation Assistant, Nuclear Medicine. Internship co-sponsored by Hospital and American University.

AFFILIATIONS

American College of Hospital Administrators - Fellow

Vermont Hospital Association - Board of Directors

St. Albans Area Chamber of Commerce - Board of Directors

United Way - Franklin/Grand Isle

PERSONAL

(b)(6)

Married; two children; 5'11", 170 lbs; excellent health
Enjoy jogging, skiing, and most outdoor sports

References furnished upon request.

Northwestern Medical Center

Northwestern Medical Center, Inc. is a private, not-for-profit, 70-bed community hospital located in St. Albans, Vermont, which exists to provide access to optimal health care in its community.

History:

What was once a pair of fierce competitors is now a single, highly successful organization. From 1889 to 1948, the health care needs of Vermont's Northwestern region were served by the St. Albans Hospital. In the late 1940's, a philanthropist funded the creation of a new hospital in gratitude for local efforts to save her son's life. However, local medical politics intervened. What was eventually created was not a replacement facility -- but a competing facility. The Kerbs Memorial Hospital was founded in 1948 -- just up the street from the St. Albans Hospital.

For thirty years, these two competitors duplicated each other's services, raided each other's staffs, fought for the same physicians, and split community loyalties. Doing so in a community which only needed one hospital drove both organizations to the brink of closure. In an effort to preserve access to hospital care within the community, the two organizations merged in 1978 to form Northwestern Medical Center (NMC or the hospital). Hospital Affiliates International (HAI was subsequently bought out by HCA Management Company which has become Quorum Health Resources) was hired to turn the situation around.

The early 1980s were a difficult time for the fledgling organization. The hospital was losing money. Care was divided between two aging facilities with outdated equipment. The medical staff was small, aging, and lacked specialists. Outmigration of patients to the tertiary care center thirty miles to the south was increasing. It became clear that simply merging the competing organizations was not enough. If drastic action was not taken, the hospital would soon become either an urgent care satellite of the tertiary care center or a nursing home. To maintain community-based hospital care, NMC's services would have to be consolidated onto one modern site, and its medical staff would have to be revitalized.

The facility's needs were addressed through a pair of renovation and expansion projects: an $8 million investment in 1988 and a $3.3 million investment in 1993. The community showed its support for these modernization efforts by exceeding the goal of both the 1988 and 1993 capital campaigns. While $1.25 million was anticipated, $2 million in donations was achieved. Patient care was consolidated onto one site and the realities of 1948 construction (4-bed wards, no air handling, no bathrooms in patient rooms, etc.) were replaced by the comforts and conveniences of modern space (single and double rooms, HVAC systems, private baths, etc.). In addition to the construction and renovations, another $5 million was invested in equipment between 1988 and 1995. Through these efforts, NMC evolved from one of the oldest facilities in Vermont to one of, if not, the youngest patient care facilities in the State.

We continue to move forward as an organization. A 24,000 square foot medical office building has recently opened on our campus. We are expanding our collaborative relationships with other area providers and continue to study our relationship with Fletcher Allen. We have just opened our new R&F Room in Diagnostic Imaging. We continue to recruit physicians to meet the needs of our community. We also continue to recruit physicians to meet the needs of our community. We also continue to pursue the sale of the St. Albans Hospital and the relocation of the personnel housed their to our main campus.

At the same time, aggressive physician recruitment efforts were underway. The Active/Associate Medical Staff grew from seventeen physicians in 1988 to forty-seven physicians in 1995. This revitalization saw additions in the areas of: anesthesiology, emergency medicine, family practice, general surgery, internal medicine, obstetrics & gynecology, orthopedic surgery, pathology, pediatrics, podiatry, psychiatry, radiology, and urology. In addition, NMC established or expanded relationships with consulting physicians from the tertiary care center, enhancing local access to services including: cardiology, neurology, neonatology, oncology, and pulmonology. The community now has access to more than 70 physicians through the NMC medical staff. They have embraced the revitalized medical staff and, in doing so, have substantially increased utilization of NMC's services and significantly reduced their outmigration to the tertiary care center.

As hoped, the modernization of the facility and the revitalization of the medical staff has reversed the hospital's financial situation. No longer is the hospital incurring financial losses – in fact, NMC has enjoyed a positive bottom line for each of the past five years. It is currently enjoying its most successful year ever – and is sharing that success with its community by not budgeting a rate increase for fiscal 1996, further increasing the availability of free care, and enhancing its wellness and prevention activities.

Current Facilities And Services:

NMC's main facility is located at the corner of Crest Road and Fairfield Street in St. Albans, VT. The hospital is licensed for 70 beds. The physical plant at this site consists of approximately 102,000 square feet. Current facilities and services include:

- a 50-bed Medical/Surgical Unit which opened in February of 1995 after comprehensive renovation and expansion;
- a 4-bed Intensive Care Unit with a 2-bed Step-down Unit which opened in January of 1995 after comprehensive renovation and expansion;
- the Family Birth Center, which opened in January of 1990 offering expectant parents the comfort of home in the security of the hospital;
- a Surgical Suite and Outpatient Department with some of the newest technology, including advanced equipment for arthroscopic surgery, laser surgery, laparoscopic cholecystectomy, and colonoscopy;
- a 24-hour physician-staffed Emergency Department which treats over 17,000 patients a year;
- Pediatric services designed to meet the special needs of the younger members of the community;
- a comprehensive range of clinical diagnostic and rehabilitative services including Physical Therapy, Respiratory Therapy, Diagnostic Imaging and the Breast Imaging Center, Laboratory, Social Services, and Cancer Rehabilitation coordination;
- Partnership in The Center For Health & Wellness with the Franklin County Home Health Agency to provide wellness programs and screening for the general community as well as local businesses and industries.

NMC owns approximately 13 acres of land immediately adjacent to the main site. A portion of that land has been leased to a developer who opened the Doctors' Office Common, a medical office complex, in June of 1995. This facility will assist in efforts to recruit new physicians as well as strengthening relationships with the physicians who have established offices in the building. NMC has relocated much of its Outpatient Physical Therapy service to the office complex to better serve its patients. In addition, the office complex will house the hospital's new Work Hardening program -- the creation of which will further reduce the outmigration of patients. To date, 24,000 square feet of a planned 36,000 square foot project have been built by the developer. The hospital's long range plan speaks to the further development of this land to create a true medical campus, with options including a Community Wellness Education Center, hospital offices, and space for other providers.

NMC continues to maintain the St. Albans Hospital site. This 60,000 square foot facility currently houses NMC's Financial Services, Utilization Review, Quality Management, Tumor Registry, Safety and Infection Control, and Mail Room, as well as a number of physician tenants. The hospital's long range plan involves selling this building and relocating all hospital personnel to the main site.

NMC operates a Physical Therapy Clinic and an Internal Medicine Practice in the Community Health Center in Enosburg Falls, VT. This is part of the hospital's growing effort to increase access to services in the outlying portions of its community.

Accreditation, Memberships, and Teaching Affiliations

Northwestern Medical Center earned a three year accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1993 and is certified for participation in the Medicare Program by the U.S. Department of Health and Human Services. NMC will be reviewed by JCAHO in June of 1996. NMC is licensed by the State Department of Health and is a member of the American Hospital Association.

The Laboratory at NMC was awarded a two year accreditation by the Commission of Laboratory accreditation of the College of American Pathologists in May, 1995. The NMC Cancer Program is accredited by the American College of Surgeons' Commission on Cancer.

The NMC Physical Therapy Department proctors approximately 8 students each year from the Physical Therapy Training Program at the University of Vermont. The hospital also sponsors administrative interns from various colleges and universities on a routine basis.

Service Area and Competition

Northwestern Medical Center is located in St. Albans at the heart of Franklin County and exists to provide access to optimal health care in the greater Franklin County / Grand Isle County community. NMC defines its primary market share as the towns of Franklin County. This area represents a population of approximately 40,000 and account for approximately 91% of NMC's patients. NMC defines its secondary market area as the towns of Grand Isle County and the Chittenden County border town of Milton. The population of the secondary market area is approximately 15,000 and represents 5% of NMC's patients. Interstate 89 and Highways 7, 104, 105, and 36 provide relatively easy access to the hospital for the residents of the region.

It should be noted that the State of Vermont defines hospital service areas not by who one seeks to serve, but on past utilization. As such, the State considers five of the eleven Franklin County towns and the northernmost Grand Isle town to be "contested" service area between NMC and other hospitals. It categorizes the two southernmost Franklin County towns, as well as the town of Milton and the southern Grand Isle towns to be part of another hospital's service area. As NMC's share of the market increases, the State's definition of NMC's service area will come to more closely resemble NMC's definition.

NMC's competition for the primary care market in this region comes from Fletcher Allen Health Care, located twenty-six miles to the south. While Fletcher Allen exists to serve the primary care needs of Chittenden County, Vermont and the tertiary care needs of the State, they also compete with the community hospitals for the rural primary care markets. During the mid to late 1980s, outmigration from NMC's service area to Fletcher Allen was high due to the aging facilities and lack of physicians available locally.

As NMC has rebuilt and revitalized its organization, it has begun to recapture its market. In 1987, NMC serviced 51.2% of the discharges from its primary service area. The organizations which now make up Fletcher Allen Health Care serviced 44.5%. By 1993, as the new construction was in its second phase and as new physicians began to settle into the community, NMC's market share had climbed to 56.6%, while Fletcher Allen's share dropped to 40.1%. The 1993 data represents the most recent market share information published by the State of Vermont.

Hospital data from 1994 and 1995 indicate that this trend continues. Since the publication of the 1993 data, new physicians have joined the NMC medical staff in the areas of orthopedics, obstetrics & gynecology, family practice, otolaryngology, pediatrics, and urology -- and each new physician enjoys a growing practice. During the 1994 Fiscal Year, NMC experienced an 7% growth in adjusted admissions. Projections for the 1995 Fiscal Year show an additional 2.4% increase in adjusted admissions over 1994. It is anticipated that the State's 1994 and 1995 hospital market share reports will document continued market share gains by NMC.

As NMC has strengthened its services and its market share, its relationship with Fletcher Allen has evolved. Collaboration has begun to slowly replace competition as the State's largest provider recognizes the viability of the hospital and the community's support for NMC's services.

MEDICAL STAFF

As of July 31, 1995, the Medical Staff consisted of 47 active full-time physicians and 22 courtesy and consulting members. Approximately 84% of the Medical Staff is Board Certified and their average age is 43 years.

The following table presents information on the active Medical Staff by specialty:

Northwestern Medical Center
Active Medical Staff
July 31, 1995

Medical Specialty	Number of Physicians	Average Age	Number of Board Certified Physicians
Anesthesiology	4	43	2
Emergency Medicine	7	38	4
Family Practice	4	38	4
General Internal Medicine	7	47	4
Psychiatry	2	50	2
Obstetrics - Gynecology	3	37	0
Pathology	1	41	1
Pediatrics	7	42	7
Radiology	1	66	1
General Surgery	3	53	2
Ophthalmologic Surgery	1	49	1
Orthopedic Surgery	2	39	1
Otolaryngology/Maxillofacial	1	48	1
Urologic Surgery	3	40	3
Podiatry	1	36	0
TOTAL	47	43	33

PHYSICIAN RECRUITMENT

NMC has increased its Medical Staff by a net addition of 11 physicians over the periods shown below and maintains a continuing physician recruitment program. The following table indicates net additions and deletions to the Medical Staff over the following periods:

	FY 1992	FY 1993	FY 1994	YTD (7/31/95)	Total
Additions	3	1	6	7	17
Departures	2	4	2	1	9
Net Gains (Losses)	1	(3)	4	6	8

STAFFING, NURSING SERVICES AND EMPLOYEE RELATIONS

As of June 30, 1995, NMC employed 305 full time equivalent employees (FTEs) represented by 400 total employees, or 22.7 hours per adjusted patient day. The salaries, including fringe benefits, for these employees, represented approximately 54% of the total expenses of the Hospital for the nine months of fiscal 1995.

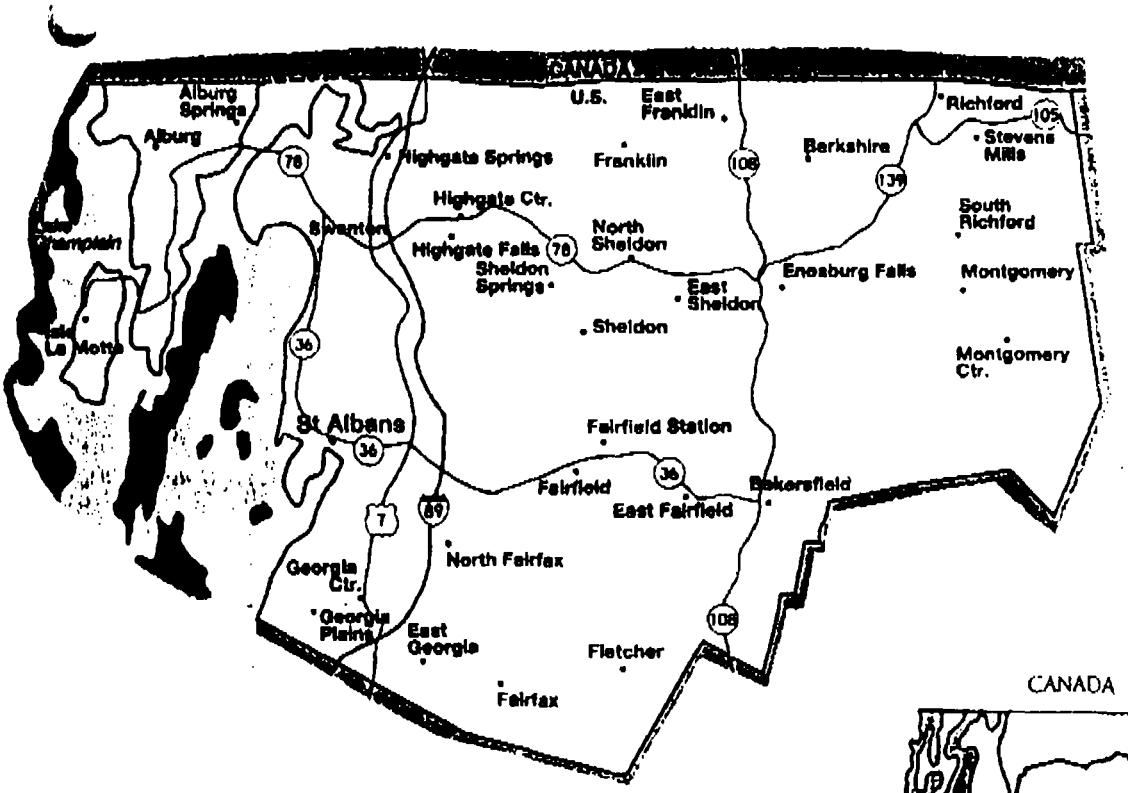
As of June 30, 1995, the Department of Nursing was comprised of 99 registered nurses, 41 licensed practical nurses, 8 technicians, 9 secretaries, 4 nurse's aides and 16 managers.

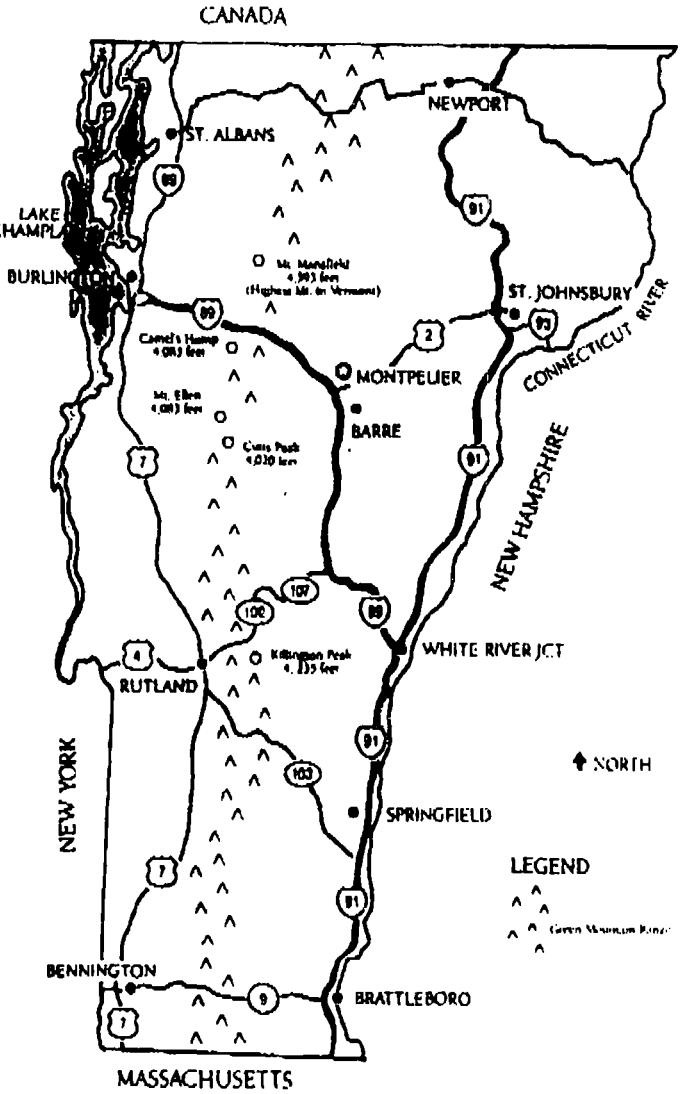
Employee turnover rates are as follows:

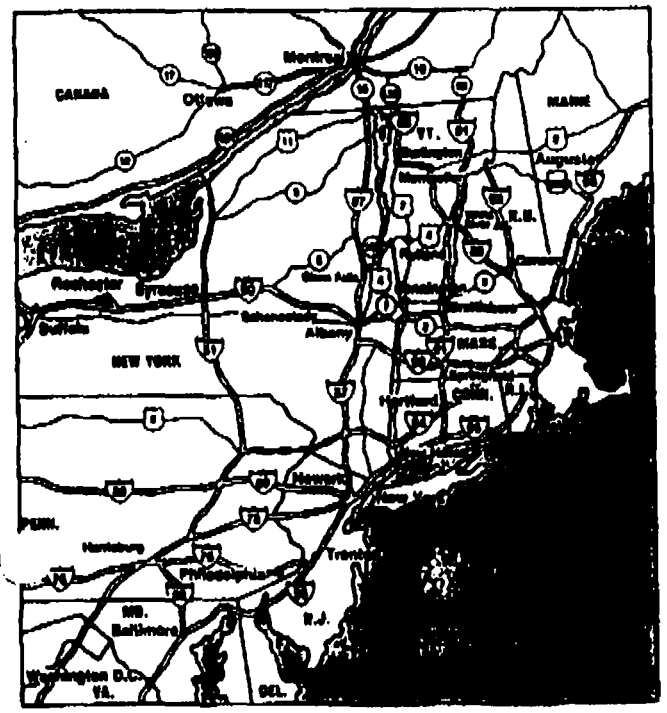
	NMC Hospital Wide	Hospital Wide Nat'l Average	NMC Nursing Personnel
FY 1993-94	12.0%	15.6%	10.8%
FY 1992-93	13.0%	14.4%	12.9%
FY 1991-92	13.5%	14.4%	9.9%

Over the last three years, average salary increases to employees were granted as follows: Fiscal 1995, 4.5%; Fiscal 1994, 5.0%; Fiscal 1993, 5.5%.

Northwestern Medical Center is located in St. Albans, Vermont and serves Franklin County & northern Grand Isle County — the northwestern corner of Vermont and New England.







Projection for Medicare Revenues 1996-2002
Under the Senate Finance Reconciliation Proposal
(in thousands of dollars)

Hospital: NORTHWESTERN MEDICAL CENTER INC
Address: BOX 868 FAIRFIELD ST
SAINT ALBANS, VT, 05478
Medicare Id: 470024

Fiscal Year	Current Law Revenue (in $1000s)	Proposed Payment Cuts (in $1000s)	Estimated Revenue Decrease (in $1000s)
1996	$6,436	$6,214	$-222
1997	6,826	6,480	-347
1998	7,266	6,760	-505
1999	7,736	7,003	-733
2000	8,242	7,305	-937
2001	8,757	7,599	-1,158
2002	9,321	7,921	-1,400
Total 1996-2002	54,584	49,282	-5,302

TO: PETER HOFSTETTER, CEO

FR: DAWN AND LINDA

DA: OCTOBER 6, 1995

RE: PRESIDENT CLINTON PHONE CALL

HERE ARE SOME FACTS:

MEDICARE % OF PATIENTS:	43%
MEDICAID % OF PATIENTS:	15%
TOTAL CARE/CAID POPULATION =	58%

MEDICARE INPATIENT AVER PAY'T	$ 4,710
MEDICARE INPATIENT AVER CHARGE	10,045
AVERAGE LOSS PER CLAIM	($ 5,335)
MEDICARE OUTPATIENT AVER PAY'T	$ 69
MEDICARE OUTPATIENT AVER CHARGE	298
AVERAGE LOSS PER CLAIM	(229)
MEDICAID INPATIENT AVER PAYT	$ 625
MEDICAID INPATIENT AVER CHARGE	1,500
AVER LOSS PER CLAIM	(875)
MEDICAID OUTPATIENT AVER PAYT	$ 110
MEDICAID OUTPATIENT AVER CHARGE	330
AVER LOSS PER CLAIM	(220)

IF COSTS FOLLOW INFLATION (ASSUME 4%)BUT PAYMENTS/REIMBURSEMENT ARE (REDUCED BY 6%), THIS WOULD RESULT IN A 10% NEGATIVE SWING TO OUR CARE/CAID REIMBURSEMENT.

CURRENT PROJECTED CARE/CAID CONTRACTUAL ALLOWANCE:= (10,878,000)
ADDITIONAL 10% LOSS, APPROX $1 MILLION

WE HAVE BUDGETTED A PROFIT FROM OPERATIONS OF $550,000.
For 1996

To: Dr. - 2nd Page

IN THE STATE OF VERMONT, WE RANK THE 14TH HIGHEST OUT OF 15 FOR BAD DEBT WRITE OFFS.

IN THE STATE OF VERMONT, WE RANK AROUND THE 13TH HIGHEST FOR DEDUCTIONS AS A % OF REVENUE

HISTORICALLY, WE HAVE EXPERIENCED A 40% DEDUCTION FROM REVENUE FOR C/A AND BAD DEBT.

WE HAVE THE 6TH LOWEST COST PER ADJUSTED ADMISSION IN THE STATE.

*****PLEASE NOTE THAT THE FLORIDA HAS CHANGED FROM PREVIOUS LISTS AND SEVERAL TYPOS HAVE BEEN CORRECTED IN NAMES AND TITLES.**

RURAL HOSPITAL CONFERENCE CALL WITH THE PRESIDENT ON THURSDAY, OCTOBER 12 FROM 11:45 AM TO 12:30 PM. Eastern Standard Time:

Participants

1). H.D. Cannington, Administrator
Jay Hospital (110 employees)
Jay (population 600), Florida
904/675-6334
Fax:904/675-3594
Press Contact: H.D. Cannington
(media market is Pensacola)

2). Peter Hofstetter, CEO
Northwest Medical Center Inc. (400 employees)
St. Albans (population 7300), VT
802/524-5911 or 524-1041
Fax:802/524-1238
Press contact: Jonathon Billings
802/524-1044
(media market: Plattsburgh,NY/Burlington,VT)

3). John Kelly, Administrator
Soldiers and Sailors Memorial Hospital (500 employees)
Penn Yan (population 5500), NY
315/536-4431 ext. 276 or 178 (H:315/536-7930)
Fax:315/536-0414
Press Contact: Harold Gray
315/536-4431, ext. 326
(media market: Rochester, NY)

4). Don Sipes, CEO
St. Luke's Northland Hospital (125 employees)
Smithville (population 2500), MO
816/532-7765 (Vickey Norton)
Fax:816/532-7136
Press contact: John Miller
816/532-7171 (pager 292-1567)
(Kansas City,MO media market)

5). Margo Arnold, CEO
West Side District Hospital (160 employees)
Taft (population 5900), CA
805/763-4211, ext. 227
Fax: 805/763-5641
Press Contact; Christine Beyer
805/763-4211, ext. 226
(Bakersfield media market)

6). Todd Linden, President/CEO
Grinnell Regional Medical Center (350 employees)
Grinnell (population 8900), IA
515/236-2300
Fax: 515/236-4048
Press contact: Chris Nolte
515/236-8637
(Des Moines and Cedar Rapids media markets)

Projection for Medicare Revenues 1996-2002
Under the Senate Finance Reconciliation Proposal
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CURRENT PROJECTED CARE/CAID CONTRACTUAL ALLOWANCE:= (10,878,000)
ADDITIONAL 10% LOSS, APPROX $1 MILLION

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For 1996

To: 12 hr - 2nd page

IN THE STATE OF VERMONT, WE RANK THE 14TH HIGHEST OUT OF 15 FOR BAD DEBT WRITE OFFS.

IN THE STATE OF VERMONT, WE RANK AROUND THE 13TH HIGHEST FOR DEDUCTIONS AS A % OF REVENUE

HISTORICALLY, WE HAVE EXPERIENCED A 40% DEDUCTION FROM REVENUE FOR C/A AND BAD DEBT.

WE HAVE THE 6TH LOWEST COST PER ADJUSTED ADMISSION IN THE STATE.

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What was once a pair of fierce competitors is now a single, highly successful organization. From 1889 to 1948, the health care needs of Vermont's Northwestern region were served by the St. Albans Hospital. In the late 1940's, a philanthropist funded the creation of a new hospital in gratitude for local efforts to save her son's life. However, local medical politics intervened. What was eventually created was not a replacement facility -- but a competing facility. The Kerbs Memorial Hospital was founded in 1948 -- just up the street from the St. Albans Hospital.

For thirty years, these two competitors duplicated each other's services, raided each other's staffs, fought for the same physicians, and split community loyalties. Doing so in a community which only needed one hospital drove both organizations to the brink of closure. In an effort to preserve access to hospital care within the community, the two organizations merged in 1978 to form Northwestern Medical Center (NMC or the hospital). Hospital Affiliates International (HAI was subsequently bought out by HCA Management Company which has become Quorum Health Resources) was hired to turn the situation around.

The early 1980s were a difficult time for the fledgling organization. The hospital was losing money. Care was divided between two aging facilities with outdated equipment. The medical staff was small, aging, and lacked specialists. Outmigration of patients to the tertiary care center thirty miles to the south was increasing. It became clear that simply merging the competing organizations was not enough. If drastic action was not taken, the hospital would soon become either an urgent care satellite of the tertiary care center or a nursing home. To maintain community-based hospital care, NMC's services would have to be consolidated onto one modern site, and its medical staff would have to be revitalized.

The facility's needs were addressed through a pair of renovation and expansion projects: an $8 million investment in 1988 and a $3.3 million investment in 1993. The community showed its support for these modernization efforts by exceeding the goal of both the 1988 and 1993 capital campaigns. While $1.25 million was anticipated, $2 million in donations was achieved. Patient care was consolidated onto one site and the realities of 1948 construction (4-bed wards, no air handling, no bathrooms in patient rooms, etc.) were replaced by the comforts and conveniences of modern space (single and double rooms, HVAC systems, private baths, etc.). In addition to the construction and renovations, another $5 million was invested in equipment between 1988 and 1995. Through these efforts, NMC evolved from one of the oldest facilities in Vermont to one of, if not, the youngest patient care facilities in the State.

We continue to move forward as an organization. A 24,000 square foot medical office building has recently opened on our campus. We are expanding our collaborative relationships with other area providers and continue to study our relationship with Fletcher Allen. We have just opened our new R&F Room in Diagnostic Imaging. We continue to recruit physicians to meet the needs of our community. We also continue to recruit physicians to meet the needs of our community. We also continue to pursue the sale of the St. Albans Hospital and the relocation of the personnel housed their to our main campus.

At the same time, aggressive physician recruitment efforts were underway. The Active/Associate Medical Staff grew from seventeen physicians in 1988 to forty-seven physicians in 1995. This revitalization saw additions in the areas of: anesthesiology, emergency medicine, family practice, general surgery, internal medicine, obstetrics & gynecology, orthopedic surgery, pathology, pediatrics, podiatry, psychiatry, radiology, and urology. In addition, NMC established or expanded relationships with consulting physicians from the tertiary care center, enhancing local access to services including: cardiology, neurology, neonatology, oncology, and pulmonology. The community now has access to more than 70 physicians through the NMC medical staff. They have embraced the revitalized medical staff and, in doing so, have substantially increased utilization of NMC's services and significantly reduced their outmigration to the tertiary care center.

As hoped, the modernization of the facility and the revitalization of the medical staff has reversed the hospital's financial situation. No longer is the hospital incurring financial losses -- in fact, NMC has enjoyed a positive bottom line for each of the past five years. It is currently enjoying its most successful year ever -- and is sharing that success with its community by not budgeting a rate increase for fiscal 1996, further increasing the availability of free care, and enhancing its wellness and prevention activities.

Current Facilities And Services:

NMC's main facility is located at the corner of Crest Road and Fairfield Street in St. Albans, VT. The hospital is licensed for 70 beds. The physical plant at this site consists of approximately 102,000 square feet. Current facilities and services include:

- a 50-bed Medical/Surgical Unit which opened in February of 1995 after comprehensive renovation and expansion;
- a 4-bed Intensive Care Unit with a 2-bed Step-down Unit which opened in January of 1995 after comprehensive renovation and expansion;
- the Family Birth Center, which opened in January of 1990 offering expectant parents the comfort of home in the security of the hospital;
- a Surgical Suite and Outpatient Department with some of the newest technology, including advanced equipment for arthroscopic surgery, laser surgery, laparoscopic cholecystectomy, and colonoscopy;
- a 24-hour physician-staffed Emergency Department which treats over 17,000 patients a year;
- Pediatric services designed to meet the special needs of the younger members of the community;
- a comprehensive range of clinical diagnostic and rehabilitative services including Physical Therapy, Respiratory Therapy, Diagnostic Imaging and the Breast Imaging Center, Laboratory, Social Services, and Cancer Rehabilitation coordination;
- Partnership in The Center For Health & Wellness with the Franklin County Home Health Agency to provide wellness programs and screening for the general community as well as local businesses and industries.

NMC owns approximately 13 acres of land immediately adjacent to the main site. A portion of that land has been leased to a developer who opened the Doctors' Office Common, a medical office complex, in June of 1995. This facility will assist in efforts to recruit new physicians as well as strengthening relationships with the physicians who have established offices in the building. NMC has relocated much of its Outpatient Physical Therapy service to the office complex to better serve its patients. In addition, the office complex will house the hospital's new Work Hardening program – the creation of which will further reduce the outmigration of patients. To date, 24,000 square feet of a planned 36,000 square foot project have been built by the developer. The hospital's long range plan speaks to the further development of this land to create a true medical campus, with options including a Community Wellness Education Center, hospital offices, and space for other providers.

NMC continues to maintain the St. Albans Hospital site. This 60,000 square foot facility currently houses NMC's Financial Services, Utilization Review, Quality Management, Tumor Registry, Safety and Infection Control, and Mail Room, as well as a number of physician tenants. The hospital's long range plan involves selling this building and relocating all hospital personnel to the main site.

NMC operates a Physical Therapy Clinic and an Internal Medicine Practice in the Community Health Center in Enosburg Falls, VT. This is part of the hospital's growing effort to increase access to services in the outlying portions of its community.

Accreditation, Memberships, and Teaching Affiliations

Northwestern Medical Center earned a three year accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1993 and is certified for participation in the Medicare Program by the U.S. Department of Health and Human Services. NMC will be reviewed by JCAHO in June of 1996. NMC is licensed by the State Department of Health and is a member of the American Hospital Association.

The Laboratory at NMC was awarded a two year accreditation by the Commission of Laboratory accreditation of the College of American Pathologists in May, 1995. The NMC Cancer Program is accredited by the American College of Surgeons' Commission on Cancer.

The NMC Physical Therapy Department proctors approximately 8 students each year from the Physical Therapy Training Program at the University of Vermont. The hospital also sponsors administrative interns from various colleges and universities on a routine basis.

Service Area and Competition

Northwestern Medical Center is located in St. Albans at the heart of Franklin County and exists to provide access to optimal health care in the greater Franklin County / Grand Isle County community. NMC defines its primary market share as the towns of Franklin County. This area represents a population of approximately 40,000 and account for approximately 91% of NMC's patients. NMC defines its secondary market area as the towns of Grand Isle County and the Chittenden County border town of Milton. The population of the secondary market area is approximately 15,000 and represents 5% of NMC's patients. Interstate 89 and Highways 7, 104, 105, and 36 provide relatively easy access to the hospital for the residents of the region.

It should be noted that the State of Vermont defines hospital service areas not by who one seeks to serve, but on past utilization. As such, the State considers five of the eleven Franklin County towns and the northernmost Grand Isle town to be "contested" service area between NMC and other hospitals. It categorizes the two southernmost Franklin County towns, as well as the town of Milton and the southern Grand Isle towns to be part of another hospital's service area. As NMC's share of the market increases, the State's definition of NMC's service area will come to more closely resemble NMC's definition.

NMC's competition for the primary care market in this region comes from Fletcher Allen Health Care, located twenty-six miles to the south. While Fletcher Allen exists to serve the primary care needs of Chittenden County, Vermont and the tertiary care needs of the State, they also compete with the community hospitals for the rural primary care markets. During the mid to late 1980s, outmigration from NMC's service area to Fletcher Allen was high due to the aging facilities and lack of physicians available locally.

As NMC has rebuilt and revitalized its organization, it has begun to recapture its market. In 1987, NMC serviced 51.2% of the discharges from its primary service area. The organizations which now make up Fletcher Allen Health Care serviced 44.5%. By 1993, as the new construction was in its second phase and as new physicians began to settle into the community, NMC's market share had climbed to 56.6%, while Fletcher Allen's share dropped to 40.1%. The 1993 data represents the most recent market share information published by the State of Vermont.

Hospital data from 1994 and 1995 indicate that this trend continues. Since the publication of the 1993 data, new physicians have joined the NMC medical staff in the areas of orthopedics, obstetrics & gynecology, family practice, otolaryngology, pediatrics, and urology -- and each new physician enjoys a growing practice. During the 1994 Fiscal Year, NMC experienced an 7% growth in adjusted admissions. Projections for the 1995 Fiscal Year show an additional 2.4% increase in adjusted admissions over 1994. It is anticipated that the State's 1994 and 1995 hospital market share reports will document continued market share gains by NMC.

As NMC has strengthened its services and its market share, its relationship with Fletcher Allen has evolved. Collaboration has begun to slowly replace competition as the State's largest provider recognizes the viability of the hospital and the community's support for NMC's services.

MEDICAL STAFF

As of July 31, 1995, the Medical Staff consisted of 47 active full-time physicians and 22 courtesy and consulting members. Approximately 84% of the Medical Staff is Board Certified and their average age is 43 years.

The following table presents information on the active Medical Staff by specialty:

Northwestern Medical Center
Active Medical Staff
July 31, 1995

Medical Specialty	Number of Physicians	Average Age	Number of Board Certified Physicians
Anesthesiology	4	43	2
Emergency Medicine	7	38	4
Family Practice	4	38	4
General Internal Medicine	7	47	4
Psychiatry	2	50	2
Obstetrics - Gynecology	3	37	0
Pathology	1	41	1
Pediatrics	7	42	7
Radiology	1	66	1
General Surgery	3	53	2
Opthalmologic Surgery	1	49	1
Orthopedic Surgery	2	39	1
Otolaryngology/Maxillofacial	1	48	1
Urologic Surgery	3	40	3
Podiatry	1	36	0
TOTAL	47	43	33

PHYSICIAN RECRUITMENT

NMC has increased its Medical Staff by a net addition of 11 physicians over the periods shown below and maintains a continuing physician recruitment program. The following table indicates net additions and deletions to the Medical Staff over the following periods:

	FY 1992	FY 1993	FY 1994	YTD (7/31/95)	Total
Additions	3	1	6	7	17
Departures	2	4	2	1	9
Net Gains (Losses)	1	(3)	4	6	8

STAFFING, NURSING SERVICES AND EMPLOYEE RELATIONS

As of June 30, 1995, NMC employed 305 full time equivalent employees (FTEs) represented by 400 total employees, or 22.7 hours per adjusted patient day. The salaries, including fringe benefits, for these employees, represented approximately 54% of the total expenses of the Hospital for the nine months of fiscal 1995.

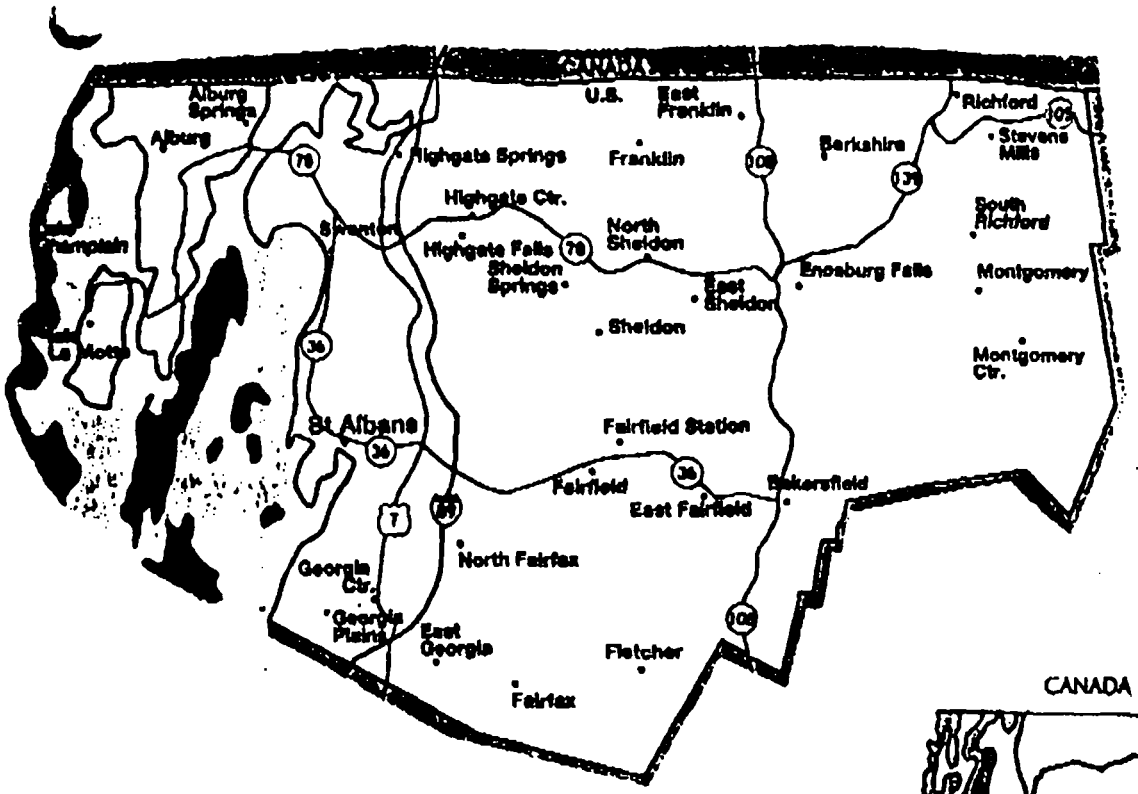
As of June 30, 1995, the Department of Nursing was comprised of 99 registered nurses, 41 licensed practical nurses, 8 technicians, 9 secretaries, 4 nurse's aides and 16 managers.

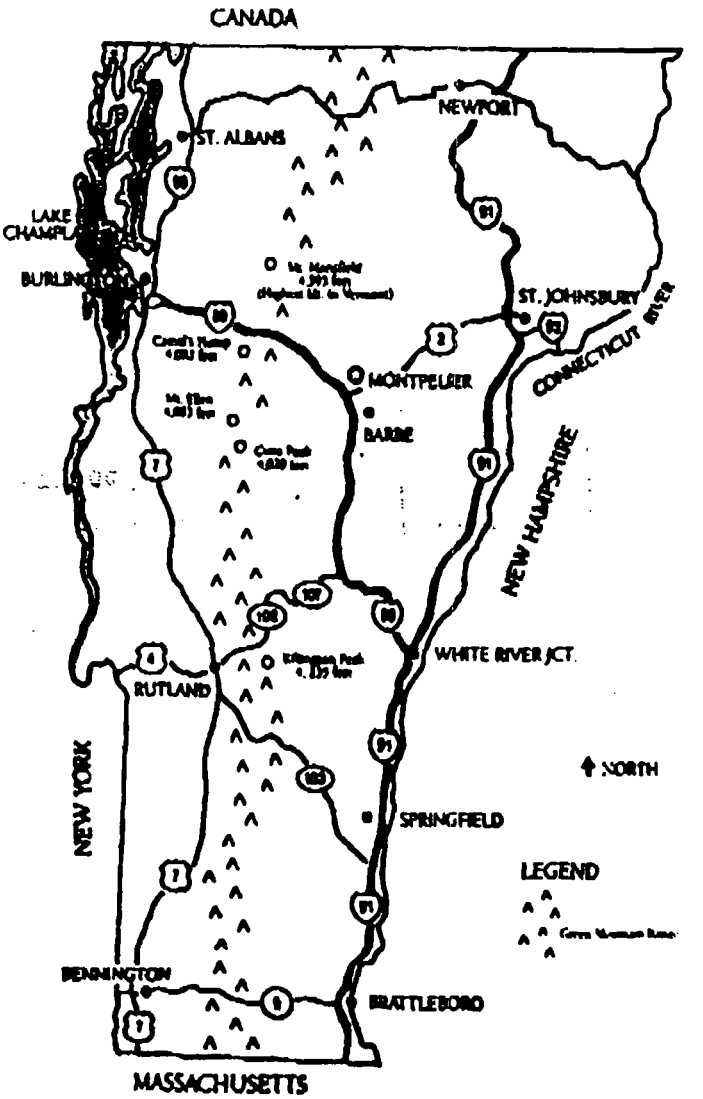
Employee turnover rates are as follows:

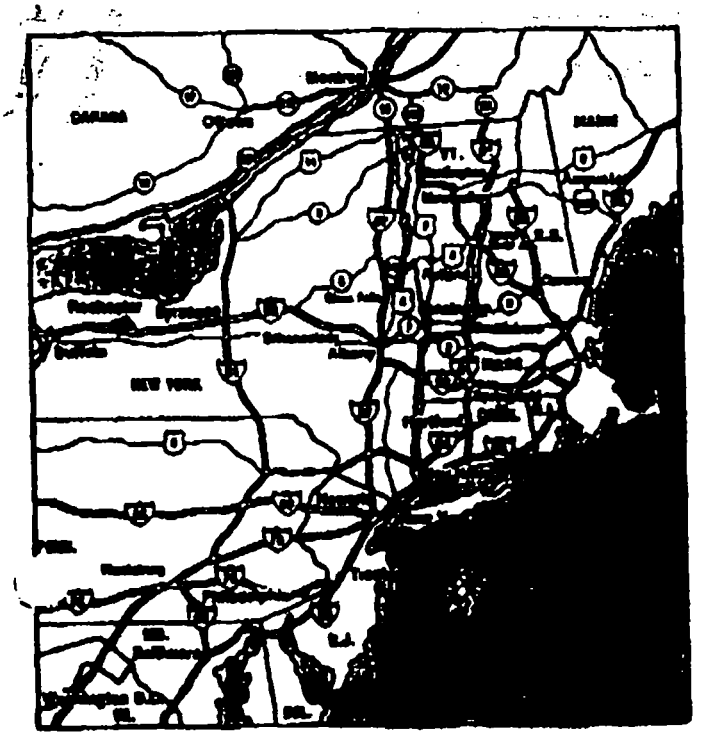
	NMC Hospital Wide	Hospital Wide Nat'l Average	NMC Nursing Personnel
FY 1993-94	12.0%	15.0%	10.8%
FY 1992-93	13.0%	14.4%	12.9%
FY 1991-92	13.5%	14.4%	9.9%

Over the last three years, average salary increases to employees were granted as follows: Fiscal 1995, 4.5%; Fiscal 1994, 5.0%; Fiscal 1993, 5.5%.

Northwestern Medical Center is located in St. Albans, Vermont and serves Franklin County & northern Grand Isle County — the northwestern corner of Vermont and New England.







PETER A. HOFSTETTER, FACHE
37 Smith Street
St. Albans, vt 05478
(802) 527-2815

EDUCATION: B.A., The American University, May 1974; Biology/Business Major - Hospital Administration

M.P.A., The American University, May 1977; Public Administration in Health Care

WORK EXPERIENCE

April 1994 - Present — Quorum Health Resources, Nashville, TN
CEO, Northwestern Medical Center, St.Albans, VT
70 Bed, JCAHO accredited facility, managed by Quorum

November 1988 to April 1994 — Quorum Health Resources, Nashville, TN
CEO, J. C. Blair Memorial Hospital, Huntingdon, PA
104 Bed, JCAHO accredited facility, managed by Quorum

May 1984 to November 1988 — Hospital Corporation of America/HMC, Nashville, TN
Administrator/CEO, Notre Dame Hospital, Central Falls, RI
45 bed, JCAHO accredited facility, managed by HCA.

March 1981 to May 1984 — Springfield Hospital, Springfield, VT
Director of Support Services/Acting Administrator
72 bed, acute care community hospital
Number two position, responsible in absence of Administrator

August 1979 to March 1981 — Temporary Nurses, Lyme NH
President/Owner
Business to assist area hospitals, nursing homes and private duty needs with staffing problems. TNI is a pool of nurses, available around the clock to supplement nursing shortages throughout the health system.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. resume	DOB (Partial) (1 page)	ca. 1995	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Jennifer Klein
OA/Box Number: 10854

FOLDER TITLE:
Rural [2]

2014-0209-S
ms740

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[002]

December 1978 – October 1980 — Dartmouth Medical School, Dept of Community and Family Medicine.
Facility, Field Activities Coordinator for the North Country Emergency Medical Services (EMS) Project; Liaison with the region's eight hospitals, physicians and nurses, development of evaluation strategies; coordination of regional planning and training activities; and assist with teaching of emergency medicine courses for Dartmouth medical students.

October 1977 to December 1978 — Arthur Young & Company, Washington, D.C.
Health Care Consultant
Member, Health Care Management Consulting Staff. Assigned to Emergency Medical Services and Burn Demonstration projects. Responsible for securing continued research through government and private grant funding.

October 1973 – October 1977 — Suburban Hospital, Bethesda, MD
Administrative Assistant - Emergency Department
350 bed community hospital, responsible for management of emergency Department's personnel, capital and operational budgets, development of physician referral system and establishment of Hospital as trauma center as part of the State of Maryland system.

Other positions held at Suburban Hospital include: Materials Management, Central Supply, Transportation Assistant, Nuclear Medicine. Internship co-sponsored by Hospital and American University.

AFFILIATIONS

American College of Hospital Administrators - Fellow

Vermont Hospital Association - Board of Directors

St. Albans Area Chamber of Commerce - Board of Directors

United Way - Franklin/Grand Isle

PERSONAL

(b)(6)

Married; two children; 5'11", 170 lbs; excellent health
Enjoy jogging, skiing, and most outdoor sports

References furnished upon request.

Effective 9-29-95
Incorporates New Senate Medicaid Formula,
New Senate Medicare Update Factor Reduction of -2.5%
and Selected CBO Estimates

PRELIMINARY ANALYSIS OF THE HOUSE AND SENATE MEDICARE REFORM PROPOSAL ON NEW YORK STATE

7-YEAR IMPACT 1996 TO 2002 - LOSSES IN $MILLIONS

REGION	TYPE OF FACILITY	FACILITY NAME	MEDICAID FEDERAL FUNDS		MEDICARE				
			HOUSE	SENATE	HOUSE	SENATE	BUDGET CAP/ LOOKBACK		
FLHC	HOSPITAL	F. F. THOMPSON HOSPITAL	$2.3	$2.0	$8.3	$10.0	$2.1	to	$5.8
		GENEVA REGIONAL HEALTH SYSTEM (ALL DIVISIONS)	$4.5	$3.9	$13.5	$15.7	$1.5	to	$4.1
		MYERS COMMUNITY HOSPITAL	$1.1	$0.9	$3.1	$3.9	$0.1	to	$0.3
		NEWARK-WAYNE COMMUNITY HOSPITAL	$4.3	$3.6	$10.7	$11.9	$2.2	to	$5.8
		SOLDIERS AND SAILORS MEMORIAL HOSPITAL OF YATES COUNTY	$2.1	$1.8	$4.6	$5.3	$1.0	to	$2.7
	NURSING HOMES	GENEVA GENERAL HOSPITAL LONG TERM CARE UNIT	$2.0	$1.6	Insufficient data to estimate facility-specific impacts				
		GENEVA NURSING HOME INC	$4.8	$3.7					
		NEWARK-WAYNE COMMUNITY HOSPITAL / DEMAY LIVING CENTER	$4.5	$3.5					
		THE HOMESTEAD OF SOLDIERS AND SAILORS MEMORIAL HOSPITAL	$3.5	$2.7					
		THOMPSON NURSING HOME INC	$5.7	$4.4					

5.6 - 8.0 nc
6.1 -/+ nc
7.7 - 9.1
3.5 2.7
11.2 12.5

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To Marilyn Yeager	From Harold Craig
Co. White House	Co. SAS Mem Hosp
Dept.	Phone # 315 536 4431
Fax # 202 456 6218	Fax # 315 536-0414

October, 1995

SOLDIERS & SAILORS MEMORIAL HOSPITAL
418 North Main Street
Penn Yan, New York 14527
(315) 536-4431

Since 1924, Soldiers & Sailors, a rural, not-for-profit, community hospital, has served residents and visitors in Yates County. Located in the central Finger Lakes region, one hour south of Rochester, the Hospital has experienced significant expansion of services, facilities and staff during the 1990's. The enclosed brochure (1992) does not list several projects completed since its publication.

- 217 beds: 49 medical-surgical, 4 intensive care, 12 psychiatric, 152 long term care
- 39 patient services
- 37 medical staff members
- 550 full and part-time staff (401 Full Time Equivalent positions)
- $20.1 million FY 1995 Operating Budget

Recent Facilities

February 1994	$ 6 million addition to existing long term care facilities: 72 beds, including 30 for multiply impaired residents; adult day health care for 10 participants; 2 respite beds
Spring 1996	Completion of a $1.5 million outpatient mental health center to house existing clinic and continuing treatment day programs

The Finger Lakes Rural Residency In Family Medicine

This innovative program was established in 1994 to train physicians to work in underserved rural communities. Soldiers & Sailors is a primary training site for inpatient medical services for six residents in partnership with the Rushville Health Center, Rushville, New York.

SOLDIERS AND SAILORS MEMORIAL HOSPITAL
PENN YAN, NY 14527

MEDICAID PROPORTION BY SERVICE
BUDGET 1995

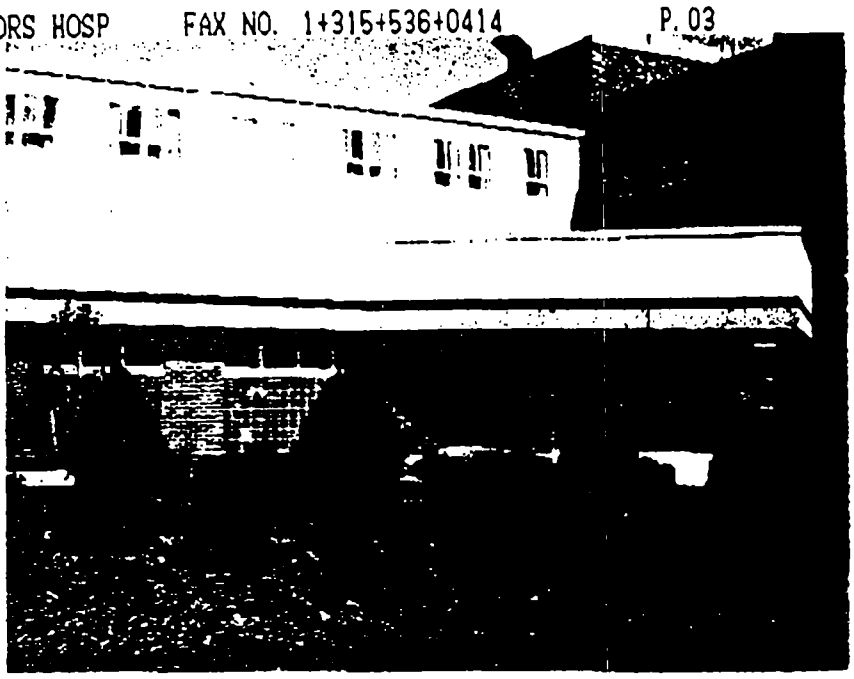
LONG-TERM CARE	74%
PRIMARY CARE CLINICS	43%
MENTAL HEATLH	
Inpatient	43%
Clinic	16%
Continuing Treatment	43%
ACUTE INPATIENT	3%
OVERALL	**35%**

MEDICARE PROPORTION
BUDGET 1995

OVERALL	**30%**

S&S

SOLDIERS & SAILORS MEMORIAL HOSPITAL



418 North Main Street
Penn Yan, New York 14527
315-536-4431

- THE HOMESTEAD
  ... Long Term Care
  536-4431
- DAISY MARQUIS JONES FAMILY HEALTH CENTER
  ... Outpatient Primary Care
  536-7409
- DUNDEE FAMILY HEALTH CENTER
  ... Outpatient Primary Care
  34 Millard Street
  Dundee, New York 14837
  607-243-7881
- OUTPATIENT MENTAL HEALTH CLINIC
  ...
  165 Main Street
  Penn Yan, New York 14527
  536-4461
- OUTPATIENT MENTAL HEALTH CONTINUING TREATMENT PROGRAM
  ...
  98 West Lake Road
  Penn Yan, New York 14527
  536-7417

"...Soldiers and Sailors is increasingly recognized as a rural hospital that is working toward continued growth, rather than simply hoping for it ... we are reshaping the Hospital for the 1990s and beyond to address a changing healthcare environment..."

John Kelly
S&S Administrator

An Introduction To Your Community Hospital ...

Since 1924, when Soldiers and Sailors opened, your community hospital has provided quality care to area residents and visitors to Yates County. Soldiers and Sailors was named to honor and memorialize individuals from our area who served in World War I, and the Hospital has proudly become one of our community's most important resources and its largest employer.

This publication is an introduction to our services, our staff and facilities and our plans for further expansion. Our commitment to providing accessible, affordable quality care involves our acceptance of a leadership role in identifying the healthcare needs of our region and working with local and regional agencies, and resource personnel, to address those needs.

Quality care requires excellence in staffing, equipment and facilities to support a diversity of hospital-based services and outreach programs. Soldiers and Sailors has, historically, attracted an outstanding medical staff, which is ably supported by highly qualified nursing, technical and support staffs.

Because we serve a rural area that has a population base of approximately 21,000, which is augmented by a sizeable number of summer residents, Soldiers and Sailors is cognizant of its role in providing services to those who have been underserved within the traditional healthcare system. The development of outpatient primary care services, located at the Hospital (Daisy Marquis Jones Family Health Center) and in nearby Dundee (Dundee Family Health Center), and the integration of inpatient and outpatient mental health services into our services program are examples of meeting such needs.

Community-based healthcare is an essential component of the quality of life available in our rural area. Soldiers and Sailors is appreciative for the strong support we have received throughout our decades of service to Yates County. The partnership between community and the Hospital has been an essential ingredient in our expansion of services, facilities and staffing.

Our directors, staff and I invite you to become better acquainted with Soldiers and Sailors, and we look forward to serving you.

John Kelly
Administrator

PATIENT SERVICES

Ambulatory Surgery
Anesthesiology
Audiology
Cardiology*
Clinical Laboratory
Coronary Care
Dentistry*
Diagnostic Imaging
- Angiography
- CT Scanning
- Echocardiography
- Fluoroscopy
- Interventional Radiology
- Mammography
- Ultrasound
- X-Ray

EKG
Emergency Medicine
Family Medicine
General Surgery
Gynecology
Inpatient Psychiatric Unit
Intensive Care Unit
Internal Medicine
Long Term Care
Neurosurgery*
Occupational Therapy
Ophthalmology
Orthopedic Surgery
Outpatient Mental Health
Pathology
Pharmacy
Physical Therapy
Podiatry
Respiratory Therapy
Social Work
Speech-Language Pathology
Sports Medicine
Urology*

*Consulting Basis

FACILITIES

Beds	
Acute Nursing	49
Intensive Care	4
Long-Term Care	80
Psychiatric	12

The original facilities of Soldiers and Sailors opened in 1924. Since then, expansion occurred in the 1950s and 1960s. The Medical Arts Building was added in 1973, and The Homestead in 1984. A $4 million building project, completed in 1991, involved renovation of every patient service area in the Hospital, including construction of a new emergency medicine department, entrance-lobby and registration-admission area.

A new intensive care unit; laboratory-phlebotomy area; an expanded physical therapy department; inpatient psychiatric unit; new radiologic equipment, including a CT Scan unit, and patient waiting areas were included in the recent project.

The modern facilities of Soldiers and Sailors afford accessibility and adequate working space for professional, technical and support staff.

Located on the the northern edge of Penn Yan, a village of 6,000, Soldiers and Sailors serves area residents and a large number of seasonal residents who have vacation homes along Keuka, Seneca, Waneta and Lamoka lakes.

A $6 million expansion of the long-term care facility, The Homestead, will be completed in early 1994. 72 additional beds and an adult day healthcare area will be included in this new venture.

PROFESSIONAL STAFF
January, 1993

NURSING PERSONNEL: 175

Acute Medical-Surgical, Emergency Department, Operating Room, Nursing Administration, Intensive Care Unit

	Full Time	Part Time	PRN/ Casual	Per Diem	Totals
RN	32	11	1	16	60
Graduate Nurse	3	1			4
LPN	16	1		1	18
Graduate Practical Nurse		1			1
Nursing Assistant	2	4			6
OR Aide	1				1
	54	18	1	17	90

Long Term Care

	Full Time	Part Time	Casual	Per Diem	Totals
R.N.	4	4	1	3	12
L.P.N.	8	4	1		13
Nursing Assistant	18	24	1		43
Restorative Aide		1			1
	30	33	3	3	69

Inpatient Psychiatric Unit

	Full Time	Part Time	Casual	Per Diem	Totals
R.N.	4	4			8
Graduate Nurse					
L.P.N.	1	1			2
	5	5			10

Outpatient Mental Health & Outpatient Primary Care

	Full Time	Part Time	Casual	Per Diem	Totals
Pediatric Nurse Practitioner	1				1
R.N.	2	1			3
L.P.N.	2				2
	5	1			6

Number of Full-time Equivalent Positions: 303
Total Number of Employees: 388
1992 Salary Budget: $6,330,935
1992 Employee Benefits Budget: $1,315,443

MEDICAL STAFF: 28

Senior
Ted D. Barnett, M.D.
Michael J. Boquard, M.D.
J. Mark Costenbader, M.D.
William H. Dean, M.D.
Timothy J. Dennen, M.D.
Eleanor H. DeWitt, M.D.
Mary D. Driesch, M.D.
Steven Lasser, M.D.
Norman W. Lindenmuth, M.D.
Robert W. McLaughlin, M.D.
Karen E. Mead, M.D.
Stephen Payne, M.D.
James Sakr, M.D.
Paul A. Shapiro, M.D.
Charles L. Stackhouse, M.D.
William F. Ware, M.D.
William P. Welbourne, M.D.
Laurence Wildrick, M.D.

Associate
Frank O. Bonnarens, M.D.
Jan Kohl, M.D.
Stewart Lipson, M.D.

Emergency Medicine
Olusola Akindele, M.D.
Lauren E. Costello, M.D.
William Craig-Kuhn, M.D.
Frances Mifsud, M.D.
William Remington, M.D.
Ravi Singh, M.D.
John K. Sullivan, M.D.

During the past three years Soldiers and Sailors has:

- Completed a $4 million construction-renovation project
- Added a 12-bed psychiatric unit
- Assumed management of outpatient mental health services
- Opened the Daisy Marquis Jones Family Health Center
- Invested $1.3 million in radiology equipment, including a new CT Scan Unit
- Added services and a full-time physician at The Dundee Family Health Center
- Increased staffing to 388, 30% growth; S&S is the largest employer in Yates County
- Expanded surgical services
- Begun a $6 million expansion of The Homestead, involving 72 additional long term care beds, services for the multiply impaired, adult day healthcare and respite beds

LOCATION

Penn Yan, the county seat of Yates County, is located in the heart of the Finger Lakes region of central upstate New York. Situated at the northern end of Keuka Lake, Penn Yan, a village of 6,000, is approximately 50 miles southeast of Rochester. Within an hour's drive are Elmira, Ithaca, Corning, while Syracuse is 1 1/2 hours by car.

A rural area, Yates County is characterized by its natural resources and beauty, agricultural and tourism industries, wineries and small town environment. Its serene hills and lakes afford bountiful opportunities for recreational activities.

Extensive information regarding Yates County and the Finger Lakes region is available from:

The Finger Lakes Association
309 Lake Street
Penn Yan, New York 14527
(315) 536-7488

Penn Yan Area Chamber of Commerce
104 Lake Street
Penn Yan, New York 14527
(315) 536-3111

John D. Kelly

Career Highlights

Chief Executive Officer, Soldiers & Sailors Memorial Hospital

- Developed high quality programs in Medical Care, Emergency Services, Long Term Care, Inpatient Psychiatry, Outpatient Psychiatry, Primary Care
- Completed 3 major building projects, totalling $13 million
  - Complete renovation of acute care hospital: 1990
  - New 80 bed long term care facility: 1984
  - New 72 bed long term care addition: 1994
- Quadrupled revenue base from $5.0 million to $20.0 million
- Increased Long Term Care capacity from 24 to 152 beds and Adult Day Health Care Program
- Developed Primary Care to provide access for entire community in one of poorest counties in New York State
- Developed first and only inpatient psychiatry unit in County
- Completed 12 years in reimbursement experiment, including global budget program for inpatient acute care. This program was rural equivalent to Rochester, New York experiment
- Participated in several grant projects funded by National Institute of Health, Health Care Financing Administration, New York State Department of Health
- One of only, if not only, hospitals in area not to have been in enforcement action by New York State Department of Health
- Developed one of first long term care units for multiply-impaired
- Community activities included coordinating village inclusion in first coordinated watershed arrangement program in the Finger Lakes Region
- Doubled employment base for institution and community
- Connected institution to newly formed Rural Residency in family medicine of the University of Rochester

- Active in Multi institutional planning and other activities of 4 county hospital consortium

- All achievements occurred in one of the most difficult hospital environments in the United States; a federally designated rural hospital in the most regulated state. During the same period 4 similarly sized or larger hospitals in same area closed or converted operations.

JOHN D. KELLY

Home Address:
447A East Lake Road
Penn Yan, New York 14527
(315) 536-7930

Business Address:
Soldiers & Sailors Memorial Hospital
418 North Main Street
Penn Yan, New York 14527
(315) 536-4431

WORK EXPERIENCE:

PRESIDENT, SOLDIERS & SAILORS MEMORIAL HOSPITAL OF YATES COUNTY, PENN YAN, NEW YORK, 1994-Present.

CHIEF EXECUTIVE OFFICER, 1982-1994

Developed and manage $20 million rural health organization which includes acute care hospital, long term care facility, satellite ambulatory care facility, hospital-based primary care practice, in and out patient mental health services, foundation and active role in development of Family Medicine educational consortium within a unique hospital multi-institutional environment which includes reimbursement demonstration with Global Budget, joint planning activities and shared service development. Successful in improving financial position of facility including break even performance over 11 year period despite constraints of New York health care environment and Federal reimbursement penalties.

Area activities have included: serving for 3 years as chairman of the administrators' committee of FLAHC, a six member hospital consortium which developed and administered the only rural health reimbursement demonstration in the Nation and joint planning and development of an allocated CT service; membership on statewide HANYS Health Services Committee; membership on the Board of Rochester Regional Hospital Association; membership on group of community leaders to deal with common administrative problems and broad community issues; membership on Human Resources Committee of Yates County Planning Board; membership on School Board Task Force to analyze area business perspective on educational needs; membership in Keuka Lake Watershed Task Force to develop inter-community approach to watershed protection.

John D. Kelly

ASSISTANT ADMINISTRATOR, CHENANGO MEMORIAL HOSPITAL AND ADMINISTRATOR, SKILLED NURSING FACILITY, CHENANGO MEMORIAL HOSPITAL, NORWICH, NEW YORK, 1977-1982

Managed Professional Services Division as Assistant Administrator, for acute hospital, with active Out Patient Department. Managed Skilled Nursing Facility. General staff responsibilities for hospital included Certificate or Need projects, creation of a satellite laboratory for another hospital, renovation and expansion of Skilled Nursing Facility.

FINANCIAL MANAGER, CAPTAIN, UNITED STATES AIR FORCE, WRIGHT-PATTERSON AIR FORCE BASE, OHIO, 1972-1975

Managed $82 Million Research, Development and Production funds for acquisition of air transportable 4,500 man Air Force Base, including Modular Air Transportable Hospital.

BASE BUDGET OFFICER, LIEUTENANT, UNITED STATES AIR FORCE, JOHNSTON ATOLL AIR FORCE BASE, THE PACIFIC, 1971-1972

Managed $7.8 million operating and maintenance budget for Atomic Energy Commission. Pacific Nuclear Testing Site. Facilities included a 2 physician remote site hospital.

EDUCATION:

CORNELL UNIVERSITY, GRADUATE SCHOOL OF BUSINESS AND PUBLIC ADMINISTRATION, SLOAN PROGRAM IN HOSPITAL AND HEALTH SERVICES ADMINISTRATION, ITHACA, NEW YORK, 1975-1977

Masters Degree (M.P.S.-H.H.S.A.). Courses included Managerial and Cost Accounting, Hospital Financial Management, Planning Analysis, Hospital Operations Management, Hospital Corporate Planning, Hospital Labor Relations and Personnel Administration.

John D. Kelly

ST. ELIZABETH MEDICAL CENTER, DAYTON, OHIO, SUMMER 1976

Administrative residency in 552 bed acute care hospital, affiliated with medical school through Family Practice residency program.

WRIGHT STATE UNIVERSITY, DAYTON, OHIO, 1972-1974

Part-time graduate and undergraduate courses in Calculus, Demography, Population Analysis and Economics.

GROVE CITY COLLEGE, GROVE CITY, PENNSYLVANIA, 1966-1970

Arts Baccalaureate Degree in English Literature.

LICENSES: Nursing Home Administrator, New York State.

Projection for Medicare Revenues 1996-2002
Under the Senate Finance Reconciliation Proposal
(in thousands of dollars)

Hospital: SPELMAN ST LUKES NORTHLAND HOSPITAL
Address: PO BOX 289
SMITHVILLE, MO, 64089
Medicare Id: 260062

Fiscal Year	Current Law Revenue (in $1000s)	Proposed Payment Cuts (in $1000s)	Estimated Revenue Decrease (in $1000s)
1996	$3,653	$3,521	$-132
1997	3,898	3,694	-204
1998	4,182	3,886	-296
1999	4,490	4,043	-446
2000	4,825	4,253	-572
2001	5,172	4,461	-711
2002	5,559	4,694	-865
Total 1996-2002	31,778	28,552	-3,226

Saint Luke's Northland Hospital
SAINT LUKE'S HEALTH SYSTEM

Background Information

Saint Luke's Northland Hospital

Missouri

Saint Luke's Northland Hospital is a two-campus health care facility in the northern Kansas City, Mo. suburbs. The 92-bed Smithville Campus, Smithville, Mo., is in Clay County; the 55-bed Barry Road Campus, Kansas City, is in Platte County. The campuses are governed by a single board of directors and served by one medical staff of more than 340 physicians. The hospital is part of Saint Luke's Health System.

The Smithville Campus, the northern metropolitan area's first hospital, provides skilled nursing care, inpatient rehabilitation services, mental health care for adults and seniors, home care, transportation services, basic emergency care and urgent care services.

The Barry Road Campus is Platte County's only acute care hospital. It provides medical/surgical care, intensive care, comprehensive outpatient services, 24-hour emergency care, radiology services, surgical services and maternity care with a level II nursery.

Smithville Campus

- Percentage of Gross Inpatient and Outpatient Revenue
  - Medicare 71.0%
  - Medicaid 9.8%
  - Insurance 16.5%
  - Self-pay, Charity, Other 2.7%

-more-

Barry Road Campus

- Percentage of Gross Inpatient and Outpatient Revenue
  - Medicare 28.9%
  - Medicaid 3.3%
  - Insurance 62.5%
  - Self-pay, Charity, Other 5.3%

- Saint Luke's Northland Hospital's Barry Road Campus serves Platte, Clay and southern Buchanan counties in northwestern Missouri. It is located in suburban Kansas City, 12 miles southwest of the Smithville Campus.

- This facility was previously named Spelman/Saint Luke's Hospital after its 1989 founding as a joint venture between Spelman Memorial Hospital, now the Smithville Campus, and Saint Luke's Hospital of Kansas City.

- In June 1995, the Barry Road Campus hosted a ground-breaking ceremony to celebrate the beginning of its $11 million expansion and renovation project. When completed, the project will nearly double the size of the emergency, maternity, radiology and surgery departments. More than 40,000 square feet will be added to the facility, and 20,000 square feet will be renovated.

- Since opening in 1989, the Barry Road Campus has recorded significant increases in the volume of patients served. In its first five years, patient visits in the emergency department increased by nearly 70 percent; the Maternity Center experienced a 280 percent increase in the number of babies delivered; and the surgery and radiology departments posted more than 100 percent increases in utilization.

-more-

Saint Luke's Health System

- Saint Luke's Health System provides a range of primary, acute, tertiary and chronic care services at multiple locations throughout the Kansas City area. The system includes Saint Luke's Hospital of Kansas City; Saint Luke's Northland Hospital; Crittenton, the metropolitan area's premiere provider of psychiatric care for children and families, and its subsidiaries; Wright Memorial Hospital, Trenton, Mo.; and Anderson County Hospital, Garnett, Kan.

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- Saint Luke's Northland Hospital's Smithville Campus serves Clay, Platte, southern Buchanan and southern Clinton counties in northwestern Missouri.

- Smithville, located on the northern fringe of the metropolitan area, has a population of approximately 2,500. The hospital is the area's largest employer with an annual payroll of $4 million.

- The Smithville Campus, which was founded in 1938 by local rural physician Arch E. Spelman, was called Spelman Memorial Hospital until 1993. At that time, both campuses changed their names and officially merged as one hospital.

- As northern metropolitan Kansas City's first hospital, the first baby in this area to be born in a hospital was born at the Smithville Campus. This facility was also the site of the area's first intensive care unit, the first home care agency and the first rehabilitation center.

- In 1995, a change in services was completed that consolidated acute care, surgical services and intensive care at the Barry Road Campus. Services now provided in Smithville include skilled nursing care, inpatient rehabilitation services, mental health care for adults and seniors, home care, transportation services, basic emergency care and urgent care services.

- This facility is under going nearly $400,000 in renovations to make room for new primary care physician offices and a new Urgent Care Center.

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Saint Luke's Northland Hospital
SAINT LUKE'S HEALTH SYSTEM

Background Information

Don Sipes

Missouri

- Sipes has a dual role with Saint Luke's Health System. He is the chief executive officer of Saint Luke's Northland Hospital's Smithville Campus in Smithville, Mo. and the corporate director of regional services for Saint Luke's Health System, Kansas City, Mo.

- As chief executive officer of the Smithville Campus, Sipes provides leadership in the development of a health system that bridges different sites and services and offers a continuum of health care that is known for quality. Sipes is primarily responsible for strategic planning and for relations with surrounding communities.

- Sipes is also responsible for overseeing health services for the Saint Luke's Health System's outlying facilities, including Wright Memorial Hospital in Trenton, Mo., the hospital affiliate relationship with Atchison Hospital in Atchison, Kan. and the operational relationship with Anderson County Hospital in Garnett, Kan.

- Before joining Saint Luke's, Sipes was the chief executive officer of the General John J. Pershing Memorial Hospital Association in Brookfield, Mo. He was with Pershing Memorial for more than 12 years and had responsibility for its three facilities, including the Brookfield facility, Pershing Regional Health Center in Marceline, Mo. and Keytesville Medical Clinic in Keytesville, Mo. He previously served as an assistant administrator at Wright Memorial Hospital in Trenton.

- Among Sipes' achievements is the successful 1988 merger of two health systems and the 1992 addition of a third. Today the trio of health facilities continues to offer a wide array of accessible services.

-more-

- Following are Sipes' professional memberships and leadership duties:
    - Chairman of the Missouri Hospital Association's board of trustees
    - Member of the Missouri Hospital Association's board of directors
    - District chairman of the Association of Independent Hospitals
    - Diplomate in the American College of Healthcare Executives
- Sipes earned a master's degree in management and supervision in health care administration at Central Michigan University in 1984. In 1973, he attended the School of Medical Technology at North Kansas City Hospital. He earned a bachelor of science degree from the University of Missouri in 1972.
- Sipes is a native of Trenton, Mo.

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West Side District Hospital

Serving the Community for Over 45 Years

Hospital Size

Acute Care Beds - 21
Skilled Nursing Beds - 63
Full Time Employees - Approximately 160

Hospital Services Provided

Acute Care
24-Hour Emergency Department
Skilled Nursing
Surgery
Cardio/Pulmonary
CT Scan
Radiology
Laboratory
Air Ambulance
Family Medical Clinic

Location

City of Taft. Approximately 40 miles southwest of Bakersfield, CA and 150 miles north of Los Angeles. Primary economic base - petroleum industry.

Service Area

Hospital serves a district of approximately 23,000 people.

Margo A. Arnold

Chief Executive Officer
West Side District Hospital
110 E. North Street
Taft, CA.
(805) 763-4211

Professional Experience

Over 20 years of management experience in the areas of healthcare, finance, personnel, strategic planning and regulatory compliance.

Chief Executive Officer, West Side District Hospital and Skilled Nursing Facilities. 1994 to Present. Administer policies and procedures, advise governing board, provide financial oversight and maintain cost effective operations. Driving force behind a positive financial turn-around of $1.4 million on a $10 million budget within a nine month period of time.

Marketing and Foundation Director, West Side District Hospital and Foundation. 1991-1994. Directed the marketing and business development of hospital services and managed fundraising and operations of hospital foundation.

Vice President, Taft National Bank. 1987 to 1991. Reviewed, approved and funded commercial and consumer loans; reviewed federal banking regulations and implemented consumer loan compliance procedures.

Branch Manager, First Interstate Bank. 1985 to 1987. Managed full service bank with a loan portfolio of $8.5 million and liabilities of $18-19 million.

Financial Services Officer, Bank of America. 1970 to 1985. Managed branch sales, training and customer service and administered human resources policies and procedures.

Professional Associations

President, Kern County Board of Trade. 1995-1996.

Vice President, Kern County Board of Trade. 1994-1995.

Member, Association of Long Term Care Administrators. 1994 to Present.

Chairman, Council on Competitiveness Business Retention. 1994 to Present.

Hospital Council Representative, Rural Hospital Conference. Washington D.C. 1995

Speaker, Bakersfield Women's Business Conference. 1995.

Speaker, Kern County Business Outlook Conference. 1994.

Legislative Deputy, Kern-Eastern Sierra Hospital Council. 1991-1994

Woman of the Year, Soroptimist International, Taft. 1991 and 1992.

GRINNELL REGIONAL

Health Care for Life

Grinnell Regional Medical Center in Brief

Grinnell Regional Medical Center is a modern 81 bed licensed facility accredited by the JCAHO (Joint Commission on Accreditation of Healthcare Organizations). The hospital was established in 1968 following the merger of Grinnell Community and St. Francis Hospitals. The name was changed from Grinnell General Hospital in 1994 to better denote the broad range of services available at the hospital and the expanded geographical area being served.

GRMC serves approximately 30,000 residents in a five county area in east central Iowa.

GRMC employs approximately 350 staff members, 52% of whom do not live in Grinnell, and is the area's sixth largest employer.

An active 25 member medical staff services the hospital. The staff consists of: 4 surgeons; 2 internists; 2 radiologists; 2 anesthesiologists; 1 orthopedic surgeon; 1 ear, nose and throat surgeon; 1 urologist; 1 pathologist; and 11 family practitioners. The hospital continues to actively recruit new physicians and has received a commitment from two new internists for 1996.

Grinnell Regional Medical Center continues to show increasing patient activity and growth. In 1994 the hospital recorded: 2,371 inpatient admissions, 31,459 outpatient visits, 123,257 outpatient procedures, 18,188 home health visits, and 232 births.

The strong patient activity has meant equally strong financial growth, making Grinnell Regional Medical Center a successful health care institution and an important contributor to the area economy.

1994 financial brief:

- Gross revenue.....$21,200,000
- Medicare discount.....$5,000,000
- Total payroll.....$6,800,000

In compiling the 1994 community benefits study for a statewide survey conducted by Drake University, it was determined that GRMC had a significant economic impact on the greater Grinnell community through subsidized services, health promotions, civic involvement, health education and community funding. Through these services almost 6,000 individuals were directly served by the hospital. Additionally, Grinnell Regional Medical Center provided care but did not receive payment for services in the amount of $354,886.

Grinnell Regional Medical Center is striving to become the benchmark for rural health care and is dedicated to meet the essential health care needs of the residents of the area. This bold vision for the future is based on strong tradition and a commitment to responsive, efficient and effective health care. This vision ensures a bright future for GRMC and the families, friends and neighbors we serve.

210 Fourth Avenue • Grinnell, Iowa 50112 • Phone: 515-236-7511 Fax: 515-236-4048

TODD C. LINDEN

Todd Linden is president and CEO of Grinnell Regional Medical Center, an 81 bed private, non-profit hospital in Grinnell, Iowa. Prior to this position he served five years as the administrator of Greene County Medical Center in Jefferson, Iowa.

Linden received his Master of Arts in Health Administration degree in 1987 and a Bachelor of Arts degree in 1984, both from the University of Iowa. He then completed a Fellowship at Iowa Methodist Medical Center in Des Moines, Iowa before joining Greene County Medical Center in 1988. In January of 1994 he was appointed to his current position in Grinnell.

In 1990 Linden received the Iowa Hospital Association's "James B. Seaman, II Young Administrator's Achievement Award". In 1992 he was named one of 24 young business leaders for the state by the Des Moines Register, and received the Iowa Jaycee's "Top Ten Outstanding Young Iowans" award in 1994. Linden served as Chair of the Iowa Hospital Association's Committee on Small and Public Hospitals from 1992 to 1994 and is currently serving on the association's board of directors. In 1995 Linden was recognized by Modern Healthcare as one of their twelve up and comers for the year.

Linden is an adjunct faculty member in the health care administration program at the University of Iowa in Iowa City and the University of Osteopathic Medicine and Health Sciences (UOMHS) in Des Moines. At UOMHS he was chosen to receive the "Student Choice Award" two of the past three years.

In June of 1993, Linden testified to the United States House of Representatives' Ways and Means Subcommittee on Health for a hearing on healthcare reform.

Linden currently is an alternate at large delegate to the American Hospital Association's (AHA) House of Delegates; a governing council member for AHA's Section on Aging and Long Term Care; an officer on the Healthcare Cooperative of Iowa board of directors; is chair of the Iowa Telemedicine Advisory Council; and is a diplomat of the American College of Healthcare Executives.

Locally, Linden serves on the Grinnell 2000 board, Poweshiek Area Development board, and the Greater Poweshiek Community Foundation board.

Linden is married to Kellie, and they have three children, Davis 10, Courtney 6, and Grant 2.

Week in healthcare: *Government settles PHO antitrust cases* *GOP Medicare plan to trim teaching payments*

Modern Healthcare

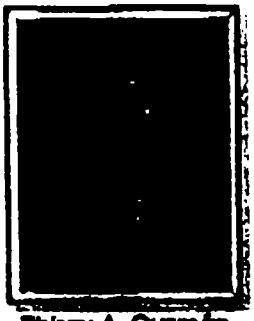
Sept. 18, 1995

WEEKLY BUSINESS NEWS


Elizabeth Alhand


Sue G. Brody


Arthur Ginsberg


Tibisay A. Guzmán


Shelley A. Horwitz


Peter Lawson


Todd Linden


Gary Mendoza


Donald R. Smithburg


Thomas P. Sokola


David Strand


Britt Travis

1995 UP & COMERS

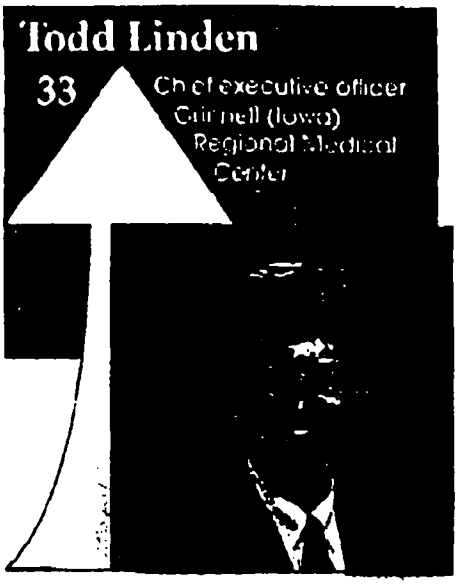
Page 31

Cover story

UP COMERS 1995

THEY REFUSE TO BE CONSTRAINED by the ways of the past. They're working to improve the quality of medical care, expand access to healthcare and formulate a cost-efficient delivery system best suited to the needs of the 21st century.

They're *Modern Healthcare's* 1995 Up & Comers, a group of healthcare professionals all 40 years old and younger nominated by the magazine staff and its readers as examples of the best healthcare has to offer. Here is our annual roster of healthcare's rising young stars.



Todd Linden's healthcare roots run deep.

The son of a hospital executive, Linden started working odd jobs at hospitals as a teen-ager in Boone, Iowa. He became familiar with all facets of hospital work and loved each one, including his first task as a 14-year-old groundskeeper at 57-bed Boone County Hospital.

"He worked in a lot of different departments, like the billing clerk's office and with the maintenance engineer, and then he would come home and ask, 'Dad, do you think there is a better way to do that?'" said Chuck Linden, a longtime chief executive officer of Boone County Hospital. Chuck Linden now serves as president of regional health services at Iowa Health System in Des Moines. "He was always interested in finding out how everything worked."

It's that inquisitive nature that has led 33-year-old Todd Linden to be a leader on several important Iowa healthcare issues.

At his first professional job as an administrator at Greene County Medical Center in Jefferson from 1988 to 1993, he came across a few men tearing up some newly seeded lawn at the hospital campus.

"They told me they were laying fiber-optic cable across the state," said Linden, now the president and chief executive officer of 81-bed Grinnell (Iowa) Regional Medical Center. "I wondered what was going on, so I started making some calls."

Linden discovered the state was going to use the fiber-optic telephone cable to link all 99 Iowa counties in a network. The cable allows the transmission of digital images from computer to computer. Schools and colleges were to be the original benefactors of the network.

But Linden figured the state's investment also could benefit healthcare.

So he continued to study the fiber optic system after coming to Grinnell in January 1994. His curiosity caught the attention of Iowa Gov. Terry Branstad, who appointed Linden chairman of the Iowa Telemedicine Advisory Council in February of that year. Among his duties, Linden helped lobby the state Legislature to have hospitals included in the $182 million network.

By the end of the 1994 spring legislative session, the state's 120 hospitals were given approval to tap the system for telemedicine uses as well as other medical, educational and information applications.

"Todd's interest in legislative issues really helps us," said Steve Brenton, president of the Association of Iowa Hospitals and Health Systems. "He's active on the cutting-edge issues."

Linden's also been at the forefront of many questions affecting rural hospitals. During congressional healthcare reform debates in 1993, Linden testified before the House Ways and Means health subcommittee on the importance of hospitals to rural communities.

During his 5½-year tenure at 53-bed Greene County Medical Center, Linden spearheaded an $8 million development project that featured a 33-unit retirement facility owned by the hospital. The development incorporates acute care, skilled care, a nursing home, home healthcare and public health all under one organization. Those services are key to Iowa towns like Jefferson with many elderly residents among its 4,300 population.

Those accomplishments drew the attention of a recruiter in late 1993. Although Linden wasn't looking for a job, he was floated an attractive offer at Grinnell.

Midway between Iowa's capital city, Des Moines, and Iowa City, home of Linden's alma mater, the University of Iowa, Grinnell offered several opportunities.

In addition to his hospital duties, he teaches part-time as an adjunct faculty member at the University of Iowa's hospital and health administration program. He has a similar role at the University of Osteopathic Medicine and Health Sciences in Des Moines.

"Teaching is very educational for me and helps me to stay sharp," Linden said. "It's a lot of fun and a nice diversion."

Linden is also working on ways students at Grinnell College, a prominent liberal arts college, can work healthcare internships into their undergraduate studies.

Under Linden's leadership, Grinnell Regional Medical Center is coming off the most profitable year in its 27-year history. The hospital reported net income of nearly $1.9 million on net revenues of $17 million in 1994, according to HCIA, a Baltimore-based healthcare information company.

But when it comes to giving credit where credit is due, Linden points to the people around him.

"I have truly been at the right place at the right time, and fortunate to be surrounded by great boards, physicians and staffs," Linden said.

He credits his father and mother, Judith, with influencing his career choice.

"My father was a fabulous healthcare administrator who could keep the balance between professional life and family life," Linden said. He and his wife have three children. "I may come back in and work until midnight or later but only after the kids go to bed," he said.

—Bruce Japsen

Senator Harkin Medicare Press Conference
September 20, 1995

When you spend your energies about what you are against it weakens you. When you spend you energies FOR something it empowers you!

Mother Teresa

I am here today to spend some energies for the people that depend on Grinnell Regional Medical Center.

Medicare is a very important program for millions of Americans. Put quite simply, people depend on it. Hospitals across this country are concerned about the magnitude of the proposed reductions in payment growth. The proposed rate of growth in payments is less than the amount needed to cover new enrollment and general inflation. Access and quality could suffer and suffer substantially in rural areas.

We realize there will be cuts, but we must ensure that the reductions are achieved in the most responsible manner possible.

The system must be reformed.

There is no way so much money can be taken out of the system without real reductions in patient care quality and access. It will mean loss of jobs, which would also be economically damaging for many rural communities. The magnitude of proposed reductions is just too much, too soon.

I am as concerned about reducing the national debt for the benefit of my children as are most other Americans. But I m also concerned about the potential damages to our ability to

meet the needs of out patients. A substantial portion of the proposed tax cuts could be used to offset Medicare spending reductions. This would reduce burden on providers and seniors while dampening partisan rhetoric surrounding the tax cut issue.

Congress will pursue Medicare reform strategies which will involve the voluntary movement of millions of seniors into health plans and HMOs, it is equally clear that the existing underlying payment methodology (AAPCC) for managed care plans is so seriously flawed as to virtually undermine any chance of success in low cost, rural states like Iowa.

As that great American philosopher Yogi Berra said, You can see a lot by looking!

So lets take a look at some of the concerns:
A health plan under the proposed HMO for Medicare in Greene County Iowa would get $266 per month per covered member compared to Dade County Florida which would receive $615 per month. That s 172% difference, yet the covered seniors paid exactly the same amount into the Medicare program!! There is a serious fairness issue here!

The conservative practice of medicine in the upper mid west has placed Iowa and other rural states at a tremendous disadvantage in the reimbursement process. In other words, if you are an efficient provider of quality care, you are at a disadvantage.

I would support an independent commission to help take Medicare out of the partisan political process. Hard choices are going to need to be made, and this commission could help keep the politics out of it.

Another example of reform would be to let hospitals and doctors directly contract with Medicare to provide managed care services to seniors.

WW II parachute packers had an unacceptable record: nineteen out of twenty parachutes opened. The manager discovered that by allowing the packers the pleasure of testing their parachutes by jumping form a plane, quality rose to 100%.....I suggest members of congress put there feet in the shoes of seniors and providers and put efforts toward reforming the Medicare system before they push us out of the airplane.

Todd C. Linden
President and CEO
Grinnell Regional Medical Center
Grinnell, Iowa 50112
515-236-2301

Methodology for Computing
The Impact of the Republican Budget Cuts on Rural America

Health Care Data

I. Number of rural Medicare beneficiaries is from HHS. Medicare spending cut in each state based on July 28, 1995 HHS estimates of the Congressional budget resolution. Rural and urban hospital profit margins also are from HHS. Average share of rural hospitals' net patient revenues in 1993 is from Frenzen, 1995. The typical rural hospital's loss of Medicare funding under the Senate Republican Medicare plan is from the American Hospital Association, October 6, 1995. Estimates of the shortage of primary care physicians in rural areas is from Mueller, 1995.

II. Number of persons in nursing homes from the National Center for Health Statistics analysis. Estimates of the number of rural Americans and rural children who will be denied Medicare coverage are from HHS based on the Congressional budget resolution.

Farming Data

I. USDA estimates of farm cuts based on Congressional Budget Resolution targets relative to current law baseline.

II. Impact of farm income based on USDA analysis.

Earned Income Tax Credit Data

I. Estimates of the number of taxpayers affected, average tax cut,and aggregate impact of cuts from Department of Treasury analysis of the Senate Finance Committee EITC proposal.

Education

I. Department of Education analysis of Title I spending cuts based on FY 1996 House Appropriations bill relative to Fiscal Year 1995 Appropriation level.

Public Health and Environment

I. EPA estimate of spending cuts based on FY 1996 House Appropriations bill compared with the President's budget request and state reported data, including data compiled by the Council Infrastructure Financing Authority. Effect of spending cuts on toxic waste clean-up compiled from EPA Superfund database.

Transportation

I. DOT estimate of Section 18 funding based on FY 1996 House Appropriation bill relative to Fiscal Year 1995 Appropriations.

Nutrition

I. USDA analysis of food assistance cuts based on the House-passed Personal Responsibility Act (passed in April 1995), compared to current law baseline.

Housing

I. HUD estimates of spending on public housing capital reflects spending levels proposed in FY 1996 House Appropriations bill compared to the President's request for consolidated public housing programs.

II. HUD estimates of homeless assistance based on spending levels proposed in FY 1996 House Appropriations bill and current formula allocation for the Emergency Shelter Grant Program.

Methods for the State Rural Analysis

1. **Medicare**: The estimates of the number of rural beneficiaries and the Medicare loss are based on the county analysis released August 8, 1995. In that study, the Conference Agreement Medicare cuts were allocated to states and counties in proportion to the Medicare spending in those counties. For instance, if a county received 1% of all Medicare payments, then its Medicare loss over seven years would be equal to $270 billion (the Conference Agreement seven-year savings) multiplied by 1%. The beneficiary counts are based on 1991 data updated to 1994. The county estimates were converted to metropolitan and non-metropolitan estimates for this analysis.

2. **Medicaid**: Three estimates are presented at the state level. The number of rural nursing home residents comes from the National Center for Health Statistics. The number or community-based poor elderly with long-term care needs comes from the Census Bureau, and is based on self-reported questions related to activities of daily living. The national number of rural Medicaid beneficiaries losing coverage and the dollar loss to rural areas are estimated assuming that states reduce their spending and coverage proportionally. According the Current Population Survey, approximately 25% of Medicaid recipients live in non-metropolitan areas.

* will Arrive Friday at 10 am

	Medicare Enrollment: 1994			
	Rural	Urban	Total	% Rural
US	9,637,000	26,614,405	36,251,405	27%
Alabama	241,900	387,800	629,700	38%
Alaska	19,400	12,300	31,700	61%
Arizona	145,800	430,900	576,700	25%
Arkansas	283,400	132,400	415,800	68%
California	233,600	3,328,200	3,561,800	7%
Colorado	96,500	312,800	409,300	24%
Connecticut	15,200	481,300	496,500	3%
Delaware	38,500	59,400	97,900	39%
District of Columbia	0	78,600	78,600	0%
Florida	286,200	2,268,300	2,554,500	11%
Georgia	347,800	463,100	810,900	43%
Hawaii	40,200	105,300	145,500	28%
Idaho	120,100	25,700	145,800	82%
Illinois	374,100	1,232,400	1,606,500	23%
Indiana	279,000	534,300	813,300	34%
Iowa	300,300	171,600	471,900	64%
Kansas	214,700	165,000	379,700	57%
Kentucky	328,200	246,100	574,300	57%
Louisiana	196,000	376,200	572,200	34%
Maine	87,100	111,000	198,100	44%
Maryland	55,800	534,800	590,600	9%
Massachusetts	63,800	859,300	923,100	7%
Michigan	319,100	1,009,300	1,328,400	24%
Minnesota	273,400	349,900	623,300	44%
Mississippi	293,800	96,000	389,800	75%
Missouri	329,600	492,800	822,400	40%
Montana	97,600	29,100	126,700	77%
Nebraska	155,900	91,100	247,000	63%
Nevada	32,100	149,400	181,500	18%
New Hampshire	51,800	100,500	152,300	34%
New Jersey	0	1,157,600	1,157,600	0%
New Mexico	110,300	94,600	204,900	54%
New York	276,600	2,340,900	2,617,500	11%
North Carolina	497,100	501,900	999,000	50%
North Dakota	71,800	30,600	102,400	70%
Ohio	353,500	1,292,400	1,645,900	21%
Oklahoma	238,200	326,866	565,066	42%
Oregon	166,100	294,000	460,100	36%
Pennsylvania	334,300	1,721,300	2,055,600	16%
Rhode Island	0	166,500	166,500	0%
South Carolina	212,300	282,200	494,500	43%
South Dakota	87,800	27,200	115,000	76%
Tennessee	299,000	453,700	752,700	40%
Texas	560,700	1,473,300	2,034,000	28%
Utah	49,500	132,600	182,100	27%
Vermont	67,000	14,300	81,300	82%
Virginia	297,600	500,200	797,800	37%
Washington	157,700	513,900	671,600	23%
West Virginia	206,100	174,139	380,239	54%
Wisconsin	289,400	463,400	752,800	38%
Wyoming	41,100	17,900	59,000	70%

Number of beneficiaries: 1994 states totals, estimated at the substate level using 1992 distribution of beneficiaries.
Source: US DHHS

	Reduction in Medicare Spending: 2002				Reduction in Medicare Spending: 1996-2002 ($ millions)			
	Rural	Urban	Total	% Rural	Rural	Urban	Total	% Rural
US	15,070	55,545	71,000	21%	57,860	210,689	270,000	21%
Alabama	607	1,054	1,661	37%	2,153	3,737	5,890	37%
Alaska	25	17	42	60%	100	66	166	60%
Arizona	273	974	1,247	22%	1,013	3,613	4,626	22%
Arkansas	346	179	525	66%	1,389	719	2,108	66%
California	527	9,366	9,893	5%	1,939	34,432	36,371	5%
Colorado	194	765	959	20%	696	2,738	3,434	20%
Connecticut	31	1,011	1,042	3%	118	3,850	3,968	3%
Delaware	83	152	235	35%	305	561	865	35%
District of Colum	0	1,197	1,197	0%	0	3,778	3,778	0%
Florida	760	7,029	7,789	10%	2,741	25,357	28,098	10%
Georgia	708	1,029	1,737	41%	2,656	3,862	6,519	41%
Hawaii	90	272	362	25%	311	942	1,253	25%
Idaho	102	23	125	82%	426	94	520	82%
Illinois	421	1,798	2,218	19%	1,721	7,357	9,078	19%
Indiana	417	895	1,312	32%	1,620	3,472	5,092	32%
Iowa	252	162	414	61%	1,065	686	1,751	61%
Kansas	371	326	697	53%	1,411	1,239	2,650	53%
Kentucky	453	356	809	56%	1,807	1,421	3,227	56%
Louisiana	427	903	1,330	32%	1,626	3,436	5,062	32%
Maine	83	110	193	43%	346	461	807	43%
Maryland	66	826	891	7%	269	3,395	3,664	7%
Massachusetts	153	2,416	2,569	6%	564	8,900	9,464	6%
Michigan	354	1,473	1,827	19%	1,462	6,078	7,540	19%
Minnesota	478	787	1,264	38%	1,714	2,821	4,534	38%
Mississippi	414	149	563	73%	1,640	592	2,232	73%
Missouri	454	827	1,280	35%	1,797	3,276	5,073	35%
Montana	101	30	131	77%	413	125	538	77%
Nebraska	161	122	283	57%	641	486	1,126	57%
Nevada	75	459	533	14%	261	1,600	1,861	14%
New Hampshire	79	164	244	33%	301	623	924	33%
New Jersey	0	1,940	1,940	0%	0	7,727	7,727	0%
New Mexico	105	104	208	50%	424	420	844	50%
New York	329	4,153	4,481	7%	1,325	16,733	18,058	7%
North Carolina	896	914	1,810	50%	3,342	3,408	6,749	50%
North Dakota	93	41	133	69%	373	164	537	69%
Ohio	401	1,760	2,161	19%	1,647	7,221	8,868	19%
Oklahoma	303	330	633	48%	1,223	1,335	2,558	48%
Oregon	282	562	844	33%	1,033	2,059	3,092	33%
Pennsylvania	524	3,261	3,785	14%	2,084	12,969	15,053	14%
Rhode Island	0	403	403	0%	0	1,451	1,451	0%
South Carolina	395	528	923	43%	1,439	1,922	3,361	43%
South Dakota	98	30	128	77%	396	120	516	77%
Tennessee	804	1,185	1,989	40%	2,931	4,316	7,248	40%
Texas	1,150	3,389	4,539	25%	4,304	12,686	16,991	25%
Utah	77	200	277	28%	295	766	1,061	28%
Vermont	72	16	88	82%	290	66	356	82%
Virginia	314	566	879	36%	1,293	2,332	3,625	36%
Washington	184	634	818	22%	740	2,549	3,289	22%
West Virginia	247	147	394	63%	994	592	1,586	63%
Wisconsin	264	501	765	34%	1,097	2,085	3,182	34%
Wyoming	28	12	41	70%	125	54	179	70%

Based on total savings in the Conference Agreement, allocated to the state and county level by the historical distribution of expenditures.

Source: US DHHS

06-Oct-95

TABLE A: NON-INSTITUTIONALIZED PERSONS AGED 16-64 WHO ARE POOR & WHO NEED LONG-TERM CARE BY STATE AND URBAN/RURAL STATUS: 1990						
STATE	Total Urban Population	# in Urban Population with LTC Needs in Poverty	% in Urban Pop. with LTC Needs in Poverty	Total Rural Population	# in Rural Population with LTC Needs in Poverty	% in Rural Population with LTC Needs in Poverty
United States	**119038486**	**1398871**	**1.18%**	**38285436**	**406258**	**1.06%**
Alabama	1,523,475	29,819	1.96%	1,006,032	18,350	1.82%
Alaska	233,222	1,112	0.48%	109,671	557	0.51%
Arizona	1,990,193	19,131	0.96%	266,214	7,762	2.92%
Arkansas	757,787	13,412	1.77%	668,104	11,516	1.72%
California	17,847,915	174,941	0.98%	1,316,189	10,434	0.79%
Colorado	1,765,018	14,521	0.82%	369,236	1,776	0.48%
Connecticut	1,683,435	12,318	0.73%	453,454	744	0.16%
Delaware	316,819	2,132	0.67%	111,849	800	0.72%
District of Columbia	411,385	8,396	2.04%	0	0	??
Florida	6,642,836	76,129	1.15%	1,166,984	14,983	1.28%
Georgia	2,642,386	38,022	1.44%	1,518,733	20,461	1.35%
Hawaii	601,557	3,479	0.58%	71,271	540	0.76%
Idaho	349,454	2,639	0.76%	249,567	1,304	0.52%
Illinois	6,178,739	77,197	1.25%	1,082,959	6,789	0.63%
Indiana	2,280,360	24,946	1.09%	1,229,255	6,142	0.50%
Iowa	1,049,686	8,461	0.81%	641,387	3,375	0.53%
Kansas	1,049,100	8,585	0.82%	446,262	2,627	0.59%
Kentucky	1,192,070	17,402	1.46%	1,128,726	27,063	2.40%
Louisiana	1,767,834	41,264	2.33%	814,429	18,055	2.22%
Maine	343,637	3,020	0.88%	429,351	2,659	0.62%
Maryland	2,562,880	25,687	1.00%	574,604	2,925	0.51%
Massachusetts	3,335,597	28,881	0.87%	609,391	1,985	0.33%
Michigan	4,206,548	57,230	1.36%	1,718,374	11,442	0.67%

TABLE B: NON-INSTITUTIONALIZED PERSONS AGED 65+ WHO ARE POOR & WHO NEED LONG-TERM CARE BY STATE AND URBAN/RURAL STATUS: 1990						
STATE	Total Urban Population	# in Urban Population with LTC Needs in Poverty	% in Urban Pop. With LTC Needs in Poverty	Total Rural Population	# in Rural Population with LTC Needs in Poverty	% in Rural Population with LTC Needs in Poverty
United States	**22189910**	**839576**	**3.78%**	**7373601**	**365608**	**4.96%**
Alabama	305,701	22,735	7.44%	194,201	21,472	11.06%
Alaska	13,888	209	1.50%	7,228	204	2.82%
Arizona	411,235	10,788	2.62%	52,100	3,072	5.90%
Arkansas	176,848	13,297	7.52%	153,333	13,288	8.67%
California	2,726,360	59,684	2.19%	259,928	4,075	1.57%
Colorado	254,869	8,404	3.30%	56,573	1,434	2.53%
Connecticut	347,263	8,534	2.46%	70,141	783	1.12%
Delaware	52,798	1,526	2.89%	23,730	682	2.87%
District of Columbia	72,259	4,339	6.00%	0	0	??
Florida	1,970,142	63,478	3.22%	322,197	11,119	3.45%
Georgia	382,083	25,823	6.76%	237,896	19,272	8.10%
Hawaii	106,703	2,335	2.19%	14,269	294	2.06%
Idaho	65,028	1,874	2.88%	50,250	1,268	2.52%
Illinois	1,126,240	38,824	3.45%	225,067	7,404	3.29%
Indiana	435,613	14,722	3.38%	214,869	6,566	3.06%
Iowa	225,595	6,909	3.06%	165,977	5,389	3.25%
Kansas	205,537	7,095	3.45%	112,790	3,691	3.27%
Kentucky	240,236	13,734	5.72%	201,649	18,757	9.30%
Louisiana	304,766	23,042	7.56%	134,542	13,652	10.15%
Maine	74,781	2,797	3.74%	78,825	2,927	3.71%
Maryland	397,288	13,940	3.51%	94,200	3,039	3.23%
Massachusetts	667,169	19,463	2.92%	100,108	1,976	1.97%
Michigan	754,314	27,652	3.67%	300,265	8,804	2.93%

Minnesota	1,976,313	13,722	0.69%	776,297	4,061	0.52%
Mississippi	727,511	18,656	2.56%	830,077	24,938	3.00%
Missouri	2,199,721	24,243	1.10%	972,515	10,781	1.11%
Montana	257,339	2,324	0.90%	227,386	1,599	0.70%
Nebraska	644,230	4,393	0.68%	305,558	1,481	0.48%
Nevada	701,774	5,321	0.76%	86,682	407	0.47%
New Hampshire	371,333	2,068	0.56%	354,249	1,097	0.31%
New Jersey	4,503,027	38,044	0.84%	527,266	1,741	0.33%
New Mexico	683,446	8,385	1.23%	244,335	7,052	2.89%
New York	9,882,315	165,227	1.67%	1,773,574	10,771	0.61%
North Carolina	2,112,875	25,128	1.19%	2,130,783	24,519	1.15%
North Dakota	209,036	1,253	0.60%	168,094	748	0.45%
Ohio	5,094,922	62,309	1.22%	1,765,612	13,301	0.75%
Oklahoma	1,306,227	17,144	1.31%	616,284	8,888	1.44%
Oregon	1,261,808	10,455	0.83%	519,236	3,227	0.62%
Pennsylvania	5,147,367	63,467	1.23%	2,327,040	14,752	0.63%
Rhode Island	547,004	4,578	0.84%	91,809	450	0.49%
South Carolina	1,178,931	19,466	1.65%	1,004,501	17,966	1.79%
South Dakota	209,655	1,809	0.86%	194,170	1,374	0.71%
Tennessee	1,893,700	27,694	1.46%	1,229,440	17,357	1.41%
Texas	8,669,490	122,221	1.41%	2,026,336	26,476	1.31%
Utah	870,919	4,470	0.51%	119,657	1,301	1.09%
Vermont	120,427	811	0.67%	245,719	1,274	0.52%
Virginia	2,753,466	22,726	0.83%	1,213,407	13,365	1.10%
Washington	2,372,579	19,116	0.81%	704,794	4,307	0.61%
West Virginia	401,950	6,118	1.52%	725,067	15,473	2.13%
Wisconsin	2,027,775	17,883	0.88%	1,026,273	4,791	0.47%
Wyoming	181,413	1,116	0.62%	97,233	472	0.49%

Source: 1990 Decennial Census. These data were derived from two questions: "because of a health condition that has lasted for six or more months, does this person have any difficulty taking care of his or her own personal care needs, such as bathing, dressing, or getting around the home OR going outside the home alone, for example, to shop or visit a doctor's office?".

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FAX COVER PAGE

TO: Jennifer Klein

FROM: Chuck Flaherty

DATE: 10/5/95

MESSAGE: Jennifer - I was able to get an overnight, 10:30 a.m. FedEx to you. Here's a summary section from our Data Report. Call if we can help in any other manner. Thanks for the continuing White House interest in rural policy!

Chuck

This transmission is 18 pages (including cover page).

Reg. Economic
Glenn Nelson
619-298-4707

EXECUTIVE SUMMARY

- **If current policies were to continue, Medicare would continue to absorb an increasing fraction of federal government expenditures and of national output. (Figure 1)**
  Over the last decade Medicare expenditures have been growing at over twice the rate of other federal spending and at almost twice the rate of growth of the overall economy. Medicare expenditures are projected to grow at about twice the rate of growth of both other federal spending and the general economy if current policies continue.

- **A higher proportion of the rural than urban population will be affected directly by changes in Medicare policy. (Figure 2)**

  Rural people are more likely than urban people to be enrolled in Medicare. The rural enrollment rate is 28 percent higher than the urban rate.

- **Changes in Medicare policy that narrow the rural-urban payment gap would improve the viability of rural health care systems and rural communities. (Figure 3)**

  Rural enrollees receive lower average Medicare payments than urban enrollees. Payments per urban enrollee are 23 percent higher than payments per rural enrollee.

- **The dollar impact of changes in Medicare payments per rural citizen, including those not enrolled in Medicare as well as enrollees, would be slightly above the average U.S. dollar impact per citizen. (Figure 4)**

  Medicare payments per rural citizen were $517 in 1992 compared to the U.S. average of $502 per capita.

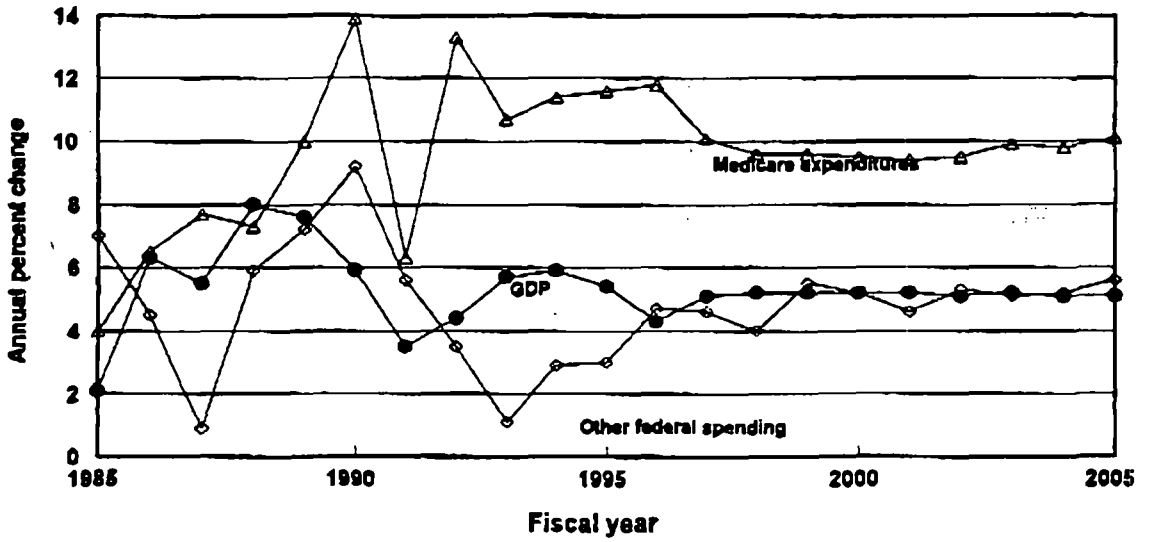
- **The resources available for dealing with financial shocks to the local and regional economy tend to decline as a region is more rural. (Figure 5)**

  Per capita income in 1993 by RUPRI rural-urban county grouping is a high of $23,843 in the core counties of large metropolitan areas and is a low of $16,028 in nonmetropolitan counties not adjacent to metropolitan areas.

- **The dependence of total personal income on Medicare is 42 percent greater in rural than urban areas. (Figure 6)**

  In rural areas the ratio of Medicare payments to personal income is 3.32 percent, which exceeds the corresponding urban percentage of 2.34 percent.

Figure 1. Annual Rate of Growth in Medicare Expenditures, Other Federal Spending, and U.S. GDP: Fiscal Years 1986-2005



Source: Congressional Budget Office

Figure 2. Percent of Population Enrolled in Part A Medicare

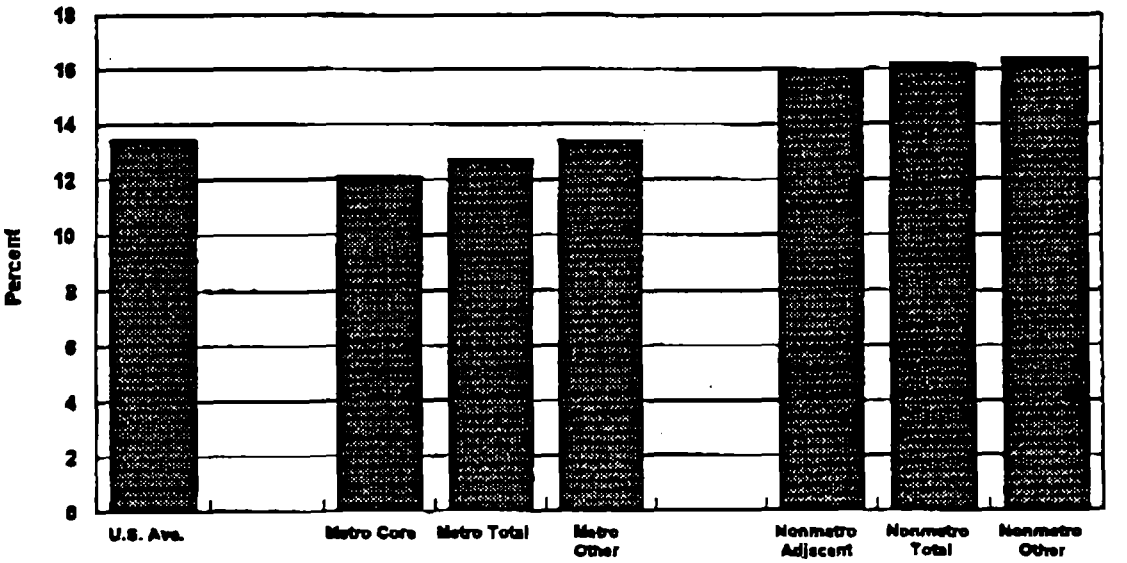


Figure 5. Personal Income per Capita

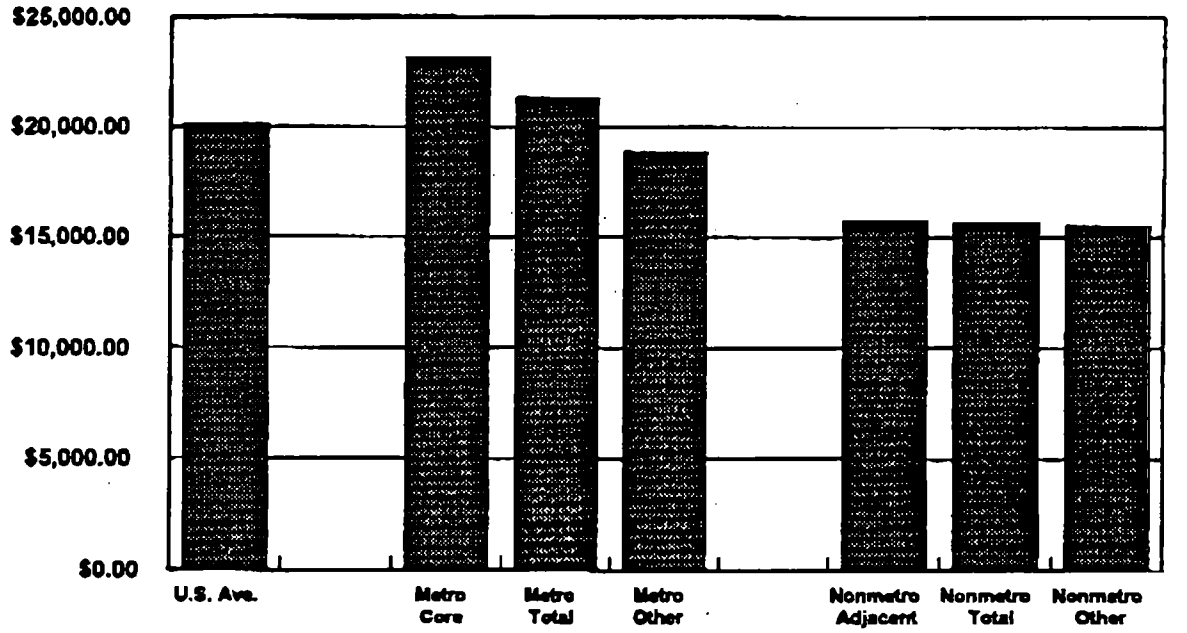
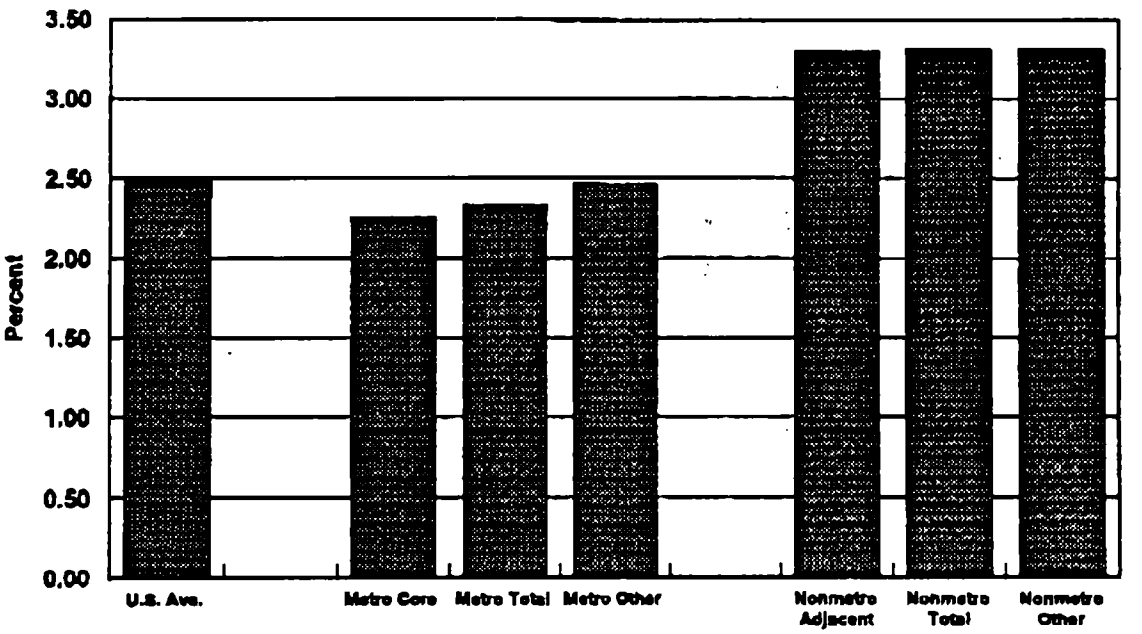


Figure 6. Medicare Payments as a Percentage of Total Personal Income



percentage of the total population to aid the reader in knowing the relative importance of the Medicare program among different county groupings and states.

Table 3 displays 1992 Medicare payments (the most recent available by county from the data source used in this study) by county grouping by state and by Part A and Part B as well as in total. Total payments in each county grouping in 1992 are expressed on a per enrollee basis, on a per capita basis, and as a percent of personal income as an aid to understanding the relative importance of Medicare payments in different county groupings. Per capita income is shown for each county grouping to assist readers in understanding how payments are related to a common measure of need for financial assistance.

The ten tables in Appendix A present detailed information for a longer time span on enrollments, payments, population, and per capita income by county grouping by state. The primary purpose of these detailed tables is to provide a useful reference document for policy makers and their staffs, who often need information by aged and disabled and by Part A and Part B as they formulate and debate policy. The information will also be useful to many analysts outside of government and to members of the public who have a special interest in a specific part of Medicare.

Two Important Limitations

While this report is an important input to assessing the spatial impacts of decisions with respect to Medicare, the information has two important limitations. First, because of extensive and systematic movements of people across rural-urban boundaries, the spatial incidence of the impacts on health service providers and on other businesses of reductions in Medicare payments from baseline projections will differ from the impacts described in this report. People often travel from a rural residence to an urban setting in order to purchase health care services and to purchase other goods and services as well; less frequently, people travel in the reverse direction for this purpose. Similarly, people often commute from a residence in a rural setting to a place of work in an urban setting or from a suburban residence to a central city place of work; again, smaller flows exist in the reverse direction. Because of these movements, providers of health care, as well as providers of other goods and services to consumers, and producers of goods and services that are intermediate inputs to consumer goods and services (e.g., manufacturers of hospital supplies and writers of software for commercial applications), will experience impacts which differ from the spatial pattern described in this report. The regional policy impact models being developed by RUPRI will provide an integrated framework for studying these three spheres of impacts--consumers, providers servicing consumers directly, and providers of intermediate goods and services--and results will be disseminated as soon as the work provides useful insights.

Another important limitation of this report is that it does not address the impacts of the off-setting fiscal decision which would accompany a change in Medicare payments from baseline projections. Decisions which change the level of Medicare expenditures necessarily entail an off-setting fiscal decision, which may be an implicit rather than explicit decision. For example, a cut in expenditures may be associated with a

Medicare Projections

The following projections of Medicare outlays are useful to readers who wish to use the information in this report as a means to calculate estimates of the implications for county groupings of future Medicare outlays and of potential policy changes.

Current Policy Projections of Medicare Outlays

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
CBO (FY)[3]	178	199	219	240	263	288	315	345	379	416	458
HCFA (CY)[4]	190	209	228	248	270	294	319	347	378	413	451

As an example of the use of these projections, assume an analyst is interested in what portion of Medicare expenditures in 2000 as projected by CBO will occur in a particular county grouping. Assume the analyst finds in Table 3 of this report that the county grouping received $400 million in 1992 which was 0.312 percent of the U.S. total of $128.3 billion. Applying this percentage to the CBO projected national expenditure of $288 billion for 2000, the analyst computes a projected expenditure of $899 million for the county grouping in 2000; the validity of this projection depends upon the degree to which the county grouping can be expected to experience Medicare trends consistent with national trends as well as on the accuracy of the CBO projection.

[3] U.S. Congressional Budget Office, The Economic and Budget Outlook: An Update, U.S. Government Printing Office, Washington, DC, August 1995, p. 26.

[4] U.S. Health Care Financing Administration, Office of the Actuary, "National Health Expenditures 1994-2005," data from the Office of National Health Statistics, facsimile, tables dated March 30, 1995.

- Of the 94 nonmetropolitan and 78 metropolitan regions examined in this study, which encompass the entire U.S., 33 of the nonmetropolitan regions have 1992 Medicare Part A enrollment rates of 17 percent or more of the population while only 1 (in Florida) of the metropolitan regions has rates this high.

- Enrollments in Part B of Medicare, the voluntary supplementary medical insurance program, parallel closely enrollments in Part A in both metropolitan and nonmetropolitan areas. The points noted above with respect to Part A enrollment also apply to Part B enrollment.

- Most Medicare enrollees are eligible because of the aged rather than disabled provisions. For the U.S. in 1992 aged enrollees in Part A equaled 12.1 percent of the total population and disabled enrollees in Part A equaled 1.3 percent of the population.

- The positive relation between the degree of rurality and higher enrollment rates is pervasive across Parts A and B examined separately and also for the aged and disabled examined in each of Parts A and B (see Appendix Tables A-1 through A-4).

- The differential between metropolitan and nonmetropolitan enrollment rates is proportionately greater for disabled enrollees than aged enrollees. For the U.S. in 1992, aged enrollment in Part A in nonmetropolitan areas was 14.5 percent of the population which is 26 percent greater than the enrolled percentage of 11.5 percent observed in metropolitan areas. Disabled enrollment in Part A in nonmetropolitan areas was 1.74 percent of the population which is 46 percent greater than the disabled enrolled percentage of 1.19 percent in metropolitan areas.

- Summarizing, a higher proportion of the rural population than of the urban population will be affected by changes in Medicare policy.

Medicare Payments Per Enrollee

- Medicare payments per enrollee vary because of different rates of utilization of Medicare services in different populations and because of different payment rates to providers in different locations. Dividing total Medicare payments by enrollees in Part A, with the latter serving as a proxy for total Medicare enrollment, yields a national average payment of $3,753 per enrollee in 1992.

- Total Medicare payments per Part A enrollee are inversely related to the degree of rurality. Total payments per Part A enrollee in 1992 were $4,321 in the core county of metropolitan areas county grouping, $3,479 in the grouping of other metropolitan counties, $3,237 in the grouping of nonmetropolitan counties adjacent to metropolitan areas, and $3,137 in the grouping of nonmetropolitan counties not adjacent to metropolitan areas. Comparing the two ends of the spectrum, the core

counties of metropolitan areas figure of $4,321 is 38 percent larger than the nonmetropolitan, not adjacent counties figure of $3,137.

- The pattern of lower Medicare payments per enrollee being associated with a more rural county grouping is pervasive across Parts A and B examined separately and also for the aged and disabled examined in each of Parts A and B.

- Summarizing, Medicare payments per enrollee are lower in rural than urban areas. In the case of the core counties of large metropolitan areas and nonmetropolitan areas, the inverse relationship between payments per enrollee and degree of rurality is sufficiently strong to completely offset the positive relationship between enrollment rates and degree of rurality. In the case of the "other metropolitan" counties and nonmetropolitan areas, the inverse relationship offsets much but not all of the positive relationship between enrollment rates and degree of rurality.

Medicare Payments Per Capita

- Medicare payments relative to the total population (not just the enrolled population) are a function of treatment rates and of payment rates to providers as well as of enrollment rates. The U.S. average Medicare payment per capita in 1992 was $502.

- Medicare payments per capita are relatively high in the core counties of large metropolitan areas ($523 per capita in 1992) and in nonmetropolitan counties ($517) as compared to payments per capita in metropolitan counties other than "core counties" ($466). These other metropolitan counties consist of suburban counties of large metropolitan areas and of counties in small and medium size metropolitan areas. The nonmetropolitan per capita payment of $517 is 11 percent greater than the per capita payment of $466 in the metropolitan counties other than core counties grouping.

- Medicare payments per capita for disabled enrollees, including both Parts A and B, follow the general pattern observed for total Medicare payments noted in the previous point. Medicare payments per capita for disabled enrollees are relatively high in the core counties of large metropolitan areas ($56 per capita in 1992) and in nonmetropolitan counties ($59) as compared to payments per capita in metropolitan counties other than "core counties" ($52).

- Part A (hospital insurance) payments per capita for aged enrollees also follow the general pattern observed for total Medicare payments noted above. Part A payments per capita for aged enrollees are relatively high in the core counties of large metropolitan areas ($293 per capita in 1992) and in nonmetropolitan counties ($302) as compared to payments per capita in metropolitan counties other than "core counties" ($266). The nonmetropolitan Part A per capita payment for the aged of $302 is 14 percent greater than the per capita payment of $266 in the metropolitan counties other than core counties grouping.

- Part B (voluntary supplementary medical insurance program) payments per capita for aged enrollees in 1992 do not follow the same pattern as the other parts of Medicare. Part B payment per capita for aged enrollees in nonmetropolitan areas is $156 which is lower than the national average of $161. The key factor explaining this result is that the Part B payment per capita for aged enrollees in nonmetropolitan areas does not approximate the $174 observed in the core counties of large metropolitan areas. In the other portions of Medicare discussed above, nonmetropolitan payments per capita exceed slightly the rates found in the core counties of large metropolitan areas. The relatively low rate of Part B reimbursement per capita for aged enrollees in nonmetropolitan counties is not explained by relative enrollment rates. Part B aged enrollees are 10.8 percent of the population in the core counties of large metropolitan areas, 11.8 percent in other metropolitan areas, and 14.3 percent in nonmetropolitan counties.

- Summarizing, the differentials observed in enrollment levels across the rural-urban spectrum are not mirrored in Medicare payments per capita because of higher levels of treatment of Medicare enrollees in metropolitan areas and/or because of higher levels of payment rates in metropolitan areas. The data used in this study do not provide sufficient information to explore these two factors. The low level of Part B payment per capita for aged enrollees in nonmetropolitan areas is a particularly important factor in explaining the disparity between enrollment patterns and per capita payment patterns across the rural-urban spectrum.

Per Capita Income

- The resources available for dealing with financial shocks to the regional economy tend to decline as a region is more rural. Per capita income in 1993 by RUPRI rural-urban county grouping varies from a high of $23,843 in the core counties of large metropolitan areas to a low of $16,028 in nonmetropolitan counties not adjacent to metropolitan areas. The U.S. average per capita income in 1993 was $20,800.

Medicare Payments as a Percent of Personal Income

- Medicare payments as a percent of personal income are larger in nonmetropolitan areas than in metropolitan areas. For nonmetropolitan counties, payments relative to income are virtually identical for the adjacent to metropolitan and for the not adjacent to metropolitan county groupings. Within metropolitan areas, the county grouping consisting of core counties of large metropolitan areas has a lower ratio of Medicare payments to income than does the other grouping of metropolitan counties. More specifically, Medicare payments equal 3.3 percent of income in nonmetropolitan areas, which is 32 percent above the 2.5 percent observed in the "other metropolitan" county grouping and is 43 percent above the 2.3 percent observed in the core counties of large metropolitan areas county grouping.

- The pattern noted immediately above for the case of total Medicare payments is present for the components of Part A and Part B and for the aged and disabled components within each part. That is, payments as a percent of personal income are lowest for the core counties of large metropolitan areas and highest for the two nonmetropolitan county groupings. Medicare payments as a percent of income in the "other metropolitan county grouping" are approximately equal to the national average, which falls between these two extremes.

- Decreases in Medicare payments from baseline projections at uniform rates over all county groupings would have a relatively larger negative impact on the nonmetropolitan economy than on the metropolitan economy, as measured by the relative decline in the purchasing power of the residents. As people adapt to lower (than baseline) Medicare subsidies through adjustments in the amounts and proportions of purchases, the decreased purchasing power would diffuse throughout all sectors of the economy rather than being limited to effects within the health care sector.

Table 1. Medicare Enrollment and Payments by Parts A and B, by Aged and Disabled, and by Rural-Urban County Grouping for the United States in 1992

	Metropolitan County Groupings			Nonmetropolitan County Groupings			United States
	Core Counties of Large Metro's	Other Metro Counties	Total	Adjacent to Metro	Not Adjacent to Metro	Total	Total
Enrollment							
Part A Total (thous.)	13,988	11,712	25,700	4,574	3,862	8,436	34,136
Aged (thous.)	12,736	10,540	23,276	4,090	3,440	7,530	30,806
Disabled (thous.)	1,252	1,172	2,424	484	422	906	3,330
Part B Total (thous.)	13,665	11,402	25,067	4,479	3,785	8,264	33,331
Aged (thous.)	12,526	10,332	22,858	4,032	3,392	7,424	30,282
Disabled (thous.)	1,139	1,070	2,209	447	393	840	3,049
Part B/Part A (percent)	97.7	97.4	97.5	97.9	98.0	98.0	97.6
Enroll. Relative To Pop. (percent)							
Part A Total	12.1	13.4	12.7	16.0	16.4	16.2	13.4
Aged	11.0	12.1	11.5	14.3	14.6	14.5	12.1
Disabled	1.1	1.3	1.2	1.7	1.8	1.7	1.3
Payments (mil. $)							
Part A Total	38,129	26,253	64,382	9,745	8,051	17,796	82,178
Aged	33,865	23,244	57,109	8,616	7,117	15,733	72,842
Disabled	4,264	3,009	7,273	1,129	934	2,063	9,336
Part B Total	22,316	14,494	36,810	5,061	4,066	9,127	45,937
Aged	20,103	12,942	33,045	4,501	3,600	8,101	41,146
Disabled	2,213	1,552	3,765	560	466	1,026	4,791
Total	60,445	40,747	101,192	14,806	12,117	26,923	128,115

(table continued on next page)

	Metropolitan County Groupings			Nonmetropolitan County Groupings			United States
	Core Counties of Large Metro's	Other Metro Counties	Total	Adjacent to Metro	Not Adjacent to Metro	Total	Total
Payments per Enrollee ($)							
Part A Total	2,726	2,242	2,505	2,131	2,085	2,110	2,407
Aged	2,659	2,205	2,454	2,107	2,069	2,089	2,365
Disabled	3,406	2,567	3,000	2,333	2,213	2,277	2,804
Part B Total	1,633	1,271	1,468	1,130	1,074	1,104	1,378
Aged	1,605	1,253	1,446	1,116	1,061	1,091	1,359
Disabled	1,943	1,450	1,704	1,253	1,186	1,221	1,571
Total/Part A Enrollment	4,321	3,479	3,937	3,237	3,137	3,191	3,753
Payments Relative to Total Pop. ($)							
Part A Total	330	300	317	341	342	342	322
Aged	293	266	281	302	303	302	286
Disabled	37	34	36	40	40	40	37
Part B Total	193	166	181	177	173	175	180
Aged	174	148	163	158	153	156	161
Disabled	19	18	19	20	20	20	19
Total	523	466	499	519	515	517	502
Payments/Tot. Pers. Inc. (percent)	2.26	2.47	2.34	3.30	3.33	3.32	2.49
Bases for Comparative Measures							
Total Personal Income (bil.)	2,672	1,651	4,323	448	364	812	5,135
Population (mil.)	115.59	87.39	202.98	28.54	23.51	52.05	255.03
Pers. Income Per Capita ($)	23,116	18,898	21,300	15,696	15,484	15,600	20,137

. Table . Number and percent of patients in home health agencies, hospices, nursing homes and board and care homes in rural areas: United States, 1991

	Total		Home health agencies		Hospices		Nursing homes		Board and care homes	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
United States	580,674	100.0	212,918	36.7	3,547	0.6	322,255	55.5	41,954	7.2
Alabama	13,440	100.0	6,578	48.9	235	1.7	6,211	46.2	416	3.1
Alaska	258	100.0	33	12.8	4	1.6	189	73.3	32	12.4
Arizona	399	100.0	206	51.6			161	40.4	32	8.0
Arkansas	16,499	100.0	5,781	35.0	4	0.0	10,047	60.9	667	4.0
California	3,414	100.0	949	27.8	95	2.8	1,558	45.6	812	23.8
Colorodo	5,165	100.0	863	16.7	54	1.0	3,899	75.5	349	6.8
Delaware	6,015	100.0	4,727	78.6	32	0.5	1,214	20.2	42	0.7
Florida	8,456	100.0	3,609	42.7	14	0.2	3,826	45.2	1,007	11.9
Georgia	25,389	100.0	9,919	39.1	9	0.0	14,085	55.5	1,376	5.4
Idaho	2,873	100.0	399	13.9	49	1.7	1,947	67.8	478	16.6
Illinois	24,141	100.0	6,414	26.6	617	2.6	16,648	69.0	462	1.9
Indiana	16,734	100.0	4,516	27.0	2	0.0	11,936	71.3	280	1.7
Iowa	29,359	100.0	8,301	28.3	284	1.0	18,581	63.3	2,193	7.5
Kansas	14,488	100.0	1,863	12.9	22	0.2	12,468	86.1	135	0.9
Kentucky	28,359	100.0	13,950	49.2	219	0.8	12,643	44.6	1,547	5.5
Lousinana	15,026	100.0	5,474	36.4	158	1.1	9,348	62.2	46	0.3
Maine	4,912	100.0	1,229	25.0	106	2.2	2,904	59.1	673	13.7
Maryland	2,896	100.0	901	31.1	26	0.9	1,875	64.7	94	3.2
Michigan	19,351	100.0	6,298	32.5	212	1.1	9,325	48.2	3,516	18.2
Minnesota	29,397	100.0	11,150	37.9	148	0.5	16,802	57.2	1,297	4.4
Mississippi	21,780	100.0	13,710	62.9			7,916	36.3	154	0.7
Missouri	27,197	100.0	6,289	23.1	241	0.9	17,664	64.9	3,003	11.0
Montana	8,460	100.0	4,572	54.0	47	0.6	3,337	39.4	504	6.0
Nebraska	11,092	100.0	1,719	15.5	4	0.0	8,865	79.9	504	4.5
Nevada	838	100.0	219	26.1			550	65.6	69	8.2
New Hampshire	3,175	100.0	1,303	41.0	53	1.7	1,541	48.5	278	8.8
New Mexico	2,715	100.0	694	25.6			1,543	56.8	478	17.6
New York	11,138	100.0	5,574	50.0	36	0.3	3,940	35.4	1,588	14.3
North Carolina	25,674	100.0	11,559	45.0	271	1.1	8,526	33.2	5,318	20.7
North Dakota	11,183	100.0	5,990	53.6			4,495	40.2	698	6.2
Ohio	10,512	100.0	3,515	26.0	56	0.4	9,443	69.9	498	3.7
Oklahoma	15,056	100.0	2,744	18.2	2	0.0	11,667	77.5	643	4.3
Oregon	3,153	100.0	1,065	33.8	8	0.3	1,582	50.2	498	15.8
Pennsylvania	17,877	100.0	5,486	30.7	35	0.2	9,358	52.3	2,998	16.8
South Carolina	8,547	100.0	4,461	52.2	28	0.3	3,014	35.3	1,044	12.2
South Dakota	8,090	100.0	2,063	25.5	7	0.1	5,789	71.6	231	2.9
Tennessee	24,212	100.0	12,776	52.8	12	0.0	10,530	43.5	894	3.7
Texas	40,670	100.0	15,329	37.7	151	0.4	24,701	60.7	489	1.2
Utah	1,951	100.0	975	50.0	13	0.7	886	45.4	77	3.9
Vermont	8,382	100.0	4,076	48.6	94	1.1	2,851	34.0	1,361	16.2
Virginia	14,421	100.0	5,780	40.1	42	0.3	6,293	43.6	2,306	16.0
Washington	3,633	100.0	886	24.4	26	0.7	2,228	61.3	493	13.6
West Virginia	8,386	100.0	3,321	39.6	21	0.3	4,255	50.7	789	9.4
Wisconsin	20,141	100.0	4,628	23.0	82	0.4	14,080	69.9	1,351	6.7
Wyoming	2,318	100.0	615	26.5	19	0.8	1,450	62.6	234	10.1

MEDICARE

- A larger percentage of rural Americans are enrolled in Medicare -- about 16% of rural residents are Medicare enrollees -- compared with and 12% of urban residents. This is because there are, on average, more elderly and disabled people in rural than in urban areas.

- Since Medicare pays nearly 20% less per beneficiary in rural areas, there is little room for additional efficiencies -- the cuts will mean fewer services or reduced access.

- Rural counties in State will lose $X in Medicare funding as a result of the re

- This will affect X rural beneficiaries, who represent x% of all State's Medicare beneficiaries.

- Only x% of State's rural Medicare beneficiaries are currently enrolled in Medicare risk HMOs.

MEDICAID

- Number of rural nursing home residents in each state who are rural → Can do % of total
- Number of poor rural people with long-term care needs.

- Medicaid is a critical source of coverage for rural Americans. Historically, states have had a hard time covering their rural residents, primarily because rural states tend to have less resources available to expand Medicaid. However, over time, the number of rural Americans covered by Medicaid has grown. Today, an estimated x million rural Americans are covered by Medicaid.

- Medicaid is particulary important since rural workers are less likely to get health insurance through their employers. In 1993, only 50% of rural workers received health insurance on the job.

- Medicaid spends x on rural health clinics --

State

The rural nursing home res. in most of whom are covered by Medicaid, could be forced out.

Poor elderly who live at home but need long term care could be deprived of hsn. that Medicare and Medicaid to people now living at hom

HOSPITALS (ORHP Jan 9, 1995)

Medicaid and Medicare finance a greater portion of discharges in rural hospitals compared with urban hospitals (this statistic is obviously related to your first bullet point)

	Percent of discharges paid by		
	Medicare	Medicaid	Combined
Rural	44 %	15 %	59 %
Urban	36 %	12 %	48 %

- Largest employer
- They are the nursing home, only provider in the community
- 70% Medicare/aid load
- Seniors won't have option to go into man. care -- will pay more for fee-for-serv. w/out choice

Medicare

$__B cut in __ ~~states~~ rural area of Alabama

Inc. cost for ____ people

~~$__B will come from hospital cuts~~

% of $ going to rural hospitals

Medicaid — Natl #

As much as $__B in cuts in rural areas.

% cut in $

% cut of people

- Know total cuts in states
- know amount in cities.

As many as ____ people in rural areas will lose coverage

Aggregate $s of $s spent in rural areas & people in rural areas

# of rural nursing home residents | nursing homes.

There are ____ w/ LTC needs. Without Medicaid, wld pay $38,000 more.

Rural Impact Events

Cabinet Calendar

Cabinet Member	October 9	October 10	October 11	October 12	October 13	OTHER
AG Reno	New Orleans, LA					
Sec. Babbitt		Radio Tuesday and Wednesday				
Sec. Glickman	Des Moines, IA?					
Sec. Shalala				Rural Florida		
Sec. Cisneros		Cambridge, MA				
Sec. Pena	Minneapolis, MN					
Sec. O'Leary		Minneapolis, MN				
Sec. Brown (DVA)	LA and San Diego?	Bakersfield?	Martinez?			10/ 7 Flint, MI 10/ 8 Battlecreek,MI
Adm. Browner	Print and Radio during the week					
Dir. Brown		Kansas City, MO?	Kansas City, MO?			
Adm. Lader	New Orleans, LA					