FINANCIAL CHALLENGES AND OPPORTUNITIES IN TURBULENT TIMES

MHA Winter CEO Meetings – January 12, 2023

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CPAs & BUSINESS ADVISORS

PRESENTER

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AGENDA

- The why
- Strategic Redirection
  - Why now?
  - Components
  - Innovation
  - The marketing connection
- Service line strategies
- Summary

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THE “WHY”

Why are we even having this conversation?

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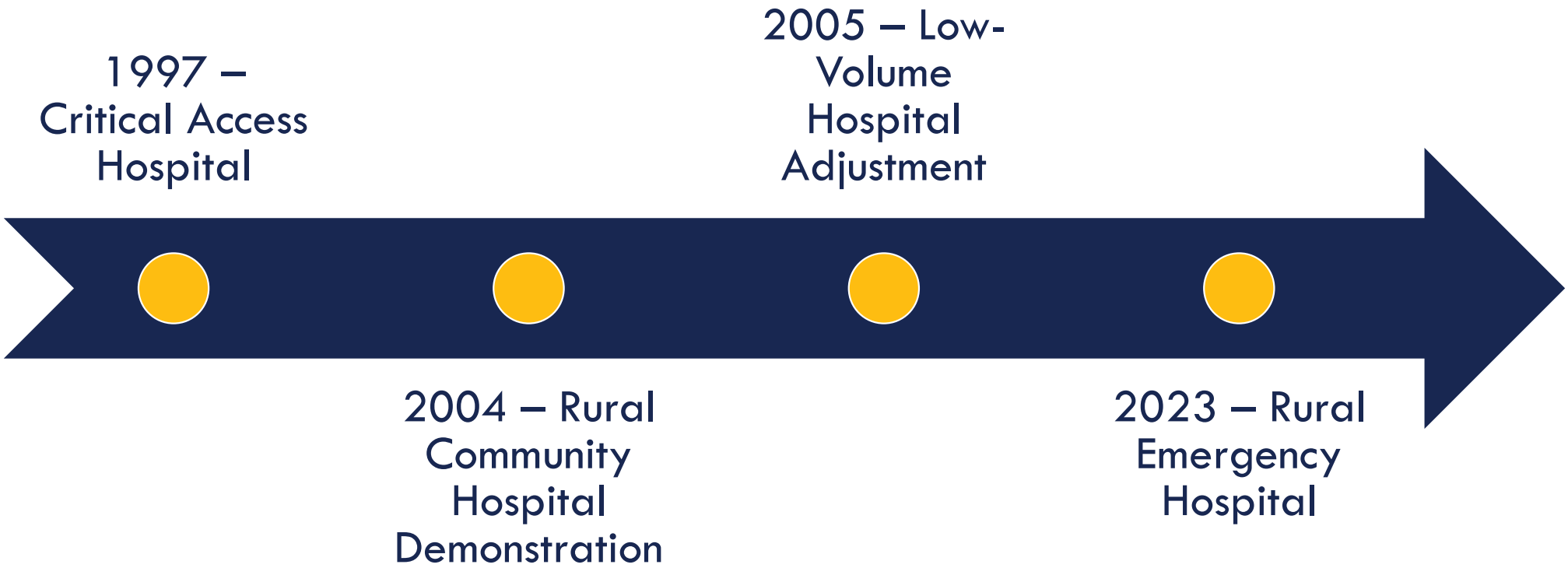
SETTING THE STAGE – HISTORICAL FINANCIAL STRESS

- More than 550 hospitals closed in the 1980's – More than 200 in rural areas.
- 440 hospitals closed in the 1990's – 186 in rural areas.
- 182 Rural Hospital Closures since January 2005.

SETTING THE STAGE – NEW PROGRAMS



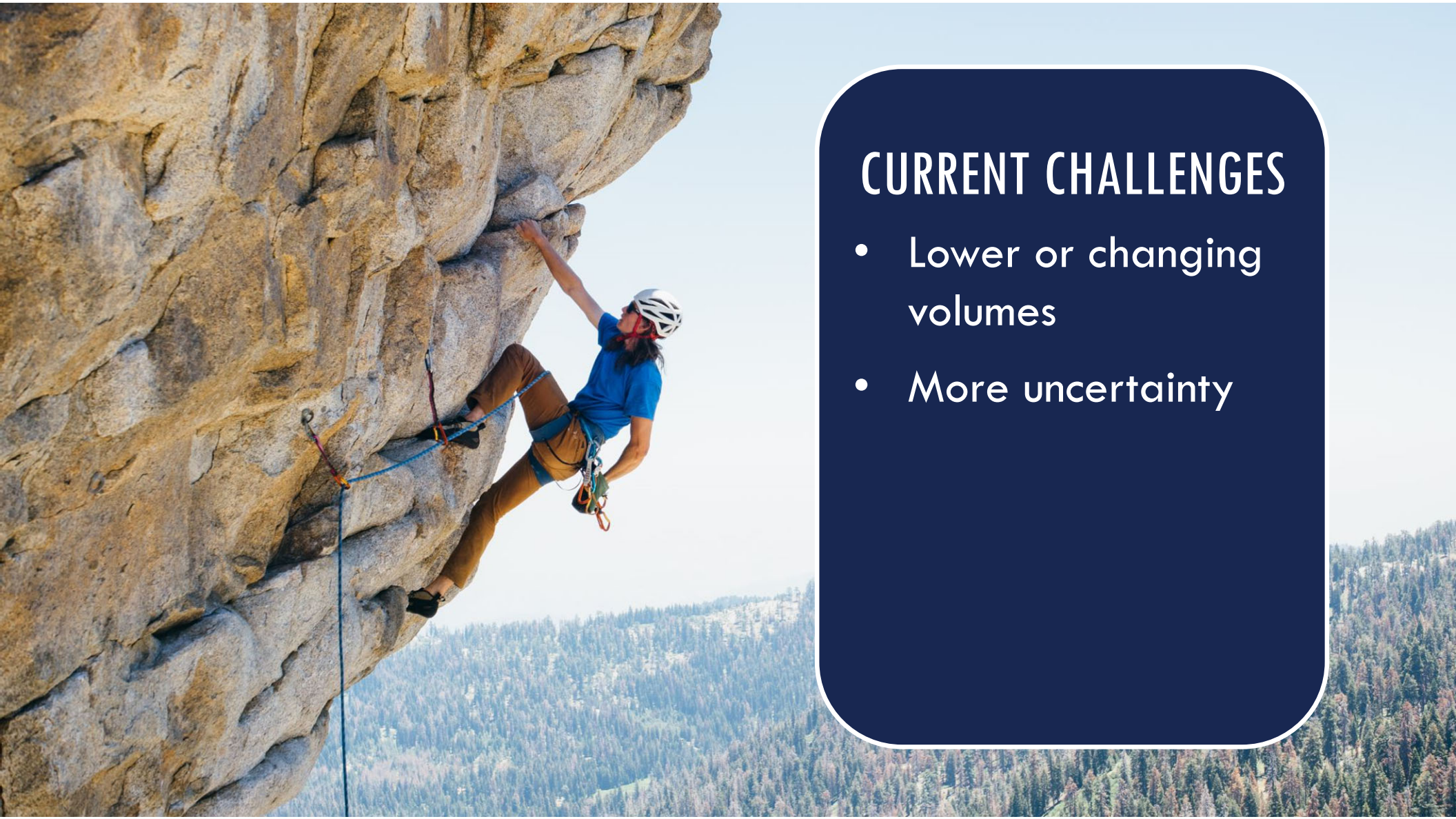
SETTING THE STAGE – PRE-COVID

- Challenges existed before COVID.
- 2020 Report states 27% of CAHs were at mid-high to high risk of financial distress.
- Big infusions of COVID funding:
  - Temporary relief.
  - Long term realities are starting to set in.

Source – University of North Carolina's Cecil G. Sheps Center for Health Services Research (2020)

CURRENT CHALLENGES

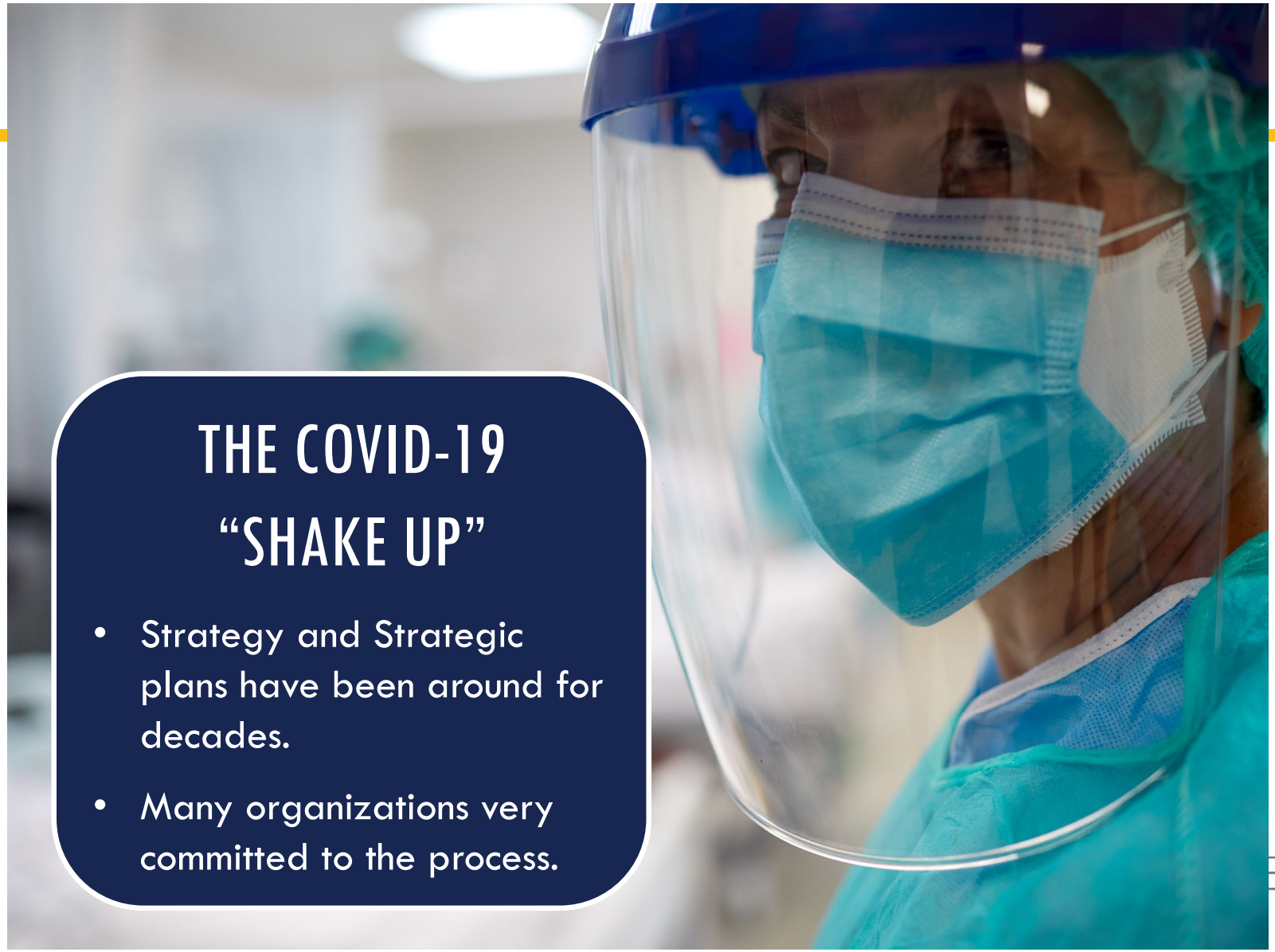
- High turnover:
  - C-Suite
  - All staff levels
- Higher costs:
  - Labor
  - Supply
  - Construction



CURRENT CHALLENGES

- Lower or changing volumes
- More uncertainty

STRATEGIC REDIRECTION



THE COVID-19 "SHAKE UP"

- Strategy and Strategic plans have been around for decades.
- Many organizations very committed to the process.

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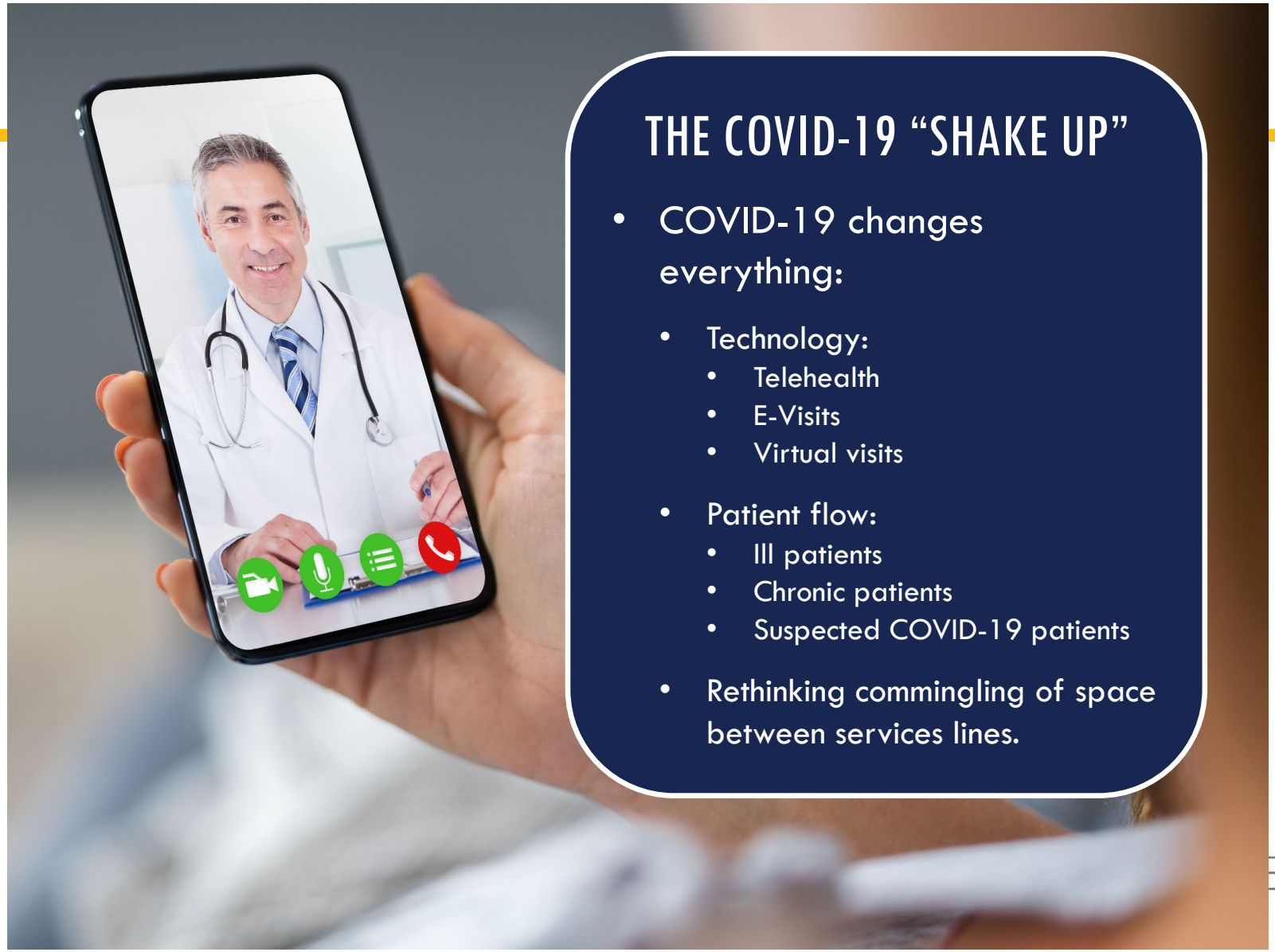

THE COVID-19 "SHAKE UP"

- COVID-19 changes everything:
  - Technology:
    - Telehealth
    - E-Visits
    - Virtual visits
  - Patient flow:
    - Ill patients
    - Chronic patients
    - Suspected COVID-19 patients
  - Rethinking commingling of space between services lines.

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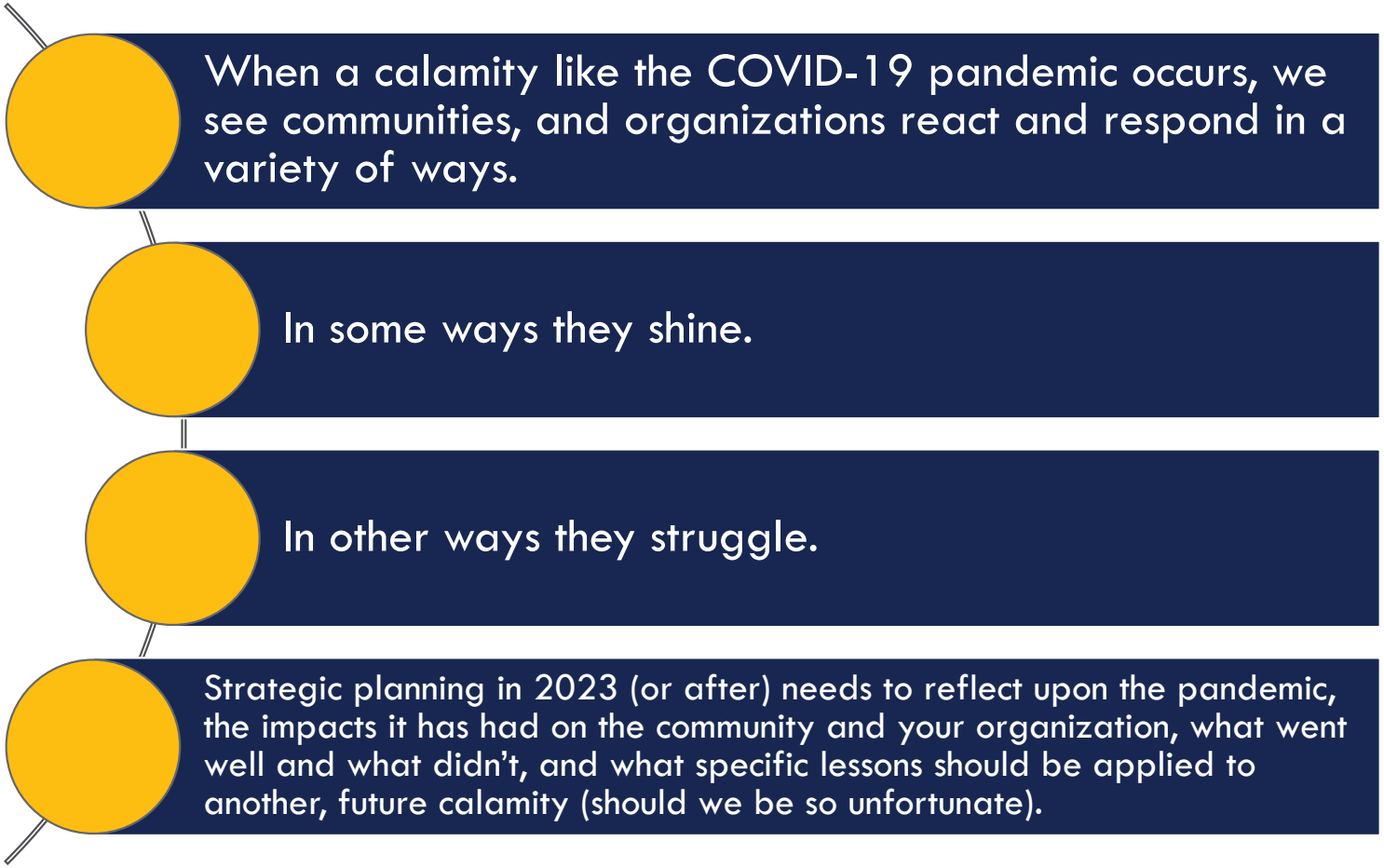
COVID-19



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HOW "HEALTHY" IS YOUR STRATEGIC PLAN?

- Current?
- Engagement?
- Complete?
- Built for the future?

ITEMS TO BE ADDRESSED

- Community Health Needs Assessment
- Patient preferences
- Data
- Technology
- Other industry trends

YOUR CHNA – IS IT MORE THAN MEETING A REQUIREMENT?

- Internal revenue code 501(r)(3) requirement
  - Every 3 years
  - Must take into account input from persons who represent the broad interests of the community serviced by the hospital facility, including those with special knowledge of or expertise in public health
  - Must be made widely available to the public

- Has the environment, its needs and its expectations changed since last CHNA?

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YOUR CHNA – IS IT MORE THAN MEETING A REQUIREMENT?

- Conducting a CHNA:
  - Define the community it serves.
  - Assess the health needs of that community.
  - In assessing the community's health needs, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.
  - Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility.
  - Make the CHNA report widely available to the public.

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Significant Variation in Community Health Needs Assessments

YOUR CHNA – IS IT MORE THAN MEETING A REQUIREMENT?

- Too many CHNAs only address the minimum requirements
- Some facilities are diving deeper……
- The CHNA focuses on gaps, but you can focus on anything you want:
  - Why are nonpatients nonpatients?
  - Why is there outmigration / leakage?
    - Service gaps?
    - Poor patient experience?
    - Poor reputation?
    - What else?
  - Ask the questions you don't want to hear the answers to.

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CHNA: VOICE OF THE CUSTOMER

- The CHNA focuses on gaps, but you can focus on anything you want:
  - Why are non-patients non-patients?
  - Why is there outmigration / leakage?
    - Service gaps?
    - Poor patient experience?
    - Poor reputation?
    - What else?
  - Ask the questions you don't want to hear the answers to.
- Do you do surveys as part of your CHNA?
  - Do one - Keep it simple
  - Ask non-patients why they're non-patients:
    - Get social service or other organizations to do surveys at their location with their constituents (non-patients)

THE FOUR QUESTIONS:

1) What is your service area? (who do you serve)
2) What is your market share?
3) Are you utilizing your available data resources?
4) Have you asked non-patients why they're non-patients?

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DATA

To set the stage, everyone should be familiar with:

- Mission, vision, values
- CHNA highlights
- Service area definition
- Population trends
- Historical inpatient and outpatient volume trends
- Volume projections if you have them
- Competitive presence and market share

"STATE OF THE UNION"

Separate perceptions from reality.

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TO QUOTE WAYNE GRETZKY

"Skate to where the puck is going to be, not where it has been"

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SERVICE AREA DATA EXAMPLES

Population

Say your service area (where the majority of your patients reside) is made up of five zip codes. What's been happening with the population? What is projected to happen?

Is your service area population growing or shrinking? How does that trend compare with the trend in your state?

What's happening with the WBA (women of birthing age) population? This can impact need for obstetrical services, pediatrics, women's health, etc.

What's happening with the 65+ population? This impacts your payer mix, swing bed utilization, and need for long term care services.

Zip Code	Est. 2016	Proj. 2021	Proj. 2026	Past 5yr change 2016 - 2021	Proj. 5yr change 2021 - 2026
Zip 1	333	346	367	3.8%	6.1%
Zip 2	837	801	765	-4.3%	-4.5%
Zip 3	322	328	340	1.8%	3.7%
Zip 4	1,060	1,074	1,112	1.3%	3.5%
Zip 5	3,413	3,475	3,600	1.8%	3.6%
Total Service Area	5,965	6,024	6,184	1.0%	2.7%
State	5,488,657	5,871,541	6,256,805	7.0%	6.6%

Service Area Age Groups	Est. 2016	Proj. 2021	Proj. 2026	Past 5yr change 2016 - 2021	Proj. 5yr change 2021 - 2026
Female 15 - 44	839	865	901	3.1%	4.2%
Male & Female:					
65 - 74	563	616	728	9.4%	18.2%
75 - 84	337	347	362	2.8%	4.3%
85+	183	185	194	1.0%	4.9%
Total PSA 65+	1,083	1,148	1,284	6.0%	11.8%
State 65+	739,611	897,932	1,092,093	21.4%	21.6%

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SERVICE AREA DATA EXAMPLES

Market Share

In your service are, people are going somewhere for inpatient care. Where are they going? Some go to you, some go to a competitor. What share are you getting? What's been the trend with this? Are you gaining or losing market share? If you've been losing, who's been gaining? What's happening that might explain the trends?

Service Area Medicare Inpatient Volumes (days)					Change	% Change
Facility	**2016**	**2017**	**2018**	**2019**	**2016 - 2019**	**2016 - 2019**
Facility 1	1,184	1,058	944	879	-305	-26%
Facility 2	498	485	647	569	71	14%
Facility 3	204	332	307	536	332	163%
Facility 4	120	95	114	119	-1	-1%
Facility 5	61	138	96	132	71	116%
All Others	404	332	538	414	10	2%
PSA Total	2,471	2,440	2,646	2,649	178	7%

Service Area Medicare Inpatient Market Share						Change
Facility	**2016**	**2017**	**2018**	**2019**	**4yr Total**	**2016 - 2019**
Facility 1	48%	43%	36%	33%	40%	-15%
Facility 2	20%	20%	24%	21%	22%	1%
Facility 3	8%	14%	12%	20%	14%	12%
Facility 4	5%	4%	4%	4%	4%	0%
Facility 5	2%	6%	4%	5%	4%	3%
All Others	16%	14%	20%	16%	17%	-1%

SERVICE AREA DATA EXAMPLES

Inpatient and Outpatient Utilization

What are the utilization trends for residents of your service area? How would your strategy be impacted knowing inpatient volumes were on the decline? What strategies would you employ knowing utilization for some outpatient services is projected to increase?

Here we see Advisory Board market estimators for inpatient and outpatient services.

Inpatient Service Line	Service Area Resident Est. Utilization		
	2021	2026	Est. 5yr Change
Cardiac Services	69	57	-18%
ENT	6	5	-14%
General Medicine	248	237	-4%
General Surgery	42	38	-10%
Gynecology	5	4	-16%
Invalid	0	0	-28%
Neonatology	64	63	-2%
Neurology	29	27	-7%
Neurosurgery	5	5	1%
Obstetrics	55	52	-5%
Oncology/Hematology (Medical)	19	17	-10%
Ophthalmology	1	1	-14%
Orthopedics	42	37	-13%
Other Trauma	6	6	-6%
Rehabilitation (Acute Care)	1	1	-1%
Spine	13	11	-16%
Thoracic Surgery	4	3	-9%
Urology	9	8	-11%
Vascular Services	11	9	-19%

These are estimations of service area resident utilization. Your hospital or clinic will get a portion of this volume, and also some inmigration (people coming to you from outside the service area).

Estimates are constructed by applying national-level per-1,000 utilization rates, adjusted by age and sex, to demographic data for the market area of interest. Advisory Board takes the local population of the area that you've selected and considers the changing characteristics of that market, such as aging (the movement of people from one demographic group to another) and population growth, using demographic data from Applied Geographic Solutions (AGS). Further, qualitative research is embedded into a wide variety of key market drivers that are expected to impact utilization in the future.

Outpatient Service Line	Service Area Resident Est. Utilization		
	2021	2026	Est. 5yr Change
Cardiology	1,905	1,886	-1%
Cosmetic Procedures	120	121	1%
Dermatology	1,042	1,068	3%
Endocrinology	16	19	17%
ENT	583	611	5%
Evaluation and Management	17,407	16,781	-4%
Gastroenterology	510	503	-1%
General Surgery	138	135	-3%
Gynecology	157	148	-6%
Lab	7,131	7,118	0%
Miscellaneous Services	3,491	3,572	2%
Nephrology	151	150	-1%
Neurology	293	317	8%
Neurosurgery	16	17	8%
Obstetrics	61	58	-4%
Oncology	35	31	-12%
Ophthalmology	1,675	1,712	2%
Orthopedics	773	842	9%
Pain Management	193	205	6%
Physical Therapy/Rehabilitation	4,344	4,740	9%
Podiatry	375	426	14%
Psychiatry	2,029	1,992	-2%
Pulmonology	477	494	4%
Radiology	5,179	4,998	-3%
Spine	23	23	3%
Thoracic Surgery	5	6	11%
Trauma	188	167	-11%
Urology	311	307	-1%
Vascular	255	262	3%

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THE INNOVATION MINDSET

“What got you here, won’t get you there!”

Marshall Goldsmith

Source: ContinuousNext Gartner research

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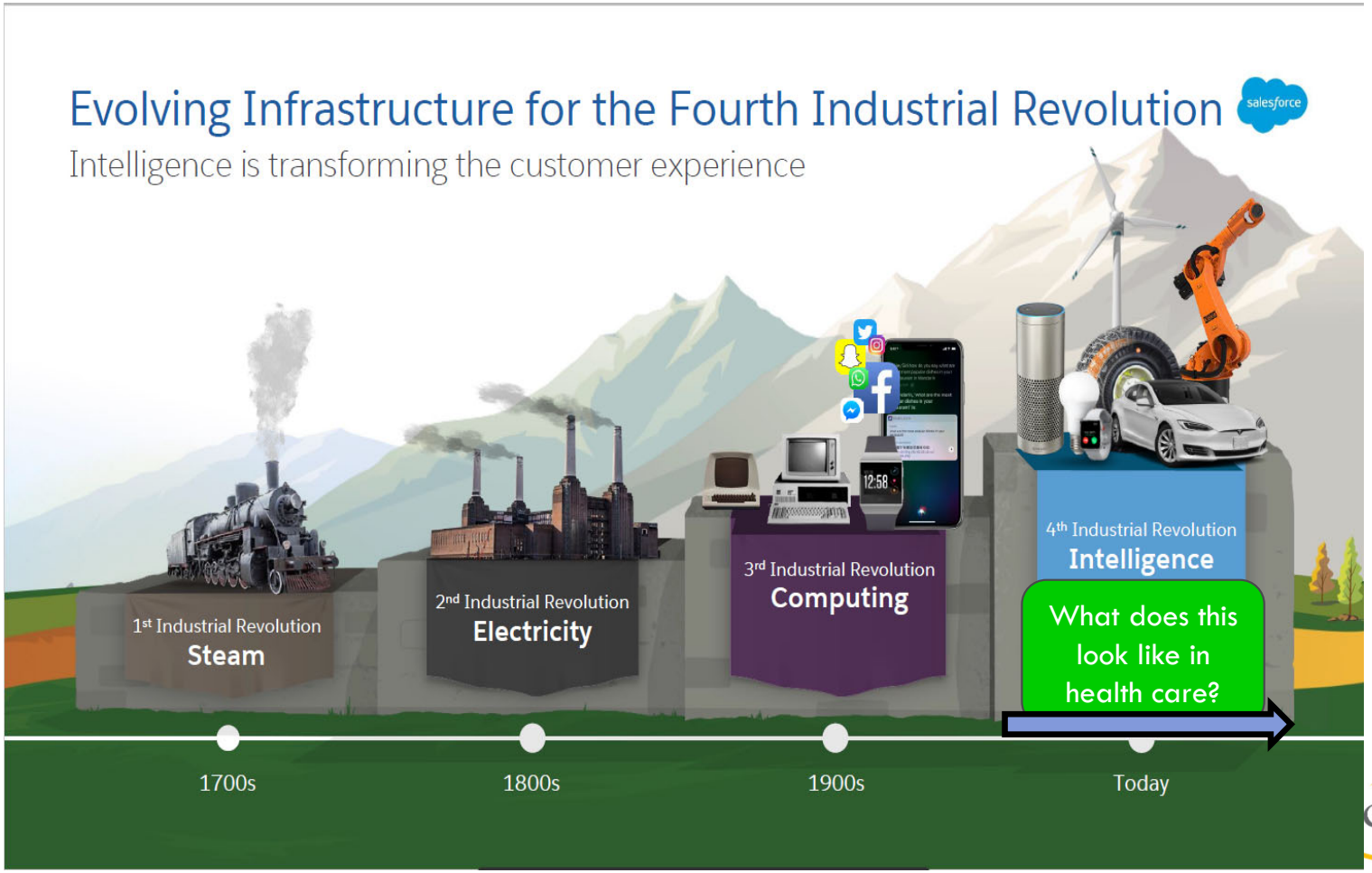
TECHNOLOGY ANOTHER REVOLUTION…



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WHAT DOES AI LOOK LIKE IN HEALTH CARE?

Top 10 AI applications:

1. Robot assisted surgery
2. Virtual nursing assistants
3. Administrative workflow assistance
4. Fraud detection
5. Dosage error reduction
6. Connected machines
7. Clinical trial participant identification
8. Preliminary diagnosis
9. Automated image diagnosis
10. Cyber security

Source: Accenture, Artificial Intelligence: Health Care's New Nervous System

Common Use Cases:

1. Medical imaging
2. Hospital workflows
3. Clinical decision support
4. Personalized medicine
5. Population health

Source: IDG Communications, Artificial Intelligence Opens New Frontiers in Healthcare

Is applicable in the Critical Access Hospital setting!

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INNOVATION IN HEALTH CARE: WHAT DOES IT LOOK LIKE?

Some thoughts:

- Virtual healthcare
- Population health
- Health apps
- Wearables
- Appointment booking
- Patient portals
- Accessible patient health records

What do you think?

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FUTURE OF TECHNOLOGY.....

So where does it go from here and why embrace this technology now?

IS THIS THE LAUNCHING PAD – THE PRICE OF ENTRY INTO THE FUTURE?

- Innovation builds upon innovation
- What will care look like in the future?
  - Things we cannot even begin to dream of
- The possibilities are endless
- Let's venture back to September 23, 1962……

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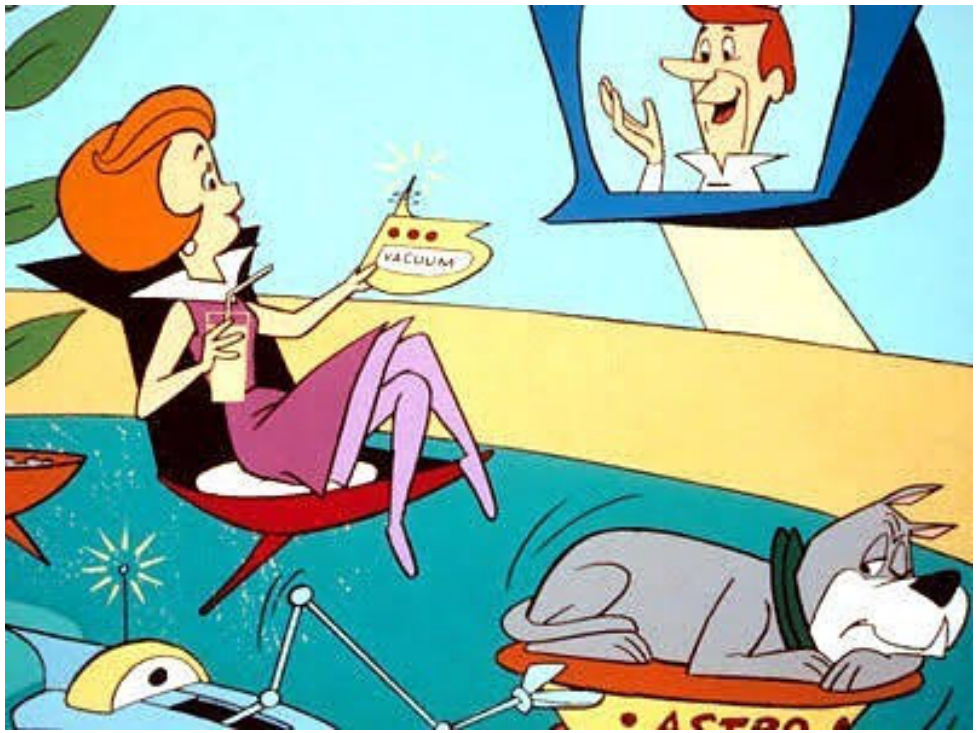
IT ALL STARTED WITH THE JETSONS……

- Video calls
- Robotic vacuums
- Tablet computers
- Robotic house help
- Smart watches
- Drones
- Holograms
- Pill cameras
- Jetpacks
- Flat screen TVs
- 3D printed food



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3D PRINTED FOOD?

Selection

Foodini

By Natural Machines

Country	Spain
Build size	250 × 165 × 120 mm
Material	Food
Price	$ 4,000

The Natural Machines Foodini is a 3D printer **able to 3D print all kinds of paste-type food**. Users can fill the Foodini's capsules with any type of paste food they wish.

Furthermore, if users choose a specific Foodini recipe, **the 3D printer gives instructions** on which ingredients to insert into the capsules.

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HOW CAN WE PARTICIPATE IN THE FUTURE STATE WITHOUT TECHNOLOGY

- Acute hospital care at home
  - https://www.johnshopkinssolutions.com/solution/hospital-at-home/
- Expansion of remote patient monitoring
  - Proactive - beyond chronic and acute issues
- Retain connection with patient panel
  - Snowbirds
  - College students
  - Expand the footprint

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PREPARING FOR THE FUTURE

- Take an inventory of your current capabilities and service offerings
  - Fill the appropriate gaps
- Monitor technology advancements
- Think outside the box
- Develop a technology strategy – Review and update frequently!

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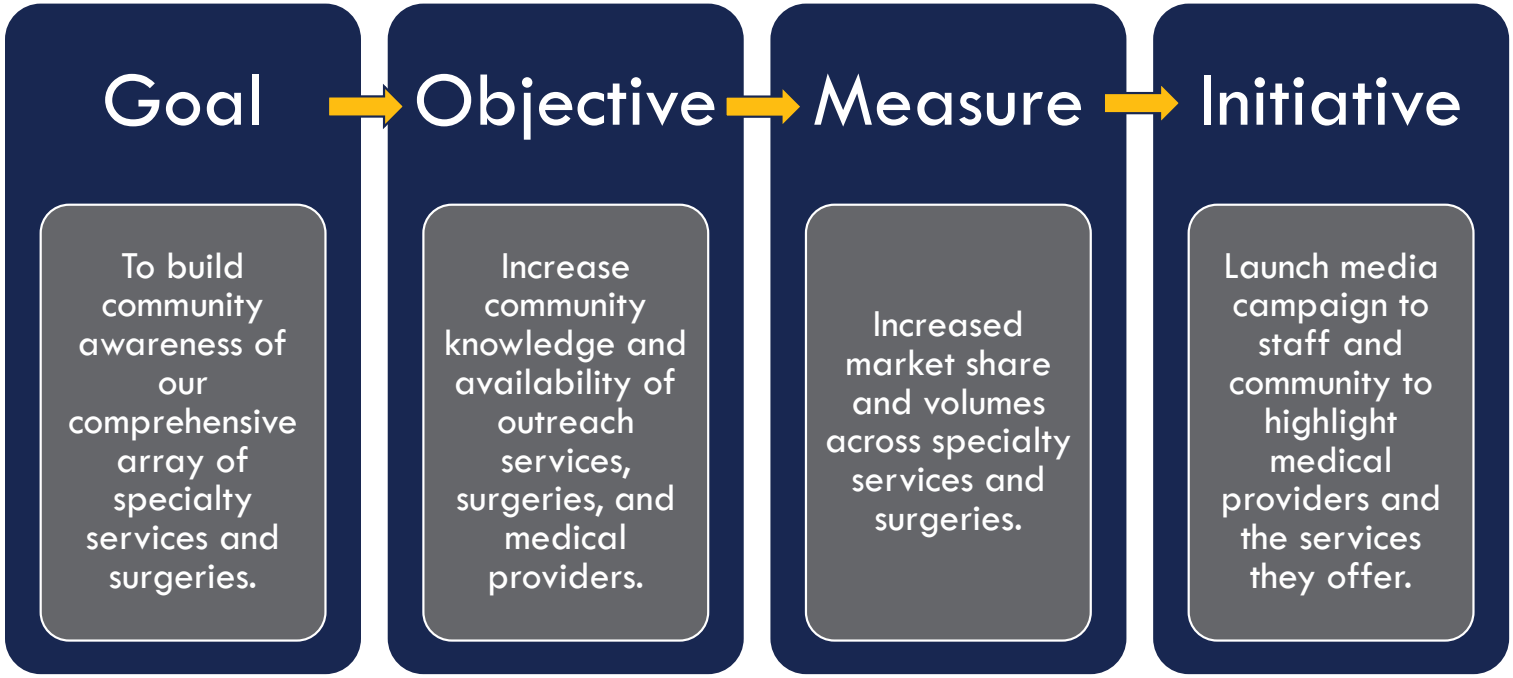
Your marketing efforts should align with your strategic plan to generate a coordinated strategy that achieves, with the defined initiatives, the short- and long-term goals spelled out in your strategic plan.

SAMPLE MARKETING STRATEGY

Pillar: Growth



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MARKETING TAKEAWAYS

- A market analysis dives deep into your service area (and/or target market) and tells a story that allows you to prioritize growth opportunities.
- Researching your market helps to identify individual preferences and perceptions.
- Your marketing efforts should align with your strategic plan to generate a coordinated strategy that achieves, with the defined initiatives, the short- and long-term goals spelled out in your strategic plan.
- Market to individuals.
- Base your decisions and strategies on DATA.

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SERVICE LINE REDESIGN

SERVICE LINE ANALYSIS

Significant funds were provided to rural providers during Covid to provide stabilization and support to providers due to the lost volumes, increased costs and historically strained balance sheets.

- Provided some artificial security
- The long-term realities are returning as funds are expended

Service lines are now in question

- Existing
- Expanded

Focus is on improving not eliminating

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ANALYSIS OF EXISTING SERVICE LINES

- Focus on historically low volume services and other services performing poorly financially
  - Home Health
  - Hospice
  - OB
  - Cardiac Rehab
  - Pulmonary Rehab
  - Outreach Clinics

ANALYSIS OF EXISTING SERVICE LINES

- New focus on historically good performers that now have low volume due to changes during Covid
  - Nursing homes
  - Clinics

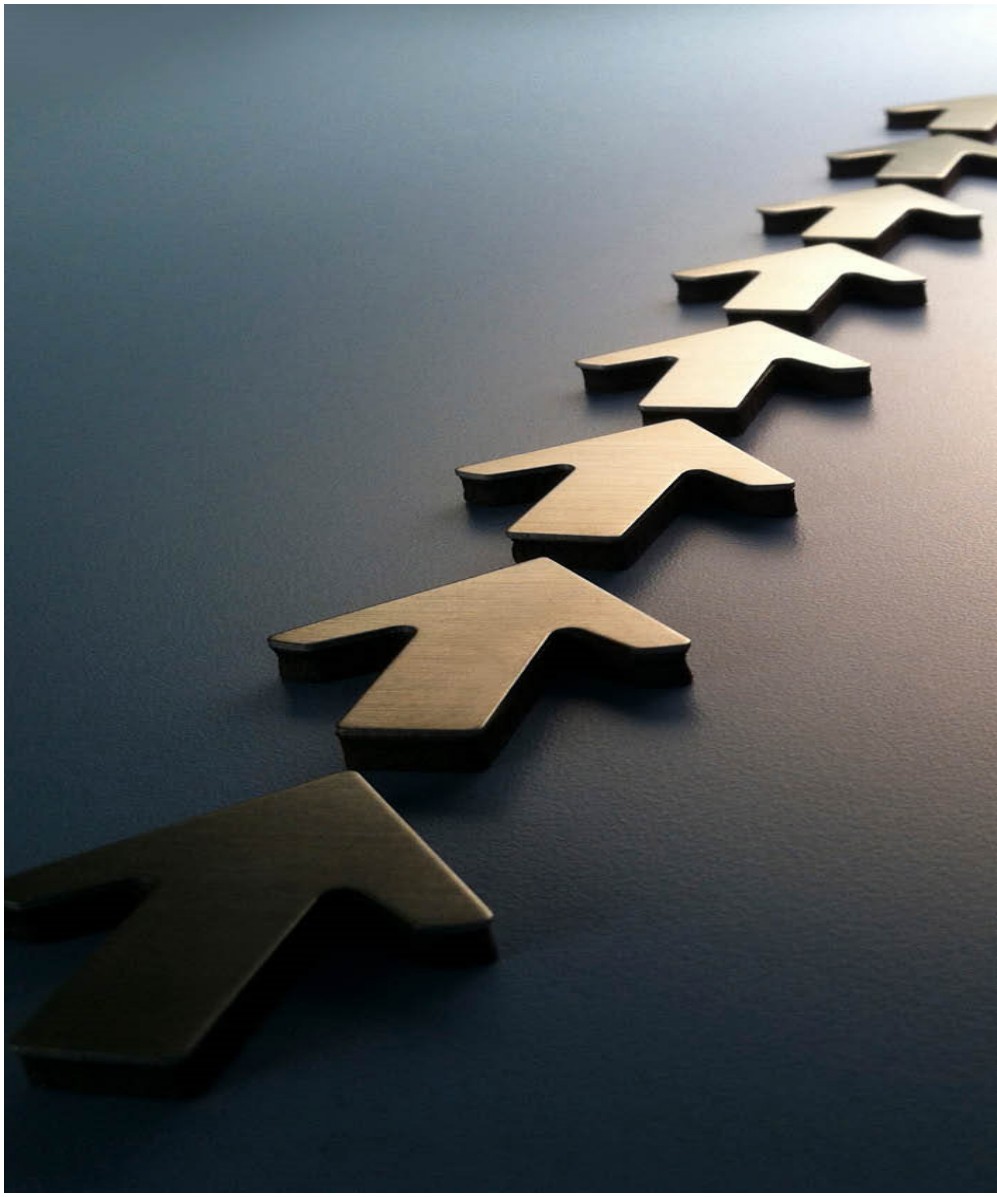
ANALYSIS OF EXISTING PROVIDERS

- Overall financial impact based on current volumes
- Cause for low volumes
  - Marketing/Awareness
  - Market size
  - Perceived or actual quality/performance issues
- Causes for poor financial performance
  - Staffing cost
  - Supply costs
  - Poorly negotiated payor agreements

The purpose of analysis of current service lines is not to find reasons to exit service lines, but rather opportunities to improve performance.

NEW SERVICE LINE ANALYSIS

Changes in patient needs and preferences are leading to the exploration of new service lines
Many external vendors are pushing their "opportunities" to the rural provider



OUTPATIENT PSYCHIATRIC CARE SERVICES

Seeing an increase in the number of providers providing outpatient psychiatric services as a strategy

- Much needed service line in most markets
- Can provide positive financial results if properly structured
- Initially saw this focus in the mid section of the country – now expanding

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OUTPATIENT PSYCHIATRIC CARE SERVICES

Keys to success

- Usually tied to an outside vendor to help create, manage and staff the program
- Focused on geriatric population
  - Medicare covers cost via cost report
  - Inclusion of non-Medicare age population can have significant negative financial ramifications due to inadequacy of payment levels

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OUTPATIENT PSYCHIATRIC CARE - EXAMPLE

	Without Outpatient Geriatric Psychiatric Services
Medicare IP Reimbursement	920,000
Sequestration	(20,000)
Subtotal	900,000
Medicare Swing Bed Reimbursement	475,000
Sequestration	(15,000)
Subtotal	460,000
Medicare OP Reimbursement	2,500,000
Sequestration	(40,000)
Subtotal	2,460,000
Total Medicare Reimbursement	3,820,000

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OUTPATIENT PSYCHIATRIC CARE EXAMPLE

Strategy

- Maximize Medicare utilization
- Repurpose space used by services with lower cost-based reimbursement
  - Non-reimbursable cost centers
  - Outpatient cost centers
  - Inpatient cost centers
- "Magic" occurs as there are shifts in overhead cost allocations
  - Movement of costs away from other lower cost-based service lines
  - Movement of costs toward higher cost-based service line

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OUTPATIENT PSYCHIATRIC CARE - EXAMPLE

	Without Outpatient Geriatric Psychiatric Services	With Outpatient Geriatric Psychiatric Services
Medicare IP Reimbursement	920,000	900,000
Sequestration	(20,000)	(15,000)
Subtotal	900,000	885,000
Medicare Swing Bed Reimbursement	475,000	460,000
Sequestration	(15,000)	(10,000)
Subtotal	460,000	450,000
Medicare OP Reimbursement	2,500,000	3,000,000
Sequestration	(40,000)	(35,000)
Subtotal	2,460,000	2,965,000
Total Medicare Reimbursement	3,820,000	4,300,000

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OUTPATIENT PSYCHIATRIC CARE - EXAMPLE

	Without Outpatient Geriatric Psychiatric Services	With Outpatient Geriatric Psychiatric Services	Difference
Medicare IP Reimbursement	920,000	900,000	(20,000)
Sequestration	(20,000)	(15,000)	5,000
Subtotal	900,000	885,000	(15,000)
Medicare Swing Bed Reimbursement	475,000	460,000	(15,000)
Sequestration	(15,000)	(10,000)	5,000
Subtotal	460,000	450,000	(10,000)
Medicare OP Reimbursement	2,500,000	3,000,000	500,000
Sequestration	(40,000)	(35,000)	5,000
Subtotal	2,460,000	2,965,000	505,000
Total Medicare Reimbursement	3,820,000	4,300,000	480,000
Program Cost			340,000
Net Impact of Adding Program			**$ 140,000**

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OUTPATIENT PSYCHIATRIC CARE EXAMPLE

What other service lines could be explored with similar results?

- Pulmonary Rehab
- Dialysis
- Infusion centers

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TELEHEALTH AND MORE

The PHE drove the need to address telehealth services

- Has your organization committed to telehealth long-term?
- What happens after the PHE?

Virtual Check-Ins

E-Visits

REMOTE PATIENT MONITORING

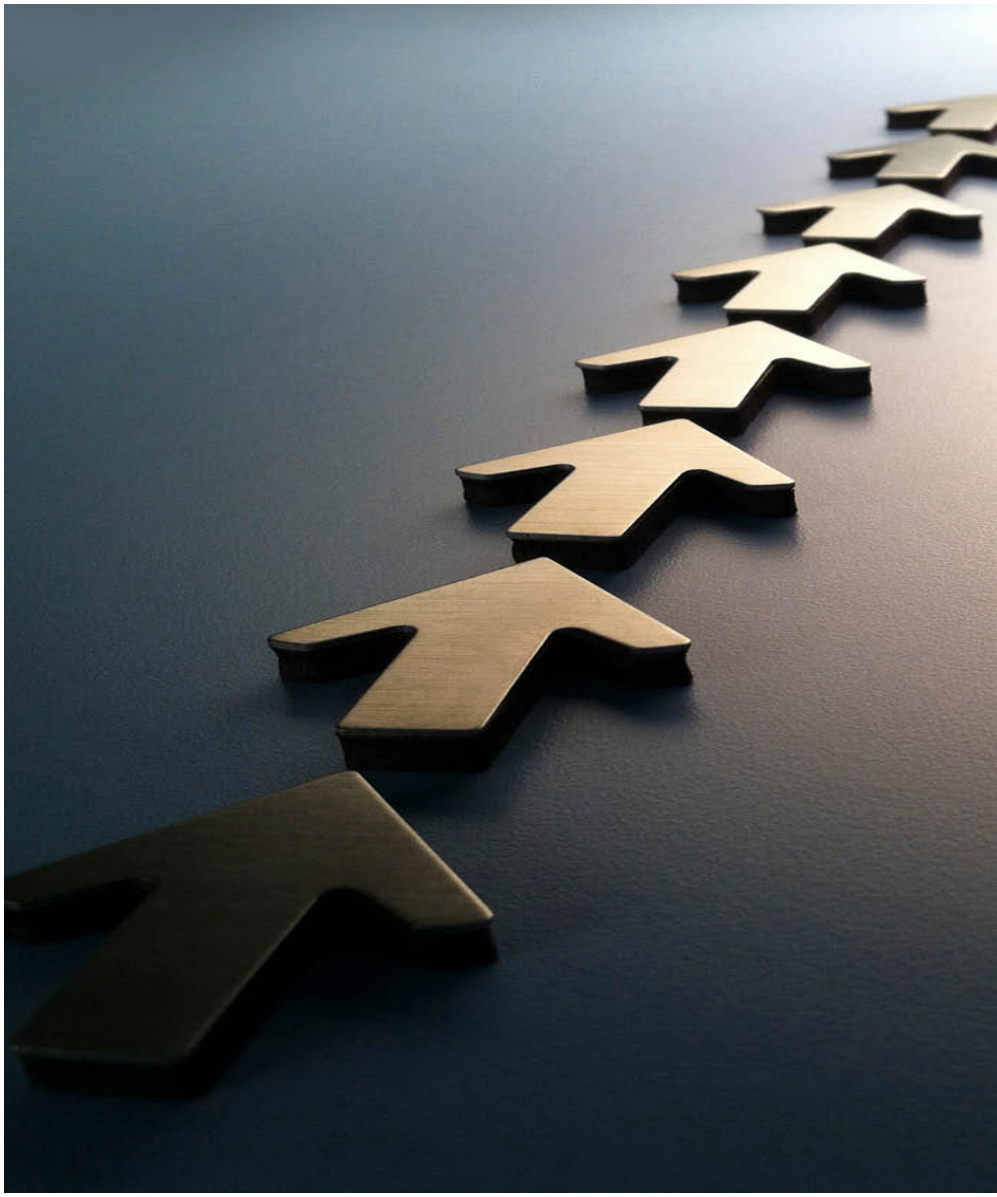
Involves collection and analysis of patient physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness.

- RPM does not require the use of interactive audio-video
- RPM does not require patient be located in a rural area or a qualified originating site.
- Reviewing the description and detail of each of the codes, the concept is this service is a remote service.

POPULATION HEALTH STRATEGIES

Providers are having to figure out ways to replace volumes that may have permanently been lost

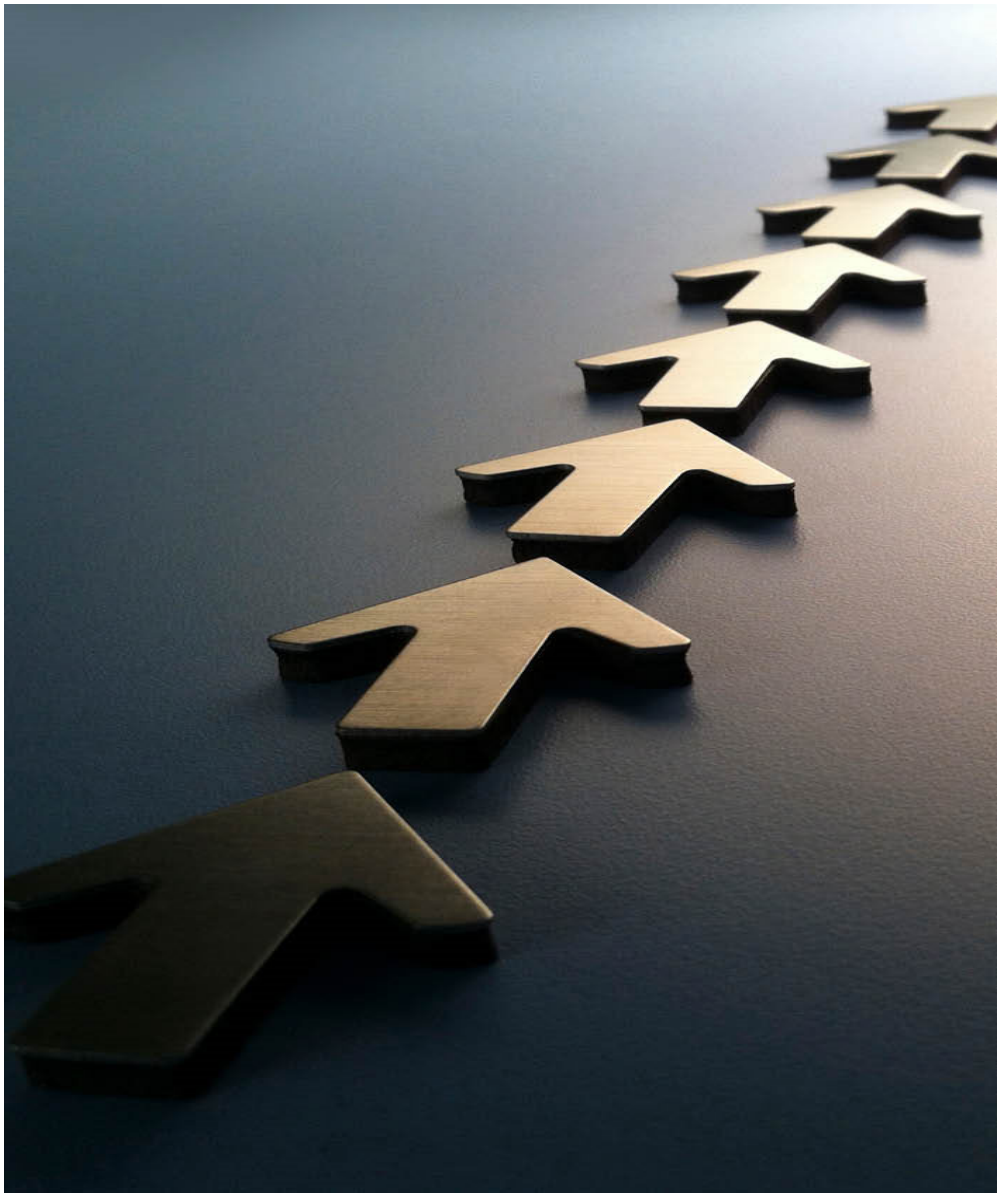
- Seeing success!
  - Population health service line strategies can help restore volumes
    - May not be in same areas
    - Can increase overall grab of market share
  - Bottomline – there can be volume (money) in strategies used by providers engaged in population health.



POPULATION HEALTH STRATEGIES

The financial opportunity:

- Increase patient loyalty
- Increase market share to protect net revenues
- Cost reduction opportunities are frequently outside of the rural provider
  - Ambulance (air and ground)
  - Intensive high-cost interventions
  - Pharmaceuticals
- Participation in shared savings if in an ACO

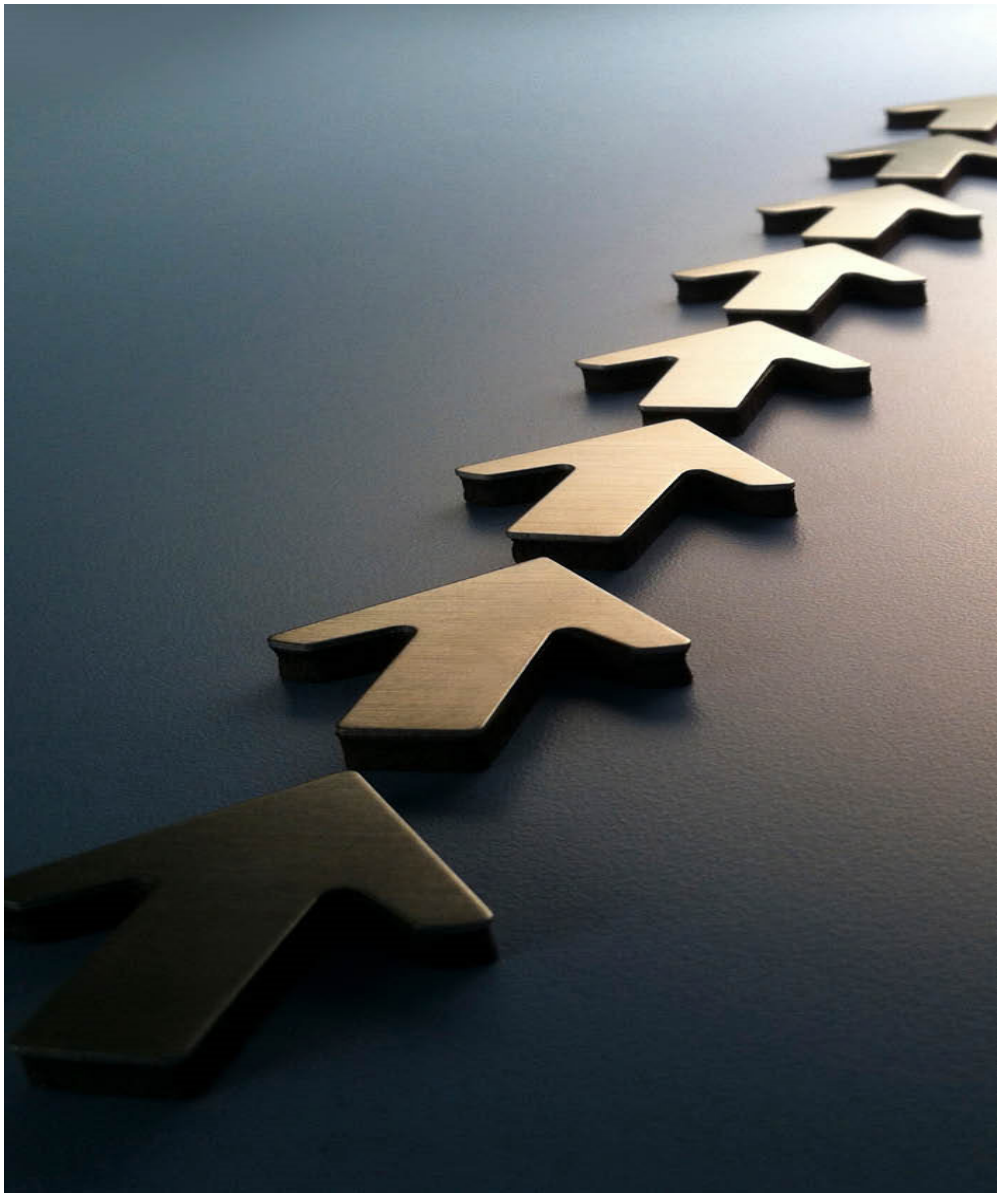


POPULATION HEALTH STRATEGIES

For years providers complained about lack of coverage and payment for preventative services

- Now many providers are not taking advantage of the opportunity
- Focusing on other issues/problems
- Avoiding the “heavy lifting” required

There is money and opportunity in the provision of wellness services



WELLNESS PAYS - FINALLY

Welcome to Medicare preventative visit
Annual Wellness Visit
Transitional Care Management
Chronic Care Management

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WELLNESS PAYS - FINALLY

LEADS TO

- Annual Alcohol Misuse Screening
- Face-to-Face Behavioral Counseling for Alcohol Misuse
- Annual Depression Screening
- Annual, Face-to-Face Intensive Behavioral Therapy for Cardiovascular Disease
- Cardiovascular Disease Screenings
- Obesity Screening
- Counseling for Obesity
- Diabetes Screening

LEADS TO

- Diabetes Outpatient Self-Management Training
- Medicare Diabetes Prevention Program
- Medical Nutrition Therapy
- Counseling to Prevent Tobacco Use
- Lung Cancer Screening
- Ultrasound Screening for Abdominal Aortic Aneurysm
- Prostate Cancer Screening
- Cervical and Vaginal Cancer Screening

LEADS TO

- Colorectal Cancer Screenings
- Screening Mammography
- Bone Mass Measurements
- Glaucoma Tests
- Hepatitis B Virus (HBV) infection screening
- Hepatitis C Screening
- HIV Screening
- Sexually Transmitted Infections Screening
- Sexually Transmitted Infections Counseling
- Flu Shots
- Hepatitis B Shots
- Pneumococcal Shots

WELLNESS PAYS - FINALLY

- Services tend to be those provided or can be provided by local providers
  - New services – Expansion of opportunities
  - Maintained or increase volumes

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WELLNESS PAYS - FINALLY

- Best practices
  - Review wellness opportunities
  - Establish a Wellness Team
    - Services
    - Processes
    - Expectations
    - Monitoring
  - CRITICAL – Develop and adjust processes to streamline delivery of the services
    - Identify a physician champion
    - Elicit and listen to provider feedback
    - Update processes as needed

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RENEWED RHC STRATEGIES

- The strategies of the past may not be the strategies of the future
- Analysis will be required
- If changing cost report requests for approval for changes may have to be submitted for consideration

EXPECTED CHALLENGES WITH THE NEW CAPS

Provider based RHCs will experience greater challenges

- MEI increases of 1-2% versus historical increases in costs that are higher
- Limitations on additional reimbursement to fund replenishment of aging buildings and equipment

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MANAGING THE NEW CHALLENGES

Expect an increased focus on direct expenses related to the RHC operations

Will providers explore options to move current high-cost services outside their RHCs and into provider-based clinics, freestanding clinics and outpatient hospital setting?

- Patient flow
- Patient access
- Patient satisfaction
- Reimbursement

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MANAGING THE NEW CHALLENGES

Overtime it is expected that a gap will be created between the cap and the actual cost per visit with the actual cost per visit exceeding the cap.

- May be minimal in initial years
- Gap could grow substantially over time

Year	MEI Cumulative	Inflation Cumulative	Shortfall
1	2.0%	4.0%	-2.0%
2	4.0%	8.2%	-4.2%
3	6.1%	12.5%	-6.4%
4	8.2%	17.0%	-8.8%
5	10.4%	21.7%	-11.3%
6	12.6%	26.5%	-13.9%
7	14.9%	31.6%	-16.7%
8	17.2%	36.9%	-19.7%
9	19.5%	42.3%	-22.8%
10	21.9%	48.0%	-26.1%

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STRATEGY

Organizations may begin to explore their mix of providers in the clinics

- Increasing percentage of PA, NP and CNM.
- Decreasing focus on physicians
- Clinical, operational and financial considerations

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SIMPLE SCENARIO

Impacted by cost per visit limit by $8 on 9,000 total visits, not impacted by productivity standard. Equated to about $24,000 in Medicare reimbursement lost

Provider replaced a physician FTE that left with an advanced practice provider saving $100,000 in expense

Was able to get under the limit by approximately $3, losing out on Medicare reimbursement by being less than limit of approximately $9,000, but netted $91,000 to bottom line.

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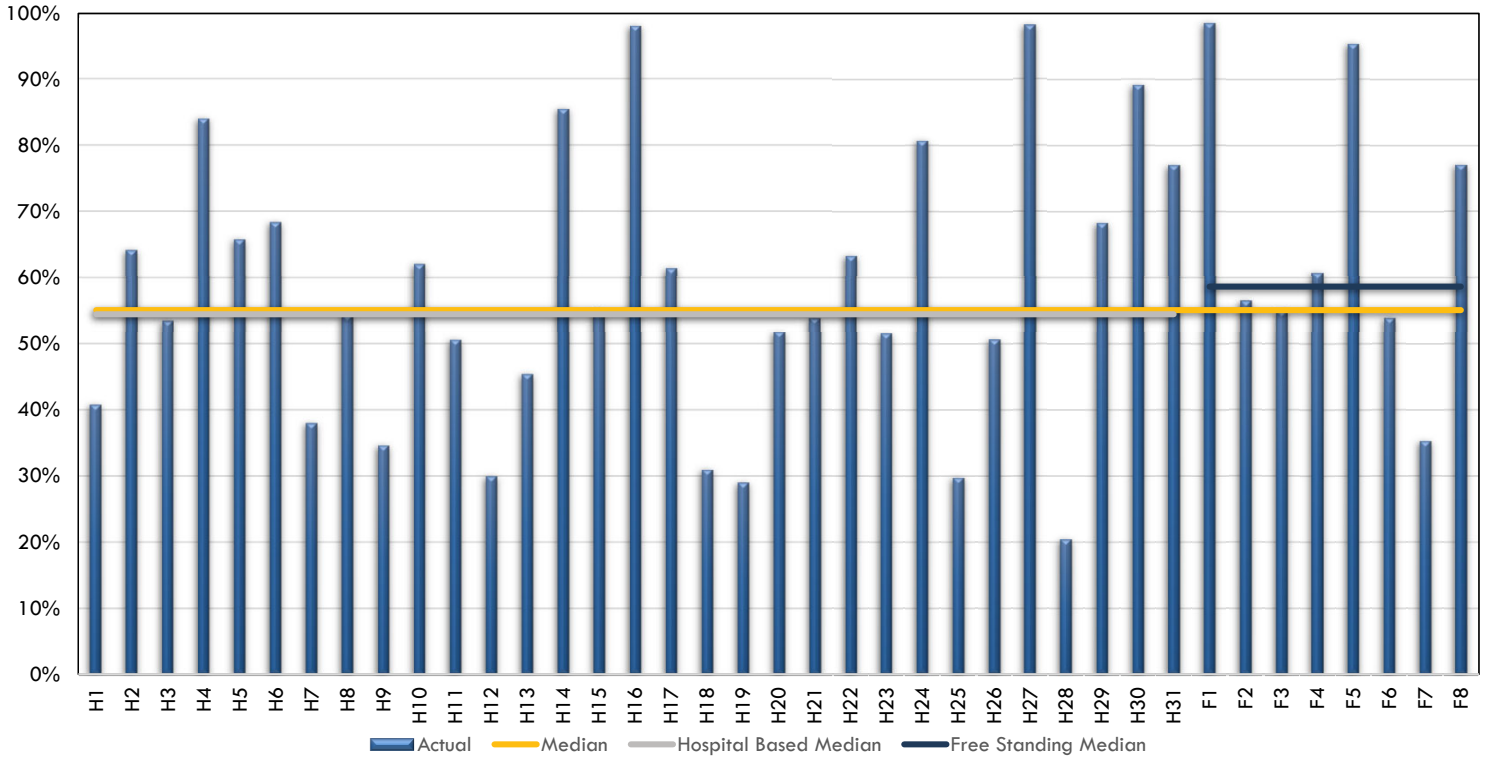
NP & PA FTE AS A PERCENT OF TOTAL PROVIDER FTE



Max = 99%
Min = 20%
Average = 59%

Median = 55%
25th Percentile = 48%
75th Percentile = 73%

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RHC PRODUCTIVITY STANDARDS

Providers impacted by productivity standards decreases Medicare reimbursement.

Productivity Standards:

Physician = 4,200 per FTE (equates to a little over 16 visits per day).

APP (PA, NP, CNM) = 2,100 per FTE (equates to a little over 8 visits per day).

Not subject to productivity standard:

- Visiting nurse
- Clinic psychologist
- Clinical social worker
- Physician services under agreement

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SIMPLE SCENARIO

Productivity standard was 10,500 visits, actual visits 9,000
Over productivity standard by 1,500 visits, replaced physician with advanced practice provider saving $100,000 in expense. (was under the cost-per visit limit)

Impact on Medicare reimbursement of approximately $60,000.

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COMPARISON VISITS PER FTE

	Physician Visits per FTE	APP Visits per FTE
Client #1	3,610	3,805
Client #2	2,240	3,865
Client #3	4,500	2,200
Client #4	4,350	3,000
Client #5	3,960	3,381

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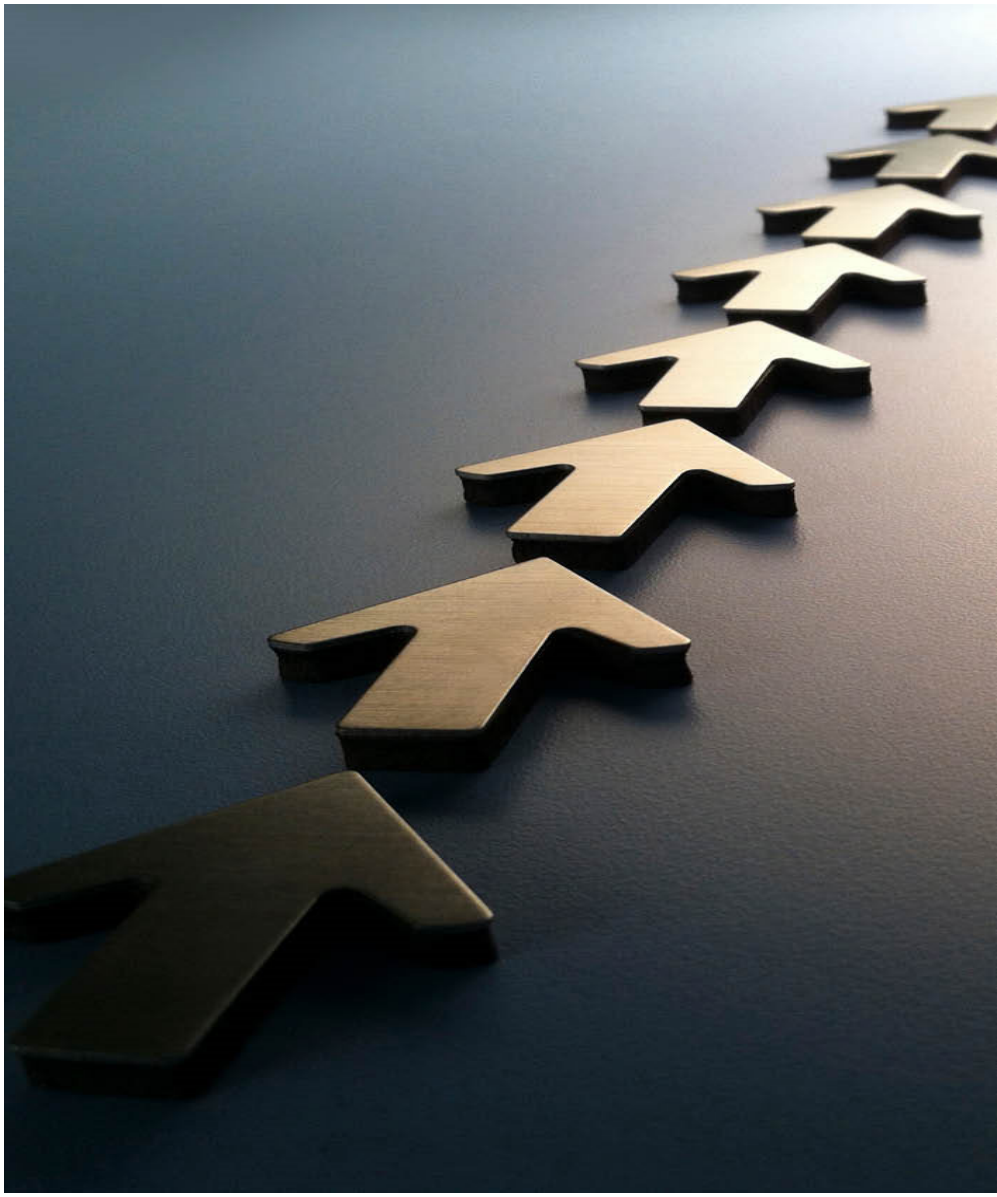
OTHER CONSIDERATIONS

- Accuracy of cost assignments
- Accuracy of vaccination costs
- Accuracy or reported visits
- Revisiting overhead allocation methodologies



QUESTIONS?

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THANK YOU!

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