CASE 3

PHYSICIAN CARE SERVICES, INC.

Physician Care Services, Inc. (PCS), was founded as a for-profit corporation on January 1, 2000. Three physicians each own 20 percent of the stock, and one physician owns 40 percent. PCS currently offers nonemergent care services in two locations—at the Alpha Center just outside the city limits of Middleboro in Mifflenville and at the Beta Center in Jasper, close to the Jasper industrial park and suburban neighborhoods. At these locations ambulatory medical care is provided on a walk-in basis. PCS centers do not offer emergency services. If a patient arrives needing emergency services, an ambulance is called to transport the patient to the nearest hospital emergency department.

The Alpha Center opened in January 2000. Originally, it only treated occupational health clients. This policy was changed in 2004 when private patients were accepted. The Beta Center opened in January 2006 and has always treated private as well as occupational health clients.

PCS specializes in providing services that are deemed convenient by the general public. Patient satisfaction remains its highest operational goal. At present, staff physicians employed by PCS do not provide continuing medical care. PCS physicians refer patients to area physicians as warranted for continuing and/or specialized medical care. Although patients often return to a PCS center, chronic illness management is not provided.

Patient Services

Occupational Health Clients

Occupational health clients are sent to a PCS center by their employer for treatment of a work-related injury (which is usually covered by workers' compensation insurance), for pre-employment or annual physicals, and for health testing, which are paid for directly by the employer. Because of special work conditions, usually involving hazardous chemicals or materials, some local corporations contract with PCS to provide comprehensive physicals in accordance with Department of Transportation and other federal and state laws and regulations. Local corporations consider PCS a cost-effective and convenient alternative to a hospital emergency department. These corporations use PCS in lieu of employing a physician. Corporate clients expect PCS to assist with all phases of case management involving worker injury. They hold PCS accountable that their workers receive timely, appropriate, and cost-effective services.

Physicals for Occupational Safety and Health Administration compliance are currently priced between $300 and $500 each. Physicals for local police and fire include pulmonary function tests (PFT), laboratory tests, and electrocardiograms (EKGs). They are currently priced between $250 and $350 per physical, depending on contractual volume. Pre-employment physicals are typically priced between $60 and $95 and include a urine dip test. Services provided for occupational health clients are billed directly to the employer.

Private (Retail) Clients

Private clients also seek medical care from PCS centers. All aspects of general medical care are provided except OB/GYN. Private patients are attracted to PCS because they do not need an appointment. PCS accepts cash, checks, and credit cards at time of service. As of 2008, PCS directly bills the larger health insurance plans covering its market area:

- Statewide Blue Shield
- American Health Plan
- Cumberland River Health Plan
- Central State Good Health Plan

At time of service, retail clients covered by these plans are screened to verify eligibility and to determine whether they have satisfied any required deductibles. If deductibles have been met, patients will be required to pay just the copay amount, and a bill is sent electronically to the insurance plan for the account's balance. If deductibles have not been

met, then the patient will pay the bill at time of service, and PCS will enter the bill into the insurance company's system as partial fulfillment of any outstanding deductible. If the patient does not have coverage from one of these insurance companies, she receives a bill to claim reimbursement directly from her insurance plan. PCS also directly bills Medicare. A recent study suggested that these four private insurance companies and Medicare cover approximately 85 percent of PCS's private clients.

Any client who has a history of bad debt at PCS or is unable to pay at time of service is referred to a hospital emergency department for service. PCS maintains an aggressive credit and bad debt collection policy and does not serve Medicaid patients.

Patients living within a 30-minute travel distance from a PCS center typically constitute 80 percent of PCS's private pay patients.

Organization and Management

Each center is located in approximately 6,000 square feet of rental space devoted to patient services. The Alpha Center is located on main roads between Middleboro and Mifflenville in a small shopping center. The Beta Center is located on the first floor of a new office building adjacent to a large shopping mall in Jasper. Ample parking is provided in both locations. Each center maintains attractive signs.

Each center is open 60 hours per week, 8:00 a.m. to 7:00 p.m. on weekdays and 9:00 a.m. to 2:00 p.m. on Saturdays. Both centers are closed on Sundays and Memorial Day, July 4, Thanksgiving, Christmas, and New Year's Day. Each center has four fully furnished patient examination rooms and one extra room. Currently each center has some excess space.

For patient care the minimum staffing at each center is one receptionist/billing clerk, one medical assistant, and one physician or nurse practitioner. Additional staff (e.g., advanced registered nurse practitioner, physician assistant, medical assistant) is scheduled based on anticipated high-volume days. Typically the nurse practitioner works on Saturdays and assists with physicals and other services on high-volume days. Physician assistants also assist on high-volume days.

The central administrative and billing office is an additional 2,500 square feet and is located adjacent to Alpha Center. The central office staff includes the president, medical director, director of nursing and patient care, business office manager, and the billing and bookkeeping staff.

Charges

Each center uses the same price schedule. The basic visit charge (CPT 99202) has changed each year.

January–December	Private Pay ($)	Occupational ($)
2010	94	161
2011	99	170
2012	104	180
2013	110	189
2014	120	201

Current detailed prices include:

CPT Procedure		
Code	Description	Price ($)
99201	Office visit, brief, new	96
99202	Office visit, limited, new	120
99203	Office visit, inter, new	201
99204	Office visit, comp, new	226
99211	Office visit, min, est	65
99212	Office visit, brief, est	96
99213	Office visit, limited, est	201
99214	Office visit, inter, est	201
99215	Office visit, comp, est	294

Additional charges are levied for ancillary testing and specialized physician services, such as suturing. A patient returning for a medically ordered follow-up is charged $96 for the return visit. Based on Current Procedural Terminology (CPT) comparison, PCS fee levels are competitive within the area. No similar medical service is offered within a 45-minute radius from each center. In the past—as part of an advertising campaign to attract private pay patients—each May and June PCS has offered discounted physicals, such as camp physicals for children at $48 and for all children in a family for $69.

Steve J. Tobias, MD, board chair and president of PCS, says national studies suggest that urgent care visits are at least $10 less than a visit to primary care physician in

private practice. Other studies indicate that urgent care visits cost $250 to $600 less than emergency department visits for the same CPT code.

Some occupational health clients are charged based on a negotiated volume-based price, especially for physicals. PCS's medical director negotiates specific fees for physicals and specific medical tests ordered by an employer. Typically, an employer approaches PCS in need of a specific type of physical, such as the annual physical required by the Department of Transportation for all operators of school buses, or specific medical test for employees. PCS submits a bid to perform a specific number of physicals based on a flat rate per physical.

As of 2007, PCS does its own payroll. Employees must have direct deposit with a local bank. Each employee receives an electronic pay stub biweekly (with accrued balance of vacation and sick time) and a W-2 at the end of the year.

Board of Directors

The board of directors is composed of the four physician owners and meets quarterly to review operations. The annual board meeting occurs in December, at which time officers are elected for the coming year. As majority stockholder, Dr. Tobias is chairman of the board and president of PCS. Jay T. Smooth, MD, is the board secretary. Other board members are Rita Hottle, MD, and Laura Cytesmath, MD. Current owners have the option of buying any available stock at its current book value. An outsider can purchase stock in this company only if all the current owners refuse to exercise this option and he receives the approval of the existing owners. It should be noted that PCS has paid a stock dividend in three of the last five years.

President and Medical Director

Dr. Tobias is also the medical director of PCS. He is a graduate of the medical school at Private University and has completed postgraduate medical education at Walter Reed Army Hospital in general internal medicine. He is board certified in general internal medicine, emergency medicine, and occupational health. He also holds a master's in public health from State University. As medical director, Dr. Tobias is responsible for medical quality assurance programs and the recruitment and retention of qualified physician employees. He is also responsible for securing the services of consulting radiologists to read all X-rays. He receives a separate salary as medical director and as president. Compensation for the medical director position began in 2008. Before Dr. Tobias founded PCS, he was a full-time emergency physician at Middleboro Community Hospital. He originally worked to establish joint venture urgent care centers with Middleboro Community Hospital. When this approach failed, he recruited the other stockholders and moved ahead with PCS. As president, Dr. Tobias is responsible for the management of all resources and strategic planning.

Dr. Tobias schedules the other physicians and the nurse practitioners. He also works in the centers and provides on-call services as needed. He has consulting medical staff privileges in the Department of Medicine at Middleboro Community Hospital.

Clinical Staff

In total, the clinical staff is composed of eight physicians, three nurse practitioners, and two physician assistants. All physicians hold medical staff privileges at an area hospital.

Name	Medical Specialty	Certification
Bennet Casey, MD	Family practice	Board certified
Mark Welby, MD	Family practice	Board certified
Steve Tobias, MD, MPH **	Emergency medicine	Board certified
Jay Smooth, MD *	Emergency medicine	Board certified
Rita Hottle, MD *	Emergency medicine	Board certified
Laura Cytesmath, MD *	Emergency medicine	Board certified
Micah Foxx, DO, MPH	Occupational health	Board certified
Melisa Majors, MD	Occupational health	Board certified
Carl Withers, ARNP	Family and adult health	
Jane Jones, ARNP	Family and adult health	
Gerri Mattox, ARNP	Family and adult health	
Rutherford Hayes, PA		
Mary Fishborne, PA		

* Owner

** Owner and president

Until 2007, staff physicians were retained as independent contractors and received no benefits above their hourly wage. Beginning in 2007 when nurse practitioners were added, physicians (and all other employees) who worked more than 1,000 hours were provided comprehensive benefits, including family medical coverage. Also as of 2007, PCS reimburses all physicians and nurse practitioners for their medical malpractice insurance. Full coverage is provided when a member of the medical staff works 1,400 hours at PCS. Others receive a partial reimbursement.

Physicians are paid $100 per hour. Nurse practitioners receive $50 per hour. These payment levels have been fixed for two years and are considered within the appropriate market range. Drs. Smooth, Hottle, and Cytesmath also work as emergency physicians at Middleboro Community Hospital. Dr. Casey serves as medical director one day per week at an area corporation, where he specializes in occupational health. Dr. Welby also works at Convenient Med Care, Inc., in Capital City. Dr. Foxx, who recently relocated to Jasper with her family, is available to work no more than six shifts per month, a condition she has established until her children reach school age. Dr. Majors also works as an emergency physician in Capital City. Physician assistants are paid $40 per hour and assist physicians on anticipated high-volume days.

Dr. Tobias schedules all members of the medical staff for work on a monthly basis with the understanding that if a physician is unable to work, it is her responsibility to secure a replacement from the qualified medical staff of PCS. Physicians and nurse practitioners work an entire shift (e.g., 11 hours on a weekday). Fridays and Saturdays are typically assigned to the nurse practitioners. Physician assistants are on call for busy days to assist physicians.

The clinical staff of PCS meets quarterly to review areas of concern. Dr. Tobias does random reviews of medical records to ensure compliance with standards of clinical practice. He is also responsible for all issues involving credentialing.

Medical Assistants

Medical assistants at each center are trained to take limited X-rays, draw specimens for laboratory testing, do EKGs, and conduct simple vision and audiometric examinations. Each center is equipped to do:

1. On-site X-ray
2. PFT
3. EKG
4. Audiometric and visual testing
5. Some laboratory testing (e.g., strep screen, dip urine)
6. Drug and breath alcohol testing

A regional laboratory processes more advanced laboratory work.

Two medical assistants are assigned to each weekday shift. One is assigned for 7 hours per day (i.e., 35 hours per week) and the other is assigned for 4 hours per weekday and Saturdays (i.e., 25 hours per week). Responsibilities include examination room

preparation, assisting the physician or nurse practitioner, patient testing, case management, scheduling visit follow-up care, and addressing patient questions. Each center maintains a pool of qualified medical assistants who are trained, evaluated, and scheduled by the director of nursing and clinical care.

Central Office Staff

Dr. Tobias devotes his time to being both the president and medical director at PCS and filling in at a center when needed. As president he is responsible for the overall management of PCS. Joan Carlton, LPN, is director of nursing and clinical care. She trains, supervises, and schedules the medical assistants. She is also responsible for ordering medical supplies, meeting with occupational health employers as needed, and general administrative duties as assigned by Dr. Tobias. If needed, she substitutes for a medical assistant at a center.

Martha Coin directs the business office and has three full-time staff. She schedules the receptionist staff at each center. She and her staff assist the receptionists and billing clerks at each center, manage all insurance billing, and manage the general ledger, including accounts payable and accounts receivable. If needed, she or a member of her staff substitutes for the receptionist at a center. The central office billing staff also maintains a list of available (and trained) fill-in receptionists to cover absences and other needs.

Receptionist Staff

One full-time (35 hours per week) front desk receptionist is hired for each center. Aside from greeting and registering all patients, the receptionist is also responsible for appointments, billing, records for occupational clients, and managing cash receipts. One or more additional receptionists are hired for the remaining 25 hours per week.

Additional Information

In 2008 PCS began using URGENT CARE MIS, an electronic medical information, general ledger, and billing system. Computer terminals were installed in the reception area in each center, at the central office, and in each examination room. PCS uses this system for all phases of financial and medical record keeping and billing, appointment services, case management, staff scheduling, and data management. This system captures, stores, and reports all CPT codes and links medical procedures with revenue and expense information. The health insurance billing system has a direct Internet link with the participating insurance companies and Medicare. PCS purchased the hardware and leased the required

software for ten years. It receives hardware maintenance, software updates, and technical assistance from the vendor.

A 2013 study of medical records indicated that the most common CPT codes at PCS are

- 99212/3 and 99202 Office/Outpatient Visit,
- G0001 Drawing Blood,
- 85029 Automated Hemogram, and
- 71010/2 Chest X-Ray.

Injuries and rechecks generally account for 20 percent of all visits.

Paper medical records that existed prior to 2008 are retained in active file for seven years, and then transferred to closed files.

When interviewed, Dr. Tobias indicated that discharging Nancy Stone, RN, as director of nursing and clinical services in 2012 was a hard decision. Some employees still regret this situation. Stone was well liked but just could not get along with some of the physicians and had a great deal of difficulty coping with multiple job responsibilities. At the end of her tenure she refused to provide patient care as needed at the Beta Center. After she was discharged, Stone complained that she had "too many duties to do well, and PCS was more interested in getting patients in and out than in providing patients quality medical care." She has retained an attorney and informed Dr. Tobias that she is suing him and PCS for "wrongful discharge." As she stated at the initial hearing for the lawsuit, "Meeting job expectations was hard when the job lacked any formal job description." Dr. Tobias shared in the interview that he felt compelled to act even though Stone is the sister of the vice president for human resources at Carlstead Rayon, a growing occupational health client of the Alpha Center, and that additional details are not available given that this case is currently being handled by legal counsel.

Dr. Tobias stated that the owners should look forward to achieving even greater corporate profitability. Dr. Tobias indicated that no one foresaw the terrible first three years of financial losses. He also said that within the past few years, PCS has earned its place in the regional medical care system and its future appears solid. It should be noted that, at the end of 2007, one of the original physician partners, who is no longer affiliated with PCS, exercised his option to be bought out by another stockholder. Dr. Tobias was the only partner willing at that time to increase his ownership in PCS.

Dr. Tobias also indicated that the owners might now be in the position to open a third and even fourth location. He also discussed purchasing buildings to house the existing centers and adding some services to better serve their occupational and private pay clients.

"We are a debt-free corporation that is beginning to earn serious profits," he said. "Along the way we have distinguished ourselves by the high quality of care we have provided—our patients and occupational health clients are delighted with our highest-level commitment to patient care, convenience, and affordable prices. While it has been a long road, I have every reason to believe we will continue to prosper and expand."

The original real estate leases on the Alpha and Beta Centers expire at the end of 2015. Dr. Tobias said that he timed the expiration of these leases to coincide with when PCS would be ready to make a major strategic move. Each current lease has a renewal clause for up to 36 months, with an escalation clause so that rents do not increase more than 15 percent per year. Tobias estimates that appropriate facilities could be acquired for $150 per square foot (including land, site improvements, and facilities) and that it would take approximately six months from the time the contract was executed to when the center could be fully operational.

When asked to identify future challenges, Tobias noted that he felt that volume had just about hit the level at which total service time averages about 20 minutes. He did indicate, however, that there might be a need for larger waiting rooms and that those patients waiting for more than 90 minutes might be a problem. Tobias was, however, pleased that patients generally reported "complete satisfaction" with the quality of care provided by PCS. Dr. Tobias repeatedly cited the competent clinical and administrative staff. Overall, he indicated that he was concerned about continued rapid growth. "Our early success with occupational health may be slowing. If we lose a significant amount of manufacturing in our area, we potentially lose occupational health clients. Our future in occupational health will follow the local economy."

Dr. Tobias noted that regional unemployment has already affected occupation health. Fewer people are being hired and working. Fees paid by the workers' compensation program have been fixed for 24 months. People who are unemployed lack health insurance. Dr. Tobias expressed a great deal of optimism that the full implementation of the new federal health insurance plan (the Patient Protection and Affordable Care Act) would significantly expand PCS's pool of private clients.

Two years ago, PCS instituted an appointment plan for occupational health clients, which Dr. Tobias reported has been very successful. Under this plan, occupational health clients are scheduled for physicals or medical testing. Under the "call before you come" system, patients (or employers) can call ahead to determine the approximate wait time, make a decision, and—if they want service—register for service at an approximate time that day, thereby ensuring themselves a specific place in the queue for service even before they arrive at a center. Every patient who arrives at a center is given an approximate wait time by the receptionist and told they need not wait in the waiting area to preserve the scheduled time for their appointment. While "first in, first out" is generally used, urgent care cases (especially injuries) are bumped ahead of nonemergency patients. Signs in the waiting area

explain to patients that some occupational health clients are served by appointment and that appointments override arrival order.

PCS advertises its services in the regional market. It uses billboards on main roads and newspaper advertising. It also uses an extensive website and social media. The director of nursing and patient care visits current and prospective occupational health clients and typically answers approximately 15 to 25 telephone inquiries per month regarding quotes for specific services, such as employee physicals.

When interviewed, other PCS physicians offered different perspectives. Three physicians expressed concern about the manner in which Dr. Tobias schedules the physicians. They were never sure exactly how many shifts per month they would work and at which center. All prefer to work at only one center and indicated that this type of stability leads to a better medical care team.

Records suggest that certain physicians may have productivity profiles significantly different from those of other physicians. It appears that on busy days, revenue per visit drops, a trend that suggests that physicians do less ancillary testing when they are busy. The target for physicians and nurse practitioners is 3 to 4 patients per hour. Three physicians have also requested extra compensation for busy days. They contend that they tend to be scheduled on "very busy days" and receive the same hourly compensation as physicians who work on slower days. Dr. Tobias indicated that he does not feel that their claim is warranted.

In 2010, two (nonowner) physicians said that because they are paid by the hour, they should be paid for the time they spend treating those patients who arrive right before closing time. Up until this change, all staff were only paid for the hours in their shift (e.g., 11 hours), which was sometimes less than the number of actual hours worked. Employees are expected to treat all patients that arrive during working hours even if this extends their work time beyond closing time. All physicians reported that they felt that their pay level was reasonable given their responsibilities.

Six occupational health nurses at area corporations were interviewed. Each indicated that she and her corporation were satisfied with PCS. A number of these nurses indicated that they appreciated PCS—specifically the medical assistants—keeping them informed about specific patients and that PCS was creative in explaining restriction and suggesting "light duty," medically appropriate work an injured worker could perform for the employer as an alternative to her regular duties until she was ready to resume her regular duties.

Dr. Tobias recently returned from a professional meeting with statistics that he felt could help PCS better estimate its future market. These statistics apply to this state:

Average Number of Physician Visits—Ambulatory Care per Person, per Year, by Age and Sex (National Statistics)

Age	Males	Females
0–14	3.37	3.09
15–44	1.99	3.92 (includes OB/GYN)
45–64	2.98	4.34
65+	4.51	5.19

NOTE: Visits unrelated to workers' compensation and occupational health

At this meeting, Dr. Tobias also learned that other urgent care corporations use the following parameters in their fiscal and market planning.

- For every 15 percent increase in a basic visit fee, there will be a 25 percent reduction in utilization of retail patients without health insurance (i.e., who pay by cash, check, or credit card).
- Patients covered by insurance, including Medicare and commercial insurance, are generally not price-sensitive as long as the annual increase in the basic visit fee does not exceed 20 percent.
- Annual increases up to 15 percent in ancillary charges do not affect the number of new visits by retail clients. It appears that ancillary charge increases above 15 percent may reduce return visits by as much as 45 percent regardless of payment source.

At the next board meeting, Dr. Tobias plans to discuss a series of new ideas and opportunities that deserve the board's attention. Currently his ideas and opportunities include the following:

Prescription Drugs for Retail Patients

This service is currently available to patients covered by workers' compensation. State law allows physicians (and nurse practitioners) to dispense prescription drugs as long as adequate records are maintained. National firms specializing in drug repackaging let PCS buy prepackaged prescription drugs ready for sale to a patient. PCS has already established its formulary

for workers' compensation patents. PCS has determined that by maintaining 12 specific drugs in pill form it can meet approximately 60 percent of the retail demand that PCS physicians create for prescription drugs. The charge for prescription drugs for workers' compensation patients is directly billed to the employer as part of the overall charge for service.

Dr. Tobias indicated that PCS should consider extending this service to all patients. By only providing "high-volume" drugs, PCS can guarantee high inventory turnover. An appropriately sized initial inventory for retail patients can be capitalized for a center for $1,000. All suppliers promise a next-day replenishment of inventory items. The shelf life of all drugs is more than one year. Even with a markup of 800 percent, PCS prescription prices will be competitively priced in the area. The question is whether this service should be expanded to retail patients. By reviewing medical records of current retail patients (non-physicals), PCS has determined the number of prescriptions received per visit by patients.

Age of Patients	Average Number of Prescriptions Received per Visit
0–14	1.20
15–44	0.80
45–64	1.10
65+	1.90

The average supplier cost per PCS prescription is estimated to be $5. To maintain the proposed inventory, additional software costing $12,500 per year is required to verify insurance coverage and copays and process insurance payments. Dr. Tobias would like to potentially begin this service within six months. Questions remain, however, whether any prescriptions issued by PCS should be refilled without another medical visit. Questions also remain as to billing procedures when patients do not have a current prescription plan card at time of service. An urgent care center in Capital City recently ended its pharmaceutical sales to retail patients because of the high number of refused claims by drug plans.

Drug Testing for Healthy Employees

The director of human resources at a local company, a current PCS occupational health client, has stated that its new labor contract includes a clause stating that "all workers and job applicants are subject to mandatory random drug testing and any worker who fails or refuses the test will be immediately discharged or not hired." The client has asked PCS to perform drug tests on referred workers or job applicants.

Note that under the new state law and workers' compensation regulations, drug testing is also required for all workers who are injured at work. Employers are also able to institute random drug testing. Some other clients have even requested that PCS select some of their workers for testing using a random selection process. A process using employee Social Security numbers has been discussed. Other occupational health clients have previously suggested that PCS begin this type of service.

Currently a test is available from a reference laboratory for a processing cost of $8 per test. Results screen for the presence of all common illegal drugs. The list price for this test is $42 and $63 if a certified medical review officer (MRO) reads the test. Dr. Tobias is a certified MRO. The test requires about 10 minutes of a medical assistant's time, specifically to maintain compliance with the chain of custody protocol during collection.

Physicals by Appointment for Employees

Increasingly, employers are issuing formal requests for proposal (RFPs) for occupational health physicals that require appointments. For example, a current RFP from a local employer is for 350 annual physicals during 2015 that must be done between 3:15 p.m. and 4:30 p.m. Monday through Friday at the Beta Center. (The company's employees work 7:00 a.m. to 3:00 p.m.) The physical must include the following components:

	PCS List Price
Medical history and examination	$70
EKG	$70
X-ray chest	$101
Urine (dip) test	$20
Complete blood count with differential	$40
Vision screen	$27
Audiometric test	$3

Each physical will take approximately 80 minutes to complete. The PCS list price for this package of services and tests is $331. PCS vendor costs for the physical (e.g., X-ray reading fees, laboratory charges) are estimated to be $70.00. The PCS bid for this contract will be evaluated on the basis of total price and fulfilling expectations related to schedule and timing.

Staffing could include one full-time physical therapist (PT) at $80 per hour (or $75,000 plus benefits) and part-time physical therapy assistants (PTAs) at approximately $25 per hour. PTs can simultaneously manage between two and five patients and supervise a PTA, who provides the direct therapy, given specific treatment plans. Dr. Tobias also says that PCS may be able to contract for the needed PT and PTAs from local nursing homes. The PT must do the initial patient evaluation and establish the treatment plan but need not be on site to supervise the PTAs.

Equipment for each center could be purchased and installed for approximately $30,000 (five year depreciation, no salvage value). Operational costs, such as laundry and medical supplies, are estimated to add approximately $15 per visit. The one-time information system upgrade for ambulatory physical therapy would cost $6,500. Other costs may need to be estimated. A consultant has recommended that PCS only service workers' compensation patients to start, but Dr. Tobias indicates that full coverage needs to be considered.

Other Issues

The board members know that one member of the board will come to the next board meeting in hopes of discussing whether PCS is for sale and how best to position PCS for sale. He believes that PCS cannot be a long-term successful player in the increasingly competitive medical marketplace. He stated, "I am very concerned that the big box stores will add walk-in services to go along with their pharmacies. I just do not see how we can compete. Our market area is just too volatile!" It is known that Dr. Tobias has always said he would be willing to sell PCS for "the right price." He has also stated when the regional economy and manufacturing pick up, PCS's occupational health business should rebound along with its overall profits.

PCS is liable for a 31 percent federal tax and 9 percent state tax on its profits. Carry-forward losses experienced in the initial years of operation have expired. Local real estate taxes on owned land and buildings are 4 percent of assessed valuation. Current assessed valuation of land in the county is approximately 40 percent of market value or total development cost.

Originally three-year renewable leases were used to secure the needed medical equipment (e.g., X-ray machines, computers) and most furniture. In 2005 PCS's accountant recommended that because PCS was now earning a profit and had used all of its carry-forward tax credits, it should consider borrowing funds to purchase needed equipment and should cancel all outstanding equipment leases. Between 2005 and 2007, it did. Each center required between $150,000 and $200,000 worth of new equipment. The only equipment leases that remain are for color copiers and general office equipment. PCS maintains a line of credit with a commercial bank in Capital City. Its cost of capital is 2.5 percent above the *Wall Street Journal* prime rate.

Based on its annual credit review, PCS has been informed that its cost of capital could increase by 1 or 1.5 percentage points over the next 18 months. The bank stated that the management and organization of PCS are seriously flawed: "PCS has become too dependent on Dr. Tobias in his many roles. His duties need to be divided between two or more qualified professionals." If PCS does not address this situation, its credit worthiness will be significantly downgraded. This situation was also noted in the 2013 audit and management letter.

Officials in the City of Jasper have requested a meeting with PCS to discuss emergency planning and expanded services. Their specific questions will include whether PCS would expand hours on Saturday and offer services on Sunday afternoon. Their letter indicated that the majority of urgent care centers nationally offer services on Saturdays (8:00 a.m. to 8:00 p.m.) and Sundays (9:00 a.m. to 7:00 p.m.). A formal response to this inquiry is due within the week.

Additional information regarding PCS utilization, patient demographics, and finances may be found in the following tables.