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Mediscene Newsletter

Volume 27 Issue 3

December 2006

Season's Greeting

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STROKE TREATMENT - NEW FOCUS AND NEW CHALLENGES

The treatment of stroke, including interventional approaches for stroke prevention, represents a major area of opportunity in interventional radiology and interventional cardiology/vascular services. More than 750,000 strokes occur annually in the U.S., and most of those who have a stroke do not receive effective treatment. There are about 4 million stroke survivors in the U.S, and 15% require full-time institutional care. About 30% have needs for assistance with daily living, and 60% suffer some loss of physical and/or mental function.

At present, as shown in the table, only 1.2% of patients who suffer an ischemic stroke are treated with FDA-approved intravenous thrombolytic therapy, and about two-tenths of 1% are treated with catheter-directed intra-arterial thrombolysis. An equal number are treated with endovascular revascularization techniques employing mechanical devices.

UTILIZATION OF STROKE TREATMENT TECHNOLOGIES

Estimated number of strokes annually in the U.S.	750,000 of which 85% are ischemic
Percentage of stroke patients treated with intravenous thrombolysis (only FDA-approved treatment)	1.2%
Percentage treated with intra-arterial thrombolysis	0.17%*
Ratio of patients treated with mechanical recanalization devices to those treated with intra-arterial thrombolysis only	1:1**
Breakdown of mechanical device use**	
MERCI Retriver	62%
Microwire	13%
Balloon/stent	25%

**Based on data from the National Inpatient Sample of 282,276 ischemic stroke patients collected from 1999-2002.*

***Based on data from the Columbia Cohort of 1,568 registered stroke patients at the Columbia University Medical Center from 2001-2004*

The Riner Group, Inc. Source: Choi, JH, et al. Stroke 2006; 27:419-424; Concentric Medical; Biomedical Business & Technology

THE QUALITY AGENDA

A recent ground breaking and ongoing study released by the Governance Institute and Solucient shows hands-on engagement of the board in oversight of quality practices differentiates top-performing hospitals. The study, based on a survey of 4,200 not-for-profit hospitals and health systems in the U.S. has found statistically significant relationships between board practices and consistently high-performing hospitals.

WHO IS INVOLVED IN SETTING THE QUALITY AGENDA FOR THE ORGANIZATION?

	Senior Administration	Medical Staff	Board Members	Nursing Staff
Respondents with Board Quality Committee	98.0%	75.0%	72.4%	66.9%%
Respondents without Board Quality Committee	98.2%	68.8%	53.2%	61.9%

The Riner Group, Inc. Source: Solucient/Governance Institute study

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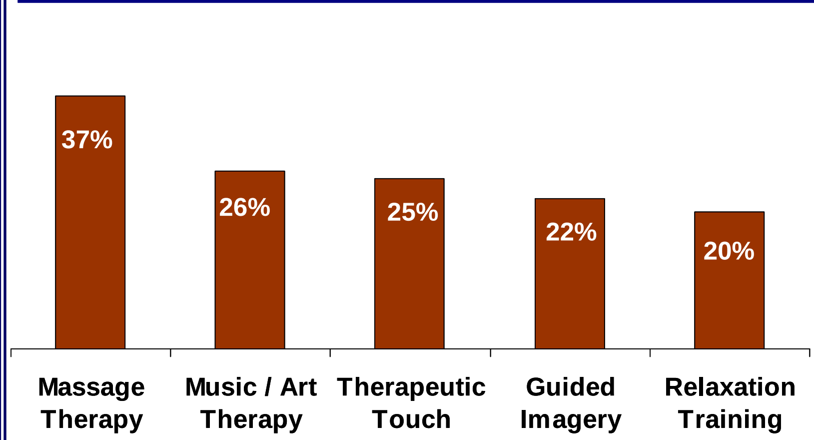
COMPLIMENTARY AND ALTERNATIVE MEDICINE

About one fourth of nearly 1,390 hospitals surveyed by the American Hospital Association (AHA) said they offer complementary and alternative medical services to patients or employees. Of those, 64% do so at a loss, while 6% of all respondents have ended such services, according to the AHA.

TOP INPATIENT COMPLIMENTRY AND ALTERNATIVE MEDICINE THERAPIES OFFERED BY HOSPITALS

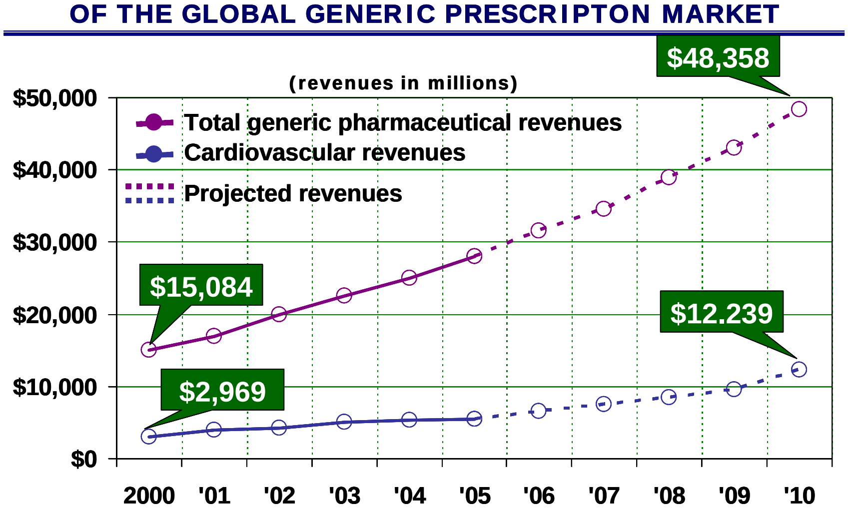


The Riner Group, Inc. Source: American Hospital Association, December 2005 survey

PHARMACIE

Cardiovascular drugs make up a significant amount of global generic prescription drug therapy.

CARDIOVASCULAR DRUGS EXPECTED TO MAKE UP 25% OF THE GLOBAL GENERIC PRESCRIPTON MARKET



Note: Based on U.S. manufacturers' revenues in 2005 dollars

The Riner Group, Inc. Source: Kalorama Information

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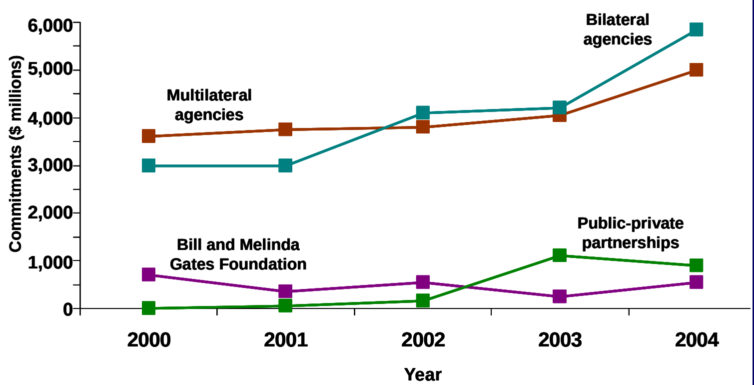
THE GLOBAL HEALTH INITIATIVES

DEVELOPMENT-ASSISTANCE FOR THE HEALTH SECTOR, 2000 to 2004



The Riner Group, Inc. Source: New England Journal of Medicine 355;11 - 9/14/06

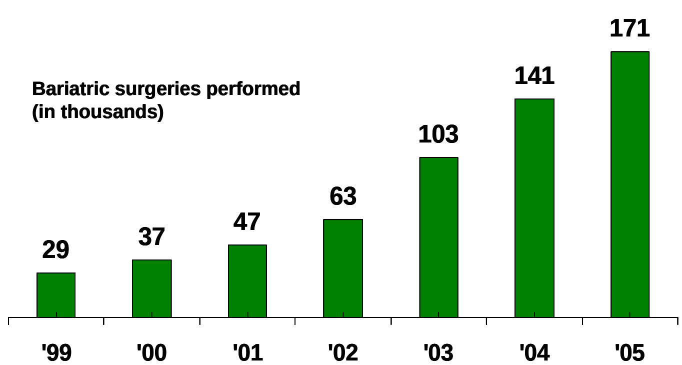
Funding for global health initiatives comes from various sources. There has been recent attention to this matter given the recent donation by Warren Buffett. The graph, however, shows other sources of funding as well as the commitment of those sources to global health initiatives.

"Bilateral agencies" include those in Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, and the United States (including the U.S. Agency for International Development). "Multilateral agencies" include United Nations agencies (the World Health Organization, the Joint Programme on HIV-AIDS, the Children's Fund, and the Population Fund), development banks (the World Bank, the Inter-American Development Bank, the Asian Development Bank, the African Development Bank, and the African Development Fund), and the European Union. "Public-private partnerships" include the Global Alliance for Vaccine and Immunization and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Data are from Catherine Michaud of the Harvard Initiative for Global Health, Cambridge, MA.

RAPIDLY GROWING BOOK OF SURGICAL BUSINESS

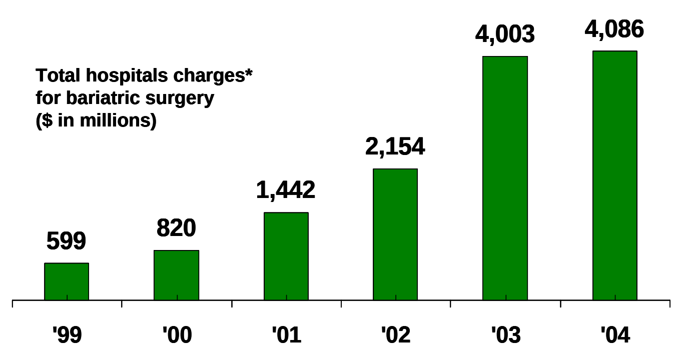
Bariatric surgical programs are on the rebound after some initial challenges. Rolled out in 2004, the American Society for Bariatric Surgery Guidelines are fast becoming the field's gold standard for care. Among other things they call for hospital programs to meet certain volume requirements, have a "full compliment" of dedicated staff and invest in special equipment – such as oversized beds, toilets, and wheelchairs to accommodate severely obese patients. These changes come after several hospitals have been rocked by high profile deaths and allegations of substandard care within the bariatric programs. However, according to the Bariatric Surgery Society, proper application of guidelines should lead to proper application of these therapies. Additionally, there is significant business in this area. According to the Bariatric Surgery Society, as many as 171,000 underwent weight loss operations in 2005, up dramatically from 63,100 in 2002 and just 16,200 in 1992.

BARIATRIC SURGERIES



The Riner Group, Inc. Source: American Society for Bariatric Surgery

BARIATRIC SURGERY REVENUES



*Hospital charges are the amount that the hospital bills for the entire inpatient stay and do not include most physician fees.

The Riner Group, Inc. Source: The Healthcare Cost & Utilization Project's Nationwide Inpatient Sample

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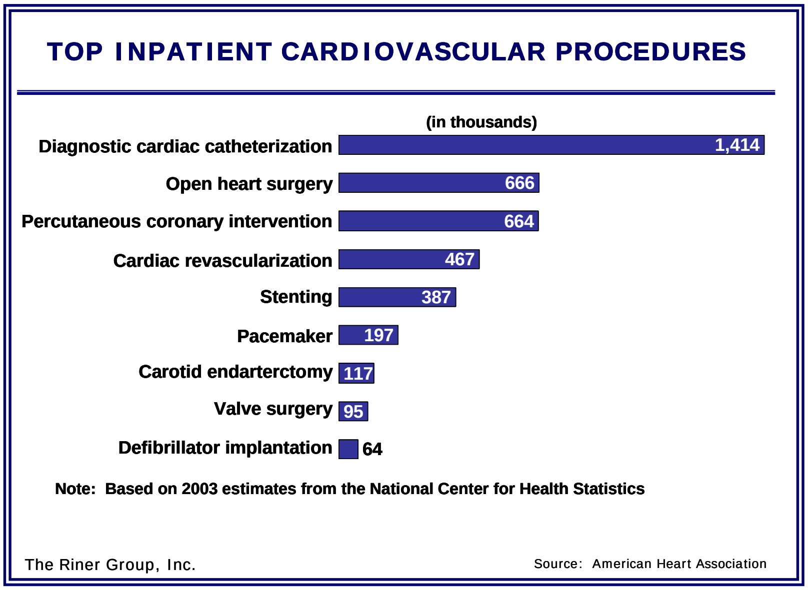
CARDIOVASCULAR SERVICELINE VITAL SIGNS

The graph shows the top inpatient cardiovascular procedures performed based on 2003 estimates from the National Center of Health Statistics



A WORD FROM YOUR GOVERNMENT PAYOR

Hospitals and medical device makers escaped deep cuts that have been proposed by Medicare for procedures including drug eluting stents, defibrillators and pacemakers. The fiscal 2007 inpatient perspective payment system final rule provided a return to a cost-based system, but no longer contains the drastic cuts first proposed for many procedures – 33% for drug eluting stents, 24% for implantable cardioverter defibrillators (ICDs), 15% for pacemakers and 28% for ablations. The American Hospital Association and the Federation of American Hospitals were concerned the impact would be too much too soon and, along with medical device industry group AdvaMed, called for at least a one year delay in implementation of any rule that would call for these drastic cuts.

Overall Medicare will increase payment rates by 3.5% on average for an increase of $3.4 billion. Cardiac specialty hospitals (recently released from a moratorium on development) will receive a lower boost – 1.2% on average – in an effort to make payments more accurate, according to CMS. CMS will use cost reports from fiscal 2004 – instead of fiscal 2003 – for its 2007 payment calculations. Surgeons and device makers had noted that some devices, such as drug eluting stents, had just barely hit the market in 2003.

The agency is also embarking on an overhaul of the diagnosis-related groups by creating 20 new DRGs and modifying 32 existing DRGs in 2007 to more accurately adjust for patients' severity of illness. By 2008, CMS hopes to have a new severity evaluation method; it started seeking input from outside contractors in September. The agency will make public comments before making changes for 2008.

CHANGES IN MEDICARE PAYMENTS FOR SELECTED CARDIAC PROCEDURES

DRG	Title	Final Rule
121	Circulatory disorders with acute MI and major complications, discharged alive	0.2%
124	Circulatory disorders except acute MI, with cardiac catheterization, and complex diagnosis	33.1%
127	Heart failure and shock	1.2%
515	Cardiac defibrillator implant without cardiac catheterization	0.1%
552	Other permanent cardiac pacemaker implant without major cardiovascular diagnosis	0.3%
556	Percutaneous cardiovascular procedure with non-drug eluting stent without major cardiovascular diagnosis	-5.4%
558	Percutaneous cardiovascular procedure with drug eluting stent without major cardiovascular diagnosis	-4.6%

The Riner Group, Inc. Source: Department of Health and Human Services

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WHAT HAS GONE UP MUST COME DOWN

The overall cancer death rate for men dropped about 1.6% per year from 1993-2003. For women, the drop was 0.8% annually from 1992-2003. The table shows death rates for the five most common cancers.

TRACKING CANCER DEATHS

MEN	WOMEN
Lung and bronchus: Down 1.9% per year from 1991 to 2003	Lung and bronchus: Up 0.3% each year from 1995 to 2003
Prostrate: Down 4% per year from 1994 to 2003	Breast: Down 1.4% per year from 1999 to 2003
Colon and rectum: Down 2.1% annually from 1990 to 2003	Colon and Rectum: Down 1.9% annually from 1984 to 2003
Pancreatic: Down 0.3% per year from 1986 to 2003	Pancreatic: Up 0.1% per year from 1984 to 2003
Leukemia: Down 0.7% annually from 1995 to 2003	Ovarian: Up 0.4% each year from 1998 to 2003

Note: The data were organized by trend periods calculated from the point at which the rate of increase or decrease changed, as a result, the year the trend commenced varies; 2003 is the latest available data

Source: "The Annual Report to the Nation on the Status of Cancer, 1975-2003," September

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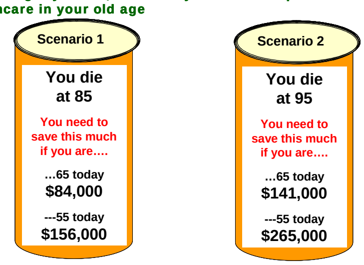
REALITY CHECK

Healthcare costs are the terrifying part of retirement for some people. Many people don't realize Medicare will pay for only about half of total medical care costs, according to the Employment Benefit Research Institute. Additionally, no one really knows what Medicare will be able to afford to pay years from now. To get costs in line with revenue over the next 75 years, the system's trustees estimate Medicare Part A spending (which pays for hospital stays) will have to be cut in half. Or taxes will have to go up. Reality would say that the only real way for retirees to be ready for these costs is to save for them. The graphs provide a snapshot of the issues at hand.

PROGNOSIS FOR HEALTHCARE INFLATION

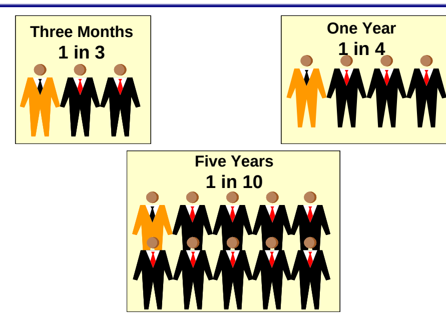
The younger you are, the more you'll need to put aside for healthcare in your old age



Note: Assumes 4% real return, median use of prescription drugs, and participation in Medigap and Medicare Parts B and D

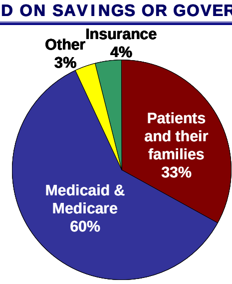
The Riner Group, Inc. Source: EBRI, 2006

THE RISK THAT YOU'LL NEED LONG-TERM CARE...



The Riner Group, Inc. Source: Congressional Budget Office

FEW INSURE AGAINST LONG TERM CARE RELYING INSTEAD ON SAVINGS OR GOVERNMENT



Note: does not include informal care, such as help provided by family members

The Riner Group, Inc. Source: Congressional Budget Office

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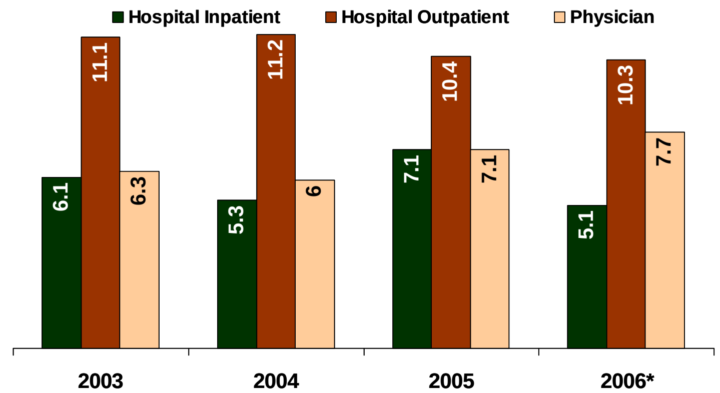
HEALTHCARE SPENDING

Total healthcare spending for privately insured individuals is rising at a slower rate for hospital inpatients on a percentage basis, according to a recent study published in the October 3rd issue of *Health Affairs, 2006.*

HEALTHCARE SPENDING PERCENTAGE GROWTH YEAR OVER YEAR



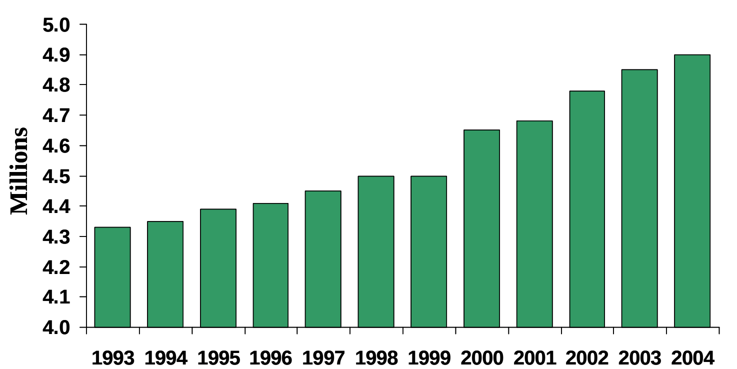
*Compares January-March 2006 with same months in 2005

The Riner Group, Inc. Source: Health Affairs, 10/3/06

HOSPITALS – AN ECONOMIC GOOD

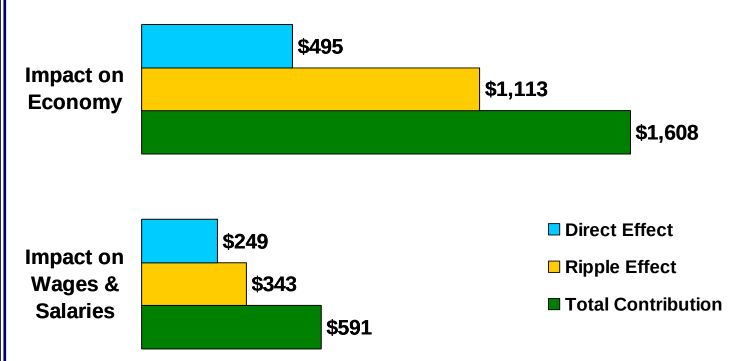
A recent AHA report highlights hospitals' major contribution to the economic health of their communities. These graphs are included in the report "Beyond Health Care: The Economic Contribution of Hospitals." The report is viewable at www.aha.org

NUMBER OF FULL-TIME AND PART-TIME HOSPITAL EMPLOYEES, 1993-2004



The Riner Group, Inc. Source: The Lewin Group analysis of AHA Annual Survey data, 1993-2004, for community hospitals

IMPACT OF COMMUNITY HOSPITALS ON U.S. ECONOMY (IN $BILLIONS) 2004



The Riner Group, Inc. Source: The Lewin Group analysis of AHA Annual Survey data, 1993-2004, for community hospitals

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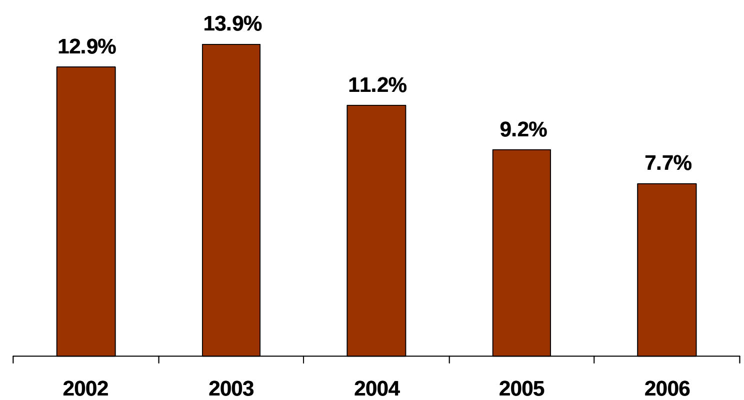
PREMIUM GROWTH

According to a report released by Kaiser Family Foundation and the Health Research Educational Trust, health insurance premiums rose 7.7% in 2006, the slowest annual rate increase since 1999. Although still about twice the rate of general inflation, the figure marks the third straight year that premium hikes have decelerated since rising 13.9% in 2003, and it's the second straight year of increases in the single digits.

PREMIUM GROWTH

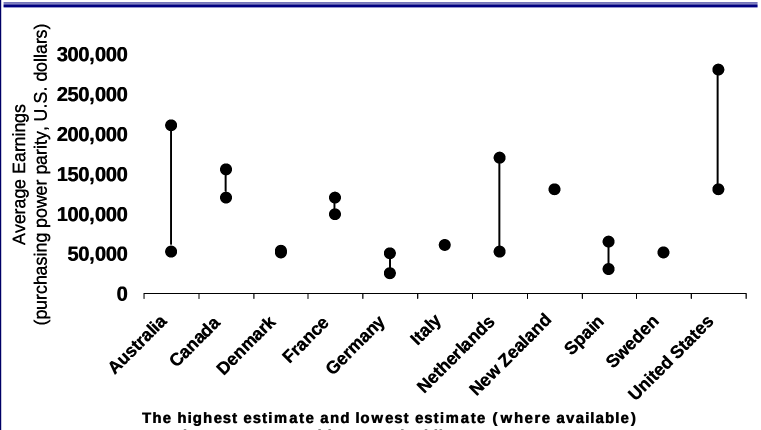


The Riner Group, Inc. Source: Kaiser Family Foundation/HRET; Survey of Employer-Sponsored Health Benefits

HOW YOUR INTERNATIONAL COLLEAGUES FAIR

In 2004, an international survey showed that the earnings of hospital-based physicians in 2002 were lower in Germany than in any other country under review.

ANNUAL AVERAGE EARNNGS OF HOSPITAL DOCTORS IN 2002



The highest estimate and lowest estimate (where available) are shown, connected by a vertical line.

The Riner Group, Inc. Source: National Economic Research Associates; NEJM 10/12/06

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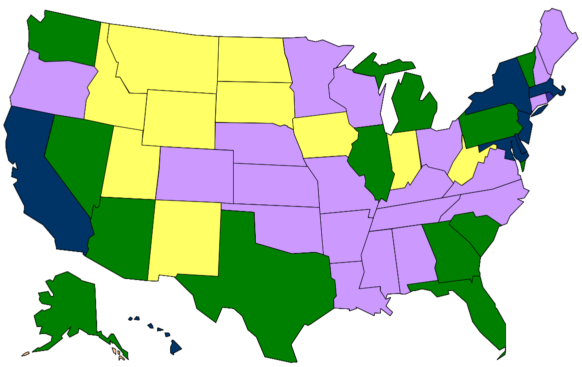
A COSTLY AFFAIR

Estimates show that about 27% of Medicare's annual $327 billion budget goes to care for patients in their final years of life. This fact alone is not surprising given Medicare's demographics – most patients are over 65 – however it is still important to note that there is significant variation in how that money is spent. In fact, there is significant variation in how the money at end of life is spent. The graph gives a brief snapshot.

COST OF END-OF-LIFE CARE

Average total cost of doctor and hospital care during the last six months of life for a Medicare patient with a chronic illness:

$14,000 and below | $14,001 to $15,000 | $15,001 to $18,000 | $18,001 and above



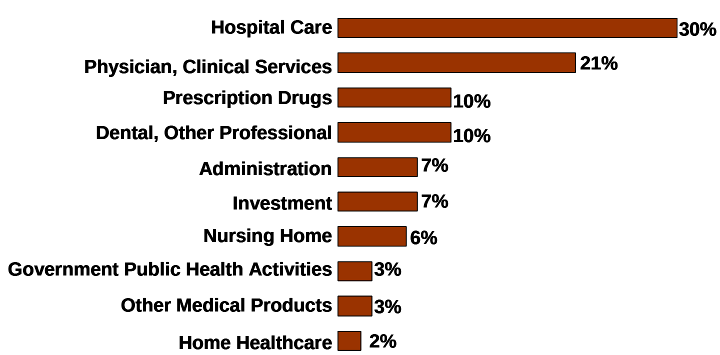
The Riner Group, Inc. Source: Dartmouth Atlas of Health Care

Alabama	$14,228.64	Montana	$13,028.69
Alaska	$17,190.75	Nebraska	$14,464.44
Arizona	$15,713.53	Nevada	$16,437.67
Arkansas	$14,464.57	New Hampshire	$14,693.47
California	$22,530.04	New Jersey	$24,531.21
Colorado	$14,299.16	New Mexico	$13,716.62
Connecticut	$18,840.26	New York	$22,944.52
Delaware	$16,826.90	North Carolina	$14,484.82
Dist. Of Columbia	$24,591.40	North Dakota	$13,025.32
Florida	$16,861.69	Ohio	$14,349.41
Georgia	$15,076.63	Oklahoma	$14,029.77
Hawaii	$19,654.23	Oregon	$14,105.98
Idaho	$12,878.37	Pennsylvania	$16,571.24
Illinois	$17,799.93	Rhode Island	$16,874.91
Indiana	$13,363.75	South Carolina	$15,398.31
Iowa	$13,157.46	South Dakota	$13,212.06
Kansas	$14,199.27	Tennessee	$14,930.83
Kentucky	$14,305.84	Texas	$16,195.26
Louisiana	$14,922.53	Utah	$12,950.56
Maine	$14,405.57	Vermont	$15,065.09
Maryland	$22,168.67	Virginia	$14,567.57
Massachusetts	$18,538.06	Washington	$15,684.14
Michigan	$16,226.46	West Virginia	$13,737.69
Minnesota	$14,908.27	Wisconsin	$14,155.42
Mississippi	$14,346.58	Wyoming	$13,911.30
Missouri	$14,566.57	National avg.	$16,776.92

WHERE THE MONEY IS SPENT

The total expected to be spent on healthcare this year in the United States is $2.2 trillion. Data from 2004[1] indicates how this money will be spent

SPENDING BREAKDOWN



Note: Does not add up to 100% due to rounding
[1]Latest data available

The Riner Group, Inc. Source: Centers for Medicare and Medicaid Services

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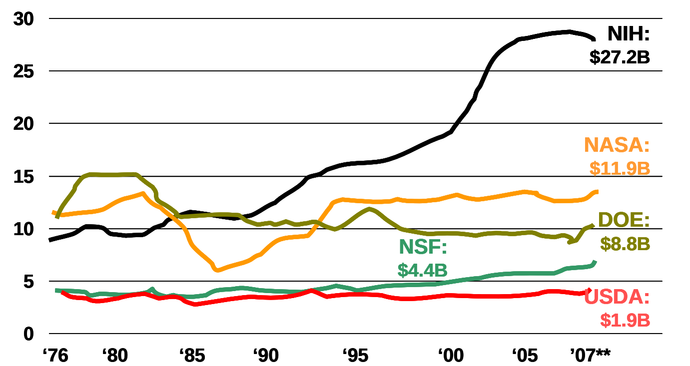
GOVERNMENT INVESTMENT IN THE FUTURE

Proponents for research funding stress that the government is an important source of innovation for future products and developments that will impact virtually every American citizen. The graph shows the research priorities of the federal government. It should be noted that in 30 years the U.S. Department of Agriculture research money has barely changed while funding for the National Institutes of Health has quadrupled. In the middle are the National Science Foundation, the Department of Energy and NASA.

RESEARCH AND DEVELOPMENT FUNDING BY AGENCY, 1976-2007*



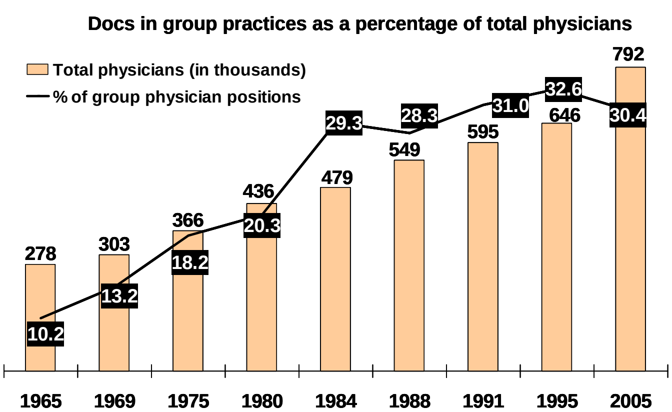
*Budget authority in constant 2006 dollars; ** Estimates at president's request

The Riner Group, Inc. Source: AAAS Reports based on OMB and Agrency R&D budget data

PHYSICIAN PRACTICE SETTING

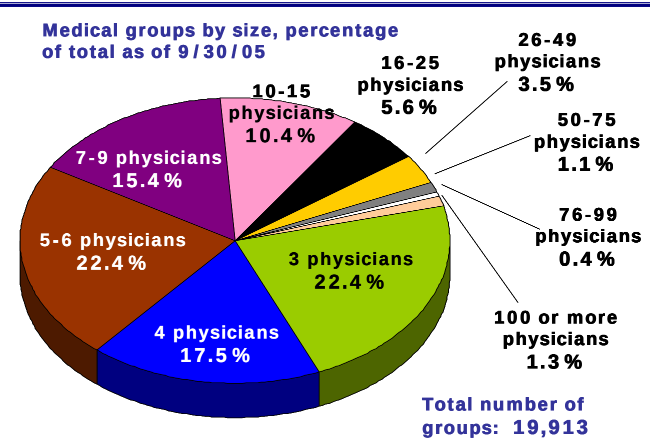
When managed care first made its entree into healthcare delivery there were predictions that a solo practitioner would not exist. In fact many practitioners still exist in solo or small groups. The data demonstrates the distribution of physician practitioners in 2005.

JOINING THE GROUP



The Riner Group, Inc. Source: American Medical Association

SMALLER GROUPS DOMINATE



The Riner Group, Inc. Source: American Medical Association

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DID YOU KNOW?

• The term "hospitalists" was coined a mere decade ago even though the role began being filled in the early 1990s. In the years since, their numbers have exploded. Today hospitalist medicine is one of the fastest growing medical specialties and salaries are on the rise. In the mid 90s there were about 800 hospitalists nationwide. By 2005 that number had jumped to 15,000 and by 2010 there may be as many as 30,000 according to the Society of Hospital Medicine, a professional association for the specialty.

Large community hospitals and teaching hospitals are more likely than smaller ones to have hospitalists. Better than 50% of teaching hospitals are using at least one hospitalist, but only one in ten community hospitals have one hospitalist. Hospitals of all types and sizes that have hospitalist programs are more likely than their peers to be top performers and make it to the top 100 according to a Solucient Study of the Top 100 hospitals.

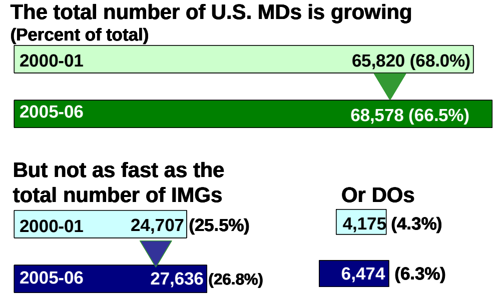
• The emergency needs of ERs – Studies have found that while demand for Emergency Room services has been growing rapidly – emergency department visits growing by 26% from 1993 to 2003 – the actual number of EDs declined by 425 over the same time period. The number of hospital beds declined by 198,000 which has led to a situation whereby patients often are boarded or held in the ED until the hospital can find a bed for the patient. These facts were provided in an Institute of Medicine report. Additionally, another finding was that children make up about 27% of all ED visits, but only 6% of EDs n the United States have all of the supplies for treating them. Therefore, most children get emergency care in ERs established for the general adult population.

• Like father, like son and daughter? – nearly three fourths of physicians are less willing than in the past to encourage their children to follow in their footsteps according to a 2005 survey of 736 doctors by Doctor's Co., a Napa, California insurer. Fear of malpractice lawsuits, quality of life and continued heavy regulation/economic constraints are issues behind this trend.

Who's filling the residency slots? – US international and osteopathic graduates fill 99.6% of the 103,106 graduate medical residency positions. U.S. graduates occupy 66.5% of those positions and while their raw number is increasing, their percentage of the total has been decreasing slowly. The number of graduates from osteopathic and international medical schools filling slots is increasing at a faster rate and occupying a somewhat larger percentage of the total.

WHO'S FILLING THE RESIDENY SLOTS

Composition changes (Increase, 2000-2006)	
Total slots	6.5%
Total programs	5.2%
U.S. MDs	4.2%
Combined total IMGs / DOs	18.1%
Canadian	-19.1%



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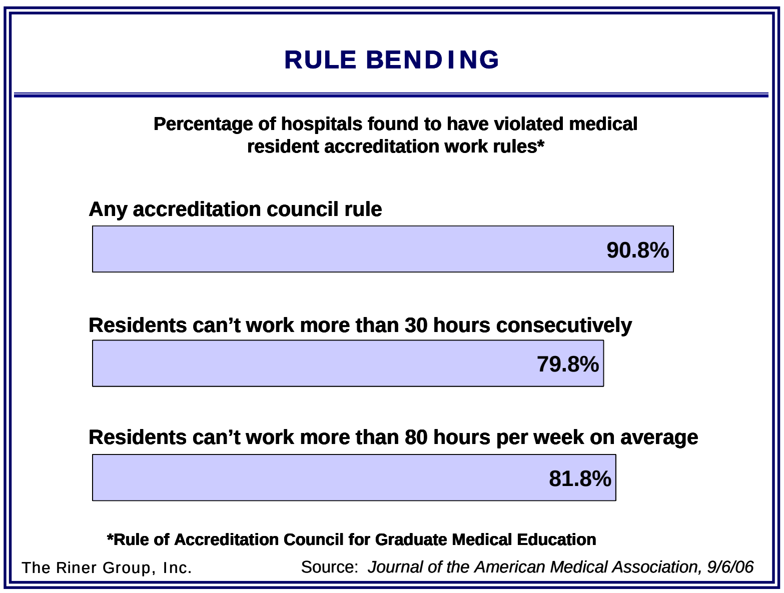
Source: Appendix 1, Sept 6, 2006
Journal of the American Medical Association

DID YOU KNOW? *(continued)*

• When employed as a resident, studies find they are often overworked according to regulation. Three years ago the national group that oversees more than 8,000 medical-residency programs instituted tough new duty-hour limits for doctors-in-training. Under pressure from lawmakers and patient-safety advocates, the Accreditation Council for Graduate Medical Education prohibited perennially overtaxed residents from working more than an average of 80 hours/week, or more than 30 hours consecutively. Since then, officials with the Chicago-based ACGME said only a tiny percentage of residents have violated the controversial guidelines. However that assessment is being sharply questioned in a new national study which found 84% of first-year residents violated at least one of the new work-hour rules in the first year. The study, which appeared in the Sept. 6 issue of the *Journal of the American Medical Association* included monthly reports from some 4,000 residents that highlighted routine violations of nearly every aspect of the work-hour rules.



• Moody's Investors Service said it downgraded nine not-for-profit hospital credits and upgraded five in the third quarter of 2006, continuing a trend of downgrades outpacing upgrades. For the first nine months of 2006, downgrades surpassed upgrades by a 1.6-1 ratio. By comparison, the number of upgrades and downgrades in the first nine months of 2005 were nearly equal.

• The majority of physicians in a recent survey (80%) said they favor a moratorium on direct-to-consumer (DTC) advertising for new drugs. The survey of 1,360 physicians was conducted by Cambridge, MA-based market data firm MedPanel. Of the 20% that opposed a mandatory waiting period for advertising about new drugs, most said consumer drug advertising educates patients and encourages them to seek treatment and forces physicians to stay up-to-date with new treatment options.

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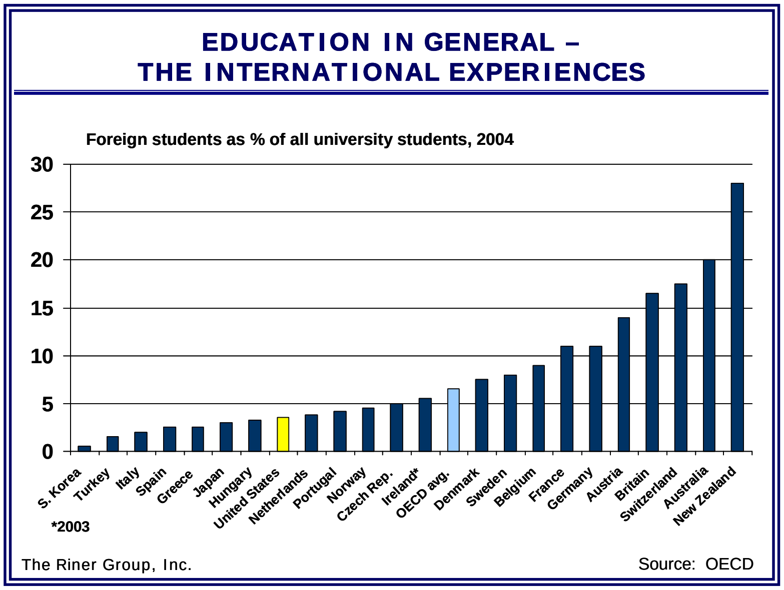
Mediscene Newsletter
Volume 27 Issue 3 December 2006

DID YOU KNOW? *(continued)*



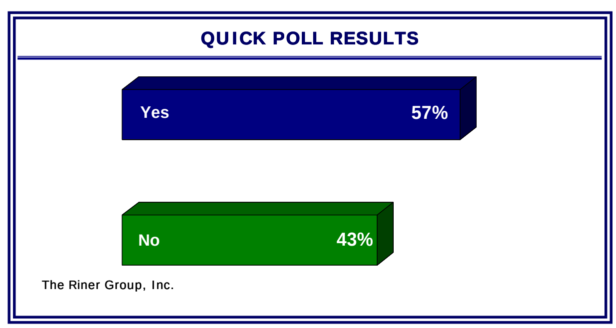
• International education – The United States serves as a resource to many international students. However New Zealand has vaulted in popularity among students who are undertaking educational activity overseas. Over a quarter of its university enrollments comes from overseas. America has so many domestic students that it ranks much lower, even though it attracts 21.6% of the world's 2.7million foreign students, a sharp decline from its share of 25.3% in 2000.

• Evidence-based medicine – keeping up. Medical science dates to the French Revolution in the late 1700s. However, the first randomized control trial comparison of the antibiotic streptomycin to a placebo for treating tuberculosis wasn't published until 1948. There have been a million randomized controlled studies since then. Today, an average of 82 randomized controlled trials are published each day in American literature. Additionally, many of these studies become outmoded quickly. All of this attributes to the dilemma that physicians face when having to process, interpret and apply evidenced-based methodologies. Add to that, only about 50-60% of the main conditions leading to hospitalization of internal medical patients have been studied in well done randomized controlled trials.

OUR QUICK POLL RESULTS

The following question was posted on the Riner Group Website for the month of April 2006.

"Do you feel that walk-in clinics being placed in Wal-Mart, CVS and other chain stores will be successful and will adversely effect full-service doctors' offices ?"



This question has been prompted by recent efforts at developing nurse practitioner run walk-in clinics in Wal-Marts, CVS and other chain stores. It should be noted that these services were tried with dentistry, chiropractic, and podiatry in the 70s and again in the 80s, and in both instances were unsuccessful. At that time convenience clinics just didn't catch on due to issues of continuity of care and the nature of the work that was being offered on a walk-in basis. The new walk in clinics are primary care focused.

There are many well known venture firms that are bankrolling these activities. Steve Case, the AOL billionaire; Michael Howe, former CEO of Arby's sandwich shops; Richard Scott, former CEO of Columbia HCA; and travel agency expert Hal Rosenbloom. It remains to be seen whether the profits per square foot for primary care clinics will justify the cost of renting valuable space in these stores. We will need to watch carefully the following as they come to the healthcare delivery scene. Timing may be everything.

- Minute Clinic, 73 stores since 2000 and planning for 1,100 by 2009.
- Take Care Health Systems**,** 16 stores since 2005 and aiming for 1,400 by 2009.
- RediClinic, 11 stores since 2005 growing to 1,000 by next year.
- Solantic, 2 stores at this time and another 10 by year end.

To view and respond to our current poll question on individual states' responsibilities for healthcare, please go to our website at www.rinergroup.com

OUR FOCUS

With over twenty-five years of business experience in healthcare, we have worked with physician practices, hospitals, health systems, academic medical centers and healthcare businesses throughout the United States with a focus on strategy, new business development and performance improvement. We specialize in integrating the business and clinical aspects of healthcare. Some of our current projects include:

- ♥ Business development strategies for hospitals, health systems, medical practices, emerging healthcare companies and healthcare related businesses
- ♥ Development of Heart Centers/Heart Hospitals, Enhancement of Cardiac Service Lines and Vascular Centers, Development of Strategic Alliances and new Business Ventures
- ♥ Group practice management enhancements and clinical practice assessments, compensation modeling
- ♥ Development of physician-hospital alignment strategies and the formation of governance and management structures for such
- ♥ Leadership programs/educational forums for healthcare industry executives, trustees, directors and clinicians
- ♥ Executive and career mentoring/coaching for physicians and healthcare executives
- ♥ Temporary management of Heart and Vascular Centers

EXAMPLES OF RINER GROUP SPEAKING ENGAGEMENTS

• "The Future of In-House Imaging, Will It Remain Viable?" – American College of Cardiology's Strategies for Success, June 24, 2006, San Francisco

• "Designing a Physician Compensation Plan for Your Practice" – MGMA, August 23-25, 2006, Seattle and November 9-10 in St. Louis

• "Designing Your Healthcare Organizations' Physician-Hospital Management Structure, What It May Look Like in 2010" – AHA Society for Healthcare Strategy and Market Development, September 7, 2006, Phoenix

• "Transitions in Traditional Hospital Business Models: The New Frontier in Hospital-Physician Relations with New Responsibilities for Trustees" – Center for Healthcare Governance, October 8-11, 2006, Washington, DC

• "Trends Impacting Healthcare Delivery" – Chief of Staff Meeting for Health Management Associates, Inc., December 2, 2006

To find out more about The Riner Group, please visit our website at **www.rinergroup.com** or contact us directly via confidential voicemail or fax.

To request specific information regarding the Riner Group, or subscribe to our newsletter, please email us at **requestinfo@rinergroup.com**

Our PRIORITY ... excellence in the business of medicine.

Our SPIRIT ... superb patient care.