

A STUDY TO DETERMINE THE BEST METHOD
OF PROVIDING PHARMACY SERVICES FOR THE
PROPOSED PROFESSIONAL OFFICE BUILDING,
HENDRICK MEMORIAL HOSPITAL, ABILENE, TEXAS

APPROVED BY THE ACADEMY OF HEALTH SCIENCES, U.S. ARMY:

APPROVED BY THE FACULTY

A Problem Solving Thesis
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Hospital Administration

By

Major James C. Carter, VC

DATE:

Waco, Texas

August 1976

ABSTRACT

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University in Partial Fulfillment of the Requirements for
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Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The purpose of this study was to determine the best
method of providing pharmacy services for the proposed Pro-
fessional Office Building, Hendrick Memorial Hospital,
Abilene, Texas.

The predicted pharmacy business that would be created
by the opening of the building was developed. The current
hospital pharmacy was evaluated to determine its capability
of handling the new workload. Five alternative methods for
provisions of pharmacy service in the building were analyzed.
These included variations based on space purchased by a firm
or individual, space leased by a firm or individual, or a
hospital operated pharmacy.

A pharmacy operated by the hospital with a manager
paid a minimum salary or a percentage of net revenue, which-
ever was greater, was recommended.

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CHAPTER I

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CHAPTER I

INTRODUCTION

Historical Development of Hendrick Memorial Hospital

From a modest beginning in 1924, Hendrick Memorial Hospital has developed into a major medical center serving regional as well as local health needs. The hospital opened in 1924, chartered as West Texas Baptist Sanitarium. At that time, it was a modern 75 bed hospital, and it provided the first hospital services to the Abilene area.¹ The original building is shown in Appendix A.

For its first twelve years, the hospital struggled financially. By 1936, it seemed that it would have to close. Mr. and Mrs. T. G. Hendrick rescued the hospital with donations to pay off outstanding debts and to provide for expansion of the existing facilities. This eleemosynary act prompted the Board of Trustees to vote to change the name of the hospital to Hendrick Memorial Hospital.²

The Hendrick Wing was to be the first of many major expansion programs that were to characterize the growth of Hendrick Memorial Hospital. The completion of the latest expansion program in 1972 which included the four and one-half million dollar Collier Surgery Building brought the estimated value of the complex to thirty million dollars.³

In recent years Hendrick had begun to enjoy its status as a regional medical center. It had a 500 bed capacity with an operating level of 400 beds. It operated the only community blood bank and 24 hour emergency room in Abilene. Its training programs included a diploma school of nursing (RN), a school of licensed vocational nursing (LVN), various technician training programs, a pharmacy internship, and an administrative residency in health care administration. It adopted a corporate structure of management in 1973.⁴

The current expansion project was expected to cost five million dollars. The office building portion was currently planned to include the pharmacy that prompted this study.⁵ Appendix B shows the current facility and the proposed expansion. The many expansion projects of the past are described in the legend of Appendix B.

Conditions Prompting the Study

This study was prompted by the desire of the administration of Hendrick Memorial Hospital to continue to provide quality medical care while holding costs at a minimum. A pharmacy located in the proposed professional office building appeared to be a potential source of revenue for hospital operations.

A five million dollar expansion program had been proposed in a continuing effort to serve Abilene and the

surrounding service area. The professional office building was included in this expansion. Two primary objectives of the hospital were served by the proposal of the office building. It was planned to recruit needed specialists to the Abilene area, particularly internists, and to bring physicians closer to the patients they admitted.

Another objective of the hospital which could not be ignored was its continued financial health. Its capacity of 500 beds was not being utilized at the time of the study. Its operating capacity had been reduced to 400 beds, and a further bed reduction was being contemplated. It was hoped that physicians present in a new professional building would admit more patients to the hospital. If the needed internists were recruited to the Abilene area and into Hendrick's office building, these physicians would be expected to utilize diagnostic and treatment departments of the hospital that were revenue producers such as laboratory, radiology, pharmacy, physical therapy, and inhalation therapy.

While the diagnostic and medical specialties would have served to enhance the hospital's financial objectives, these specialties were also known to be the most desirable for supporting a pharmacy. Although professional office buildings have traditionally included pharmacies, no published studies were available that described profitability of these pharmacies from a hospital's point of view.⁶

Statement of the Problem

The problem was to determine the best method of providing pharmacy services for the proposed Professional Office Building, Hendrick Memorial Hospital, Abilene, Texas.

Objectives

The objectives of the study were to:

1. Anticipate prescription business to be generated by the opening of the Professional Office Building.
2. Evaluate adequacy of the existing pharmacy in hospital to handle projected workload from the Professional Office Building.
3. Analyze the alternatives and select the best method for providing pharmacy services to the Professional Office Building.

Criteria

Criteria used to analyze the alternative solutions available to the hospital were as follows:

1. Any pharmacy operation in the Professional Office Building must be self-supporting when the operation matures.
2. The selected alternative must meet applicable local, state, and federal regulations.
3. It should enhance or at least maintain current hospital-community pharmacist relations.

Limitations

The limitations imposed on this study were as follows:

1. No contact was allowed with the Taylor County Pharmaceutical Association or any local pharmacists outside the hospital.

2. Taxable status of the pharmacy was not considered since this issue should be resolved only through competent legal advice.

3. No potential tenants who would generate a pharmacy workload were interviewed since none have been identified.

Assumptions

For the purposes of this paper it was assumed that:

1. Necessary manpower can be recruited to staff the pharmacy under the selected alternative.

2. Space will be allocated for a pharmacy in the construction project.

3. Financial data developed for 1975 will be adequate to represent future trends.

Research Methodology

The following research methods were utilized in collecting, evaluating, and analyzing data for use in this study. The literature concerning pharmacies in professional

office buildings, hospital operation of professional office buildings and outpatient pharmacy services in hospitals was reviewed for applicability to the problem. Hospital plans for the project were used to assist in developing cost and operational data. Informal interviews were conducted with the administrative staff of the hospital and other individuals outside of the hospital with expertise in the area.

These interviews were used to develop data on hospital objectives for the project, to draw expert information on project requirements, and to elicit individual opinions on alternative feasibilities. After locating hospitals through personal contacts, a survey and personalized cover letters were sent to facilities identified as having professional office buildings with pharmacies. This survey was used to develop experience data on this type of a facility. The survey form is included as Appendix C.

Review of the Literature

Although pharmacies have traditionally occupied space in professional office buildings along with physicians, very little literature has appeared on the subject.⁷ Additionally, hospitals have constructed many of these buildings adjacent to their other facilities. These have often included pharmacies operated in various ways. No published material was located that explored the alternative methods of operating these pharmacies. The review of the literature was

limited to those areas surrounding the problem that can be interpreted as applicable.

Pharmacies in professional office buildings

Pharmacy business generated by physicians in a professional office building has been extremely difficult to predict. Accurate prediction of prescription business generated by a group of physicians has been limited unless their specialty mix was known. Medical specialties have traditionally written more prescriptions than the surgical specialties.⁸ Based on national data from 1969, the average number of prescriptions filled per physician per year was about 7,000. Dr. Paul C. Olsen predicted that a pharmacy in a professional office building might be expected to fill 16 to 20 per cent of the prescriptions written by the physicians in the building. This was based on his experience as a professor and consultant in pharmacy administration. Assuming that the occupants of the building would match national averages for prescription writing, each physician would generate about 1300 prescriptions per year for the pharmacy to fill.⁹

Data accumulated by the Lilly Digest - 1974, best represented pharmacy activity in prescription-oriented pharmacies for 1973.¹⁰ These have been described as "apothecary type," "professional type," and "pharmaceutical center type" pharmacies. They are distinguished by having more

than 50 per cent of sales generated by prescription activity and by occupying less than 1200 square feet of floor space. Nearly 50 per cent of the pharmacies identified in this group had prescription sales equivalent to over 75 per cent of revenue, and most of these pharmacies were located in medical office buildings. Characteristics of this group were limited floor space (average of 733 square feet) and high rent (average of \$9.06 per square foot per year). The pharmacies averaged 84.9 per cent of sales as prescriptions and filled approximately 90 prescriptions per day. Of the prescription-oriented pharmacies, those with over 75 per cent of sales in prescriptions showed the highest income for a proprietor-pharmacist.¹¹ No data was provided on the number or types of physicians served.

Hospital operation of professional office buildings

The first hospital-erected medical office building was opened in 1928 by Baptist Memorial Hospital in Memphis, Tennessee.¹² The presence of physicians' private offices in or adjacent to hospitals had been found to be mutually beneficial for hospitals, physicians, and patients.¹³ In a 1958 study, there were 101 non-profit short term hospitals in the United States identified as providing office space for private physicians. Of these, 34 were in a separate wing or building constructed or purchased for offices by the hospital.¹⁴ The trend of physicians locating in or near hospitals had increased in more recent years.¹⁵

Outpatient pharmacy services in hospitals

There had been a trend in recent years of increasing use of hospital based outpatient services. These increases had necessarily led to increased use of outpatient pharmacy services in the hospital. Since outpatient pharmacies had similarities in services and problems that might be expected in a professional office building operated by a hospital, this area was investigated.¹⁶

Several reasons have been proposed to explain the increased use of hospital based outpatient services including the pharmacy. People have identified the hospital as the primary provider of health care. This was felt to be due to a decrease in primary care physicians and a mobile patient population that had no family physician.¹⁷ Historically, medically indigent patients had used hospital outpatient services in charity hospitals.¹⁸

Pharmacy services for outpatients had normally been provided to three categories of patients in hospitals. Medically indigent patients had been provided medications that were totally or partially financed by public and private assistance programs. Hospital employees had often been provided discounted drugs as a portion of employee benefit programs. Private patients seen in the hospital had been offered pharmacy service on a retail basis as a convenience service. Additionally, some investigational drugs used and

dispensed by hospitals had been unavailable in community pharmacies. The only category that had caused controversy between community pharmacists and hospital pharmacists had been the private patient that received retail, outpatient pharmacy service.¹⁹

In response to state board of pharmacy actions that would have prohibited hospital pharmacists from dispensing medications to outpatients, hospital pharmacists objected. As a response to these actions, the American Society of Hospital Pharmacists adopted the following resolution in 1960.

Resolved that the American Society of Hospital Pharmacists, in annual convention assembled, asserts and believes that hospital pharmacists have unquestionable and unchallengeable moral, legal and ethical rights to serve patients, both indigent and non-indigent, by filling prescriptions written by members of the hospital's medical staff for outpatients.²⁰

In 1964, the "Commission of Outpatient Dispensing" was formed jointly by the American Society of Hospital Pharmacists and the American Pharmaceutical Association to resolve problems existing between hospital and community pharmacies. The American Hospital Association and the American Medical Association were invited to join in the study in what then became the "Commission on Pharmaceutical Services to Ambulant Patients by Hospitals and Related Facilities." The findings of the commission were published as the Challenge to Pharmacy in Times of Change in 1966.²¹

A position reflecting agreement between the American

Pharmaceutical Association and the American Society of Hospital Pharmacists on outpatient dispensing resulted. Prescriptions generated for private patients in the hospital could be filled by the hospital pharmacy. However, prescriptions of private patients generated outside of the hospital should not be filled by the hospital pharmacy.²²

Although the issue of who may be provided outpatient pharmacy services by a hospital pharmacy had been resolved, other issues had continued to plague hospital operation of outpatient pharmacies and to strain relationships between hospital and community pharmacists. Two legal decisions issued by federal courts in recent years could be expected to impact on hospital pharmacies or hospital owned pharmacies.

In December 5, 1973, the United States Supreme Court upheld a North Dakota statute that restricted majority ownership of pharmacies to registered pharmacists.²³ This particular statute included a clause which stated that the provisions "shall not apply to hospital pharmacies furnishing service only to patients in such hospital."²⁴ This exemption was not addressed by the court, but the North Dakota statute would be expected to become a model for other states to follow.²⁵ It would be reasonably assumed that, should a similar law be passed in Texas, even with the hospital exemption, a hospital owned pharmacy in a professional

office building would be illegal.

More immediate, national impact was expected from the ruling of United States Court of Appeals for the Ninth Circuit on December 26, 1974. This court ruled that non-profit hospitals could not dispense to outpatients, medications purchased at hospital prices lower than those available to retail pharmacies. In the ruling, the court defined the following classes of patients to whom the lower priced drugs could not be sold:

- a. Take home prescriptions to departing inpatients.
- b. Renewal of prescriptions to former inpatients.
- c. Dispensing to outpatients for home use.
- d. Sales to hospital employees, students, or physicians or to physicians for use in their private practices.
- e. Sales to walk-in customers who are not hospital patients.

This ruling did not prohibit hospitals from selling medications to the above classes of patients, but it did state that drugs bought at prices discriminatory to retail druggists could not be sold to those patients.²⁶

Summary

The non-availability of literature on alternative methods of operating pharmacies in medical office buildings restricted the review of the literature to related subjects that impacted on the study. It was found that pharmacies

were commonly located in professional office buildings, but that data on business generated for this type pharmacy was limited. It appeared that many pharmacies operated successfully in these surroundings, but the sources of workload were not stated. Similarly, hospitals had operated professional office buildings for a number of years with apparent mutual value to hospitals, physicians, and patients alike. Pharmacies were not addressed in these sources. Outpatient pharmacy services in hospitals had been well addressed in the literature. Conflict was noted between community pharmacists and hospitals and their hospital pharmacists. Two court rulings had clouded the issues to the point that hospital operation of a pharmacy in a professional office building could be interpreted as illegal. Additionally, a ruling on drug dispensing complicated accountability of materials for hospital owned, outpatient pharmacies.

Footnotes

¹Hendrick Memorial Hospital, Our First Fifty Years--1924-1974 (Abilene, Tex.: Hendrick Memorial Hospital, 1974), p. 1.

²Ibid., p. 5.

³Abilene Reporter News, Special Section on Hendrick Memorial Hospital, September 22, 1974, pp. 2, 5.

⁴Joel T. Allison, Administrative Assistant, Hendrick Memorial Hospital, Abilene, Texas, Personal Interview, March 13, 1975.

⁵Abilene Reporter News, p. 5.

⁶William J. Turenne, ed., Lilly Digest - 1974 (Indianapolis, Ind.: Eli Lilly and Company, 1974), p. 27.

⁷Ibid.

⁸Harlan Frey, Pharmacy Design Consultant, McKesson and Robbins Drug Company, Arlington, Texas, Personal Interview, March 6, 1975.

⁹Paul C. Olsen, "The Drugstore in a Medical Building," Drug Topics, CXIV (June 22, 1970), 40.

¹⁰Turenne, pp. 27-8.

¹¹Ibid.

¹²C. Rufus Rorem, Physicians' Private Offices at Hospitals (Chicago: American Hospital Association, 1959), p. 84.

¹³Ibid., pp. 74-5.

¹⁴Ibid., p. 76.

¹⁵Francke, et. al., Mirror to Hospital Pharmacy (Easton, Pa.: Mack Printing Co., 1964), p. 7.

¹⁶George P. Provost, "Hospital-Based Pharmacy Service for Ambulatory Patients," American Journal of Hospital Pharmacists, XIX (May, 1972), 393.

¹⁷Robert J. Allen and Fred M. Eckel, "The Pharmacist's Role in a Hospital-Based Outpatient Clinic," Drug Intelligence and Clinical Pharmacy, VI (August, 1972), 278.

¹⁸Arthur Osol, ed., Remington's Pharmaceutical Sciences (14th ed.; Easton, Pa.: Mack Publishing Co., 1970), p. 1797.

¹⁹Ibid.

²⁰Ibid.

²¹William E. Hassan, Jr., Hospital Pharmacy (3rd ed.; Philadelphia: Lea and Febiger, 1974), p. 235.

²²Eric W. Martin, Dispensing of Medication (7th ed.; Easton, Pa.: Mack Publishing Co., 1971), p. 1087.

²³Henry Putzel, Jr., Reporter of Decisions, United States Reports, Vol. 414 (Washington, D.C.: United States Government Printing Office, 1975), p. 156.

²⁴Grover C. Bowles, Jr., "Hospitals Await Effects of Ruling That Restricts Ownership of Pharmacies to Pharmacists," Modern Hospital, CXXII (February, 1974), 88.

²⁵Putzel, p. 156.

²⁶Federal Reporter, 2nd Series, Vol. 510 F.2d. (St. Paul, Minn.: West Publishing Co., 1975), p. 489.

CHAPTER II

DISCUSSION

General Information

The area surrounding Hendrick Memorial Hospital had already reflected the trend of physicians and accompanying pharmacists to locate near major hospitals.¹ The hospital's proposed venture was intended to continue and enhance this trend. Observation of the area identified approximately 40 physicians and dentists practicing within two blocks of Hendrick Memorial Hospital in various types of office accommodations including individual offices, specialty groups, and one medical office building.

The medical office building was located directly across North 19th Street from the proposed professional office building (see building 20, Appendix B). Twenty-eight physicians and a community pharmacy were located in the building. The building was owned by its occupants, including the pharmacist who operated the pharmacy. The predominance of the occupants in this building and of the practitioners in other facilities in the area were of surgical specialties. Purchase of the medical office building was once considered by Hendrick Memorial Hospital as an investment. However, the two parties were not able to agree on terms of sale.

At the time that the purchase of the medical office building was considered, the pharmacy appeared viable and very successful. More recently, the pharmacist/proprietor had continued to operate the pharmacy successfully. In addition to this pharmacy, a discount drugstore was located next to the medical office building. This firm also appeared to have a viable pharmacy business based on personal observation and the knowledge of the chief of the hospital pharmacy.² Since contact with local pharmacists was prohibited by the administration of the hospital, exact business activity of these firms could not be determined. This contact was prohibited primarily because the hospital did not want to be concerned with inquiries from local pharmacists during the conceptual planning for a pharmacy. It did appear that both firms were fairly low volume operations (less than 100 prescriptions per day), but successfully operated. Both seemed to typify the characteristics expected of their modes of operation, i.e., the pharmacy in the medical office building competed with service, where the discount pharmacy competed with price reputation. The medical office building pharmacy devoted most of its space to prescriptions, and the discount pharmacy used much of its space for non-prescription business.

In the conceptual phase, Hendrick Memorial Hospital did not intend to compete with either the professional

offices in the area or the local pharmacies. Their earlier stated intent was to bring more physicians to the hospital area, particularly those in medical diagnostic and treatment specialties. Their purposes would not be served by luring physicians away from buildings already located in the area. Additionally, the expected rental rate of \$7.20 per square foot of floor space per year needed in the proposed building would be unlikely to draw many local physicians from equivalent facilities in the Abilene area with average charges of \$4.80 per square foot of floor space per year.^{3,4} With this in mind, pharmacy business generated by these physicians would have been additive to that already in the area.

Development of Pharmacy Business

The proposed professional office building at Hendrick Memorial Hospital was expected to house approximately 35 physicians. Among this total, it was expected to have at least six internists and hopefully more. Other primarily medical specialists, such as dermatologists, allergists, and otolaryngologists were also intended to be included.⁵ Some office suites will surely have been occupied by members of the surgical specialties, but this group will not have been emphasized. They were already well represented in the immediate vicinity.

Prescription business

The prescription business received by a pharmacy in

a professional office building would have been dependent on several factors. Included would have been location of the pharmacy, buying habits of the patients, and prescriptions written.⁶

The conceptual architectural plan of the building had located space for the pharmacy between the front door of the building and the elevators. Patients would be required to pass by it when entering or leaving the building. The location was also exposed to the outside of the building potentially allowing customers convenient walk-in access from outside the building. The proposed location was considered excellent. The possibility of a drive-in window was discussed, but driveway access expense was considered excessive for its value.⁷

Prescription customers would shop for convenience, habit, service, or price. The pharmacy in a professional office building could not have competed with the discount pharmacies on price. The discounter would have had volume purchasing and cheaper floor space on its side. The successful professional office building pharmacist would have used the other three factors to his advantage. He would have filled the convenience prescriptions and provided excellent service to develop a customer habit. Reputation would then have stimulated the growth of his business.⁸

In a proposed facility, the business generated by

the physicians must be the primary factor considered in determining potential prescription business. Using the figures presented in Chapter I, 35 physicians, with a specialty mix that represented the national average, would write 245,000 prescriptions per year. If the pharmacy filled 18 per cent (average of Dr. Olson's predicted 16-20 per cent) of those written, this would be 44,100 prescriptions filled per year. This would be approximately 150 prescriptions per working day.⁹ The author previously referenced indicated that a pharmacist practicing good marketing techniques could fill 50 per cent of the prescriptions written.^{10,11} A consultant employed by a pharmaceutical firm also indicated that 50 per cent of the prescriptions could potentially be filled by the pharmacy. He also stated that a heavy prescription writer (an internist, obstetrician, or general practitioner) would write about 60 prescriptions per day. Conceivably, six internists would write 360 prescriptions per day, of which a pharmacist might fill 180 as a maximum.¹²

With background data provided, a rather arbitrarily based evaluation must have been developed to determine a working figure of new prescriptions generated in the area that might be expected to be filled. Since the medical specialties were expected to predominate among the 35 occupants of the building, the annual prescriptions written were increased by 6 per cent for a total of 260,000. With a range of

estimates from 16 to 50 per cent fill, a rather pessimistic figure of 23 per cent was chosen to represent percentage of prescriptions that might be expected to be filled. Using 300 working days per year, approximately 200 new prescriptions per day with a reasonable chance of being filled in the area, would be generated. This figure should not be construed as an exact figure, but only as an estimate of potential workload generated. Additionally, this figure was not entirely supported by data retrieved from a limited survey (see Appendix D).

Adequacy of Existing Hospital Pharmacy

The hospital pharmacy was considered for its adequacy in handling workload generated by the professional office building. Among the factors considered in the evaluation were location, design and space limitations, services currently provided, and legal and ethical considerations.

The hospital pharmacy was located on the fifth floor of the service wing of the hospital (see building 6, Appendix B). Access to the pharmacy from the proposed building (see building 20, Appendix B) would be accomplished by walking from the main floor of the building across an open area to the present hospital. Negotiation of a maze of corridors and an elevator was required once in the hospital to reach the pharmacy. It took this writer three days in the hospital to be able to accomplish this trip without confusion.

A patient, often already in a confused state, presumably would encounter similar difficulty. Once directions were known, the trip could be made in about ten minutes.

The pharmacy was designed primarily to serve inpatient needs. The limited outpatient service that was provided was accomplished through a pass-through window to the hallway. No waiting area was provided. Prescriptions were filled for outpatients on one counter in the pharmacy. This counter was in space shared with that used for inpatient prescriptions. No excess space was located in the pharmacy area that could have been used for a separate outpatient prescription filling and dispensing operation.

Approximately 30 outpatient prescriptions were filled daily from the hospital pharmacy. Most of these were dispensed at a discount to employees. Two to four a day were dispensed to departing inpatients upon the attending physicians' requests. The filling of these prescriptions was considered a nuisance because it occupied 30 per cent of one registered pharmacist's time and required the stocking of approximately \$6,000 extra inventory to meet packaging requirements.¹³

Should the ruling of the United States Court of Appeals for the Ninth District concerning the dispensing of medications to outpatients be upheld, hospital pharmacies dispensing to outpatients would have to set up separate

purchasing, control, and dispensing mechanisms for these drugs. This would impose added costs on the pharmacy.¹⁴

Based on the position taken by the American Pharmaceutical Association and the American Society of Hospital Pharmacists, a fine line had existed on the ethics of dispensing medications by the hospital pharmacy to outpatients from a separate professional office building. This may or may not have been interpreted as prescriptions generated in the hospital.¹⁵

Based on the limitations set forth in the previous paragraphs, it appeared that adequate outpatient service to the professional office building could not have been provided by the existing pharmacy. Additionally, a productive spinoff could be realized by the hospital pharmacy with the opening of a pharmacy in the professional office building. The hospital pharmacy could have discontinued outpatient service altogether. This would have eliminated \$6,000 in stock and freed counter, shelf, and floor space in the pharmacy for more productive effort. Thirty per cent of a pharmacist's time would be freed for use in more productive hospital programs such as IV additive, unit dose, and clinical pharmacy programs.

Analysis of the Alternatives

Pharmacies located in hospital constructed professional office buildings had operated through various

arrangements. The most common of these identified through the survey and direct contacts were as follows: the hospital operated the pharmacy either directly or through a foundation, the hospital leased space to an individual or firm to operate the pharmacy, or the hospital sold space to an individual or firm to operate the pharmacy. These methods of operation and their variations were analyzed to determine their applicability to the current situation.

General information

Five alternatives for operation of the pharmacy in the professional office building were considered. These were based on the three primary methods of operating these facilities that were mentioned above. The alternatives chosen for analysis were as follows:

- a. The hospital could sell the space allocated for the pharmacy to a firm or individual.
- b. The hospital could lease the space allocated for the pharmacy to a firm or individual for a set rate.
- c. The hospital could lease the space allocated for the pharmacy to a firm or individual for a minimum rate or a percentage of the gross revenue, whichever was greater.
- d. The hospital could operate the pharmacy themselves using a manager paid a minimum salary or a percentage of net revenue, whichever was greater.
- e. The hospital could operate the pharmacy

themselves using a salaried manager.

For analysis of the alternatives, several groups of data were developed.

A questionnaire that was sent to hospitals identified as having pharmacies in professional office buildings had its results summarized in Appendix D. As can be readily seen from the summary, there was extreme variation in the information received. Although the small sample would have made statistical analysis of little value, the variation appeared to make one point--prescription activity cannot be predicted with much accuracy based on the number of occupants. In this case, the number of prescriptions filled per occupant per day varied from 0.29 to 8.00. This survey also showed a preponderance of hospital operated pharmacies although this pattern was not supported by other contacts.

In the financial analysis of the various alternatives, several levels of prescription activity were examined because of the variability in the survey results. Those chosen were 200, 100, and 50 prescriptions per day. The highest number was selected because this level would represent an extremely successful pharmacy under any alternative and would probably not be exceeded in the setting of the problem. The middle level represented what was considered to be a good prescription business, and it approximated the average number of prescriptions filled in this type pharmacy.¹⁵ The lowest

level was chosen because it represented the minimum activity required to justify the presence of a pharmacy.^{16,17} Based on the survey results, interviews with Dr. Olsen, Mr. Frey, Mr. Moore, and Mr. Chandler, and the literature reviewed, estimated probabilities were assigned to the various levels of prescription activity of each alternative for computation of expected values. These sources revealed that a community pharmacist with incentive reimbursements could have expected performance at the levels shown for the leased or purchased alternatives. The pharmacist would be motivated to provide physicians with drug information and prescription pads. He also could be expected to develop a good client/pharmacist relationship. The manager in the hospital owned pharmacy would have been less likely to offer these prescription building services. The manager for the hospital receiving a percentage of the net revenue would be motivated to work toward the higher prescription levels because of monetary incentives. At the lower levels of prescription activity, his reimbursement would have been his guaranteed minimum and not of any incentive value. It was concluded that his performance at the two lower levels would be equally likely to occur. The salaried manager would not have perceived any significant reward for better performance. He would not have been motivated to practice marketing techniques that would have positively influenced prescription business such as the previous

alternatives. His performance could be expected to be significantly poorer in the pharmacy and the probabilities were accordingly reduced.^{18,19,20,21} The probabilities are shown in Appendix E.

Using the sources as summarized in Appendix F, an estimated income statement was prepared for each alternative at the various levels of prescription activity previously mentioned (see Appendixes G, H, I, and J). Under the income statements, the expected values were calculated. These statements were developed based on summary data in the Lilly Digest - 1974.²² Averages from this source were used except where data was known or where the alternative required variation. The price per prescription was adjusted from \$4.72 to \$5.25 to allow for inflation since the report was published. Wages and salaries were based on estimates provided by Mr. Lamar Moore, Jr., who owned several pharmacies in Abilene and other Texas cities.²³ Rent or mortgage payments were based on data developed for the entire building by Hendrick Memorial Hospital, with the exception of the lease based on a percentage of gross revenue.²⁴ In the case of a hospital operated pharmacy, indirect costs were developed for use where appropriate and are explained in the next paragraph. Other expenses were based on the Lilly Digest - 1974, with adjustments for services to be provided by the hospital in rental fees, mortgage payments, or indirect costs.^{25,26,27} The

expected values for the various management alternatives are summarized in Appendix K.

Indirect costs and marginal indirect costs were developed in conjunction with the hospital accountant.²⁸ The depreciated building, interest, plant operation, housekeeping, and security costs were computed but not considered in the alternatives with one exception because they were constant and equally applicable to each alternative. In the case of the hospital operated pharmacy with the manager's salary based on net revenue, these costs were considered for determination of his salary because he would have been responsible for recovering them for the hospital. They were not, however, considered as expenses to the hospital. The annual amount of these indirect costs was computed to be \$6,779.²⁹ Marginal indirect costs that would have been applicable in hospital owned alternatives but not in leased or purchased alternatives were considered as expenses for the hospital owned alternatives. These were administrative and general and materials management costs. It was recognized that the marginal costs might have impacted quite differently from the current multiplier as used by the hospital, but there was no accurate way of predicting the actual change in marginal costs. Therefore, the hospital's current multiplier was used. The marginal indirect costs at each level of prescription activity are presented in Appendix L.

Pharmacy operated in space purchased by firm or individual

This alternative would have been simple for the hospital to implement. A satisfactory buyer would be located, financing would be arranged, and a services contract would be negotiated. It was determined to be self-supporting at all levels of activity. The expected value to the proprietor was \$46,895.50 per year (see Appendix G). The profit motive would be an incentive to the pharmacy. It would be operated under applicable local, state, and federal laws like any other community pharmacy. It would not be hampered by purchasing requirements laid down by the United States Court of Appeals for the Ninth Circuit.³⁰ Since it was a method preferred by many community pharmacists, it would be expected to enhance hospital-community pharmacist relations.³¹

On the negative side, no continued net revenue would be generated for the hospital. Control of the operation would have been lost for all practical purposes. An occupant that proved undesirable would have been very difficult to dislodge.

Arrangements for the pharmacy to fill discounted out-patient prescriptions for employees would have been difficult to accomplish and enforce. Should a law similar to that in North Dakota be passed in Texas, non-pharmacist ownership of this facility would have become illegal.³² If the occupant was unsuccessful in the business, a foreclosure could have left the hospital without pharmacy services in the building

for an extended period.

Pharmacy operated in space leased by a firm or individual for a set fee

This type operation would be expected to have very similar implications to the one above. A pharmacist could start a business here with a limited outlay of capital. The leased pharmacy also was self-supporting at all levels of activity and had an expected value of \$46,895.50 per year for the proprietor (see Appendix G). It would not be hampered by laws that might affect a hospital operated pharmacy in drug purchasing.³³ It is also a commonly used arrangement for community pharmacists and would be expected to enhance hospital-community pharmacist relations.³⁴

As with the purchased facility, no continued net revenue would be generated for the hospital. The lease payments would only be expected to cover operating costs of the facility.³⁵ Control would be limited, although not lost. Termination agreements could be written into the lease. Discounted prescriptions for employees could be arranged as part of the lease agreement, but adequate service might not be provided without pressure from the hospital administration. Non-pharmacist ownership could also become a problem. The loss of the tenant would mean a re-negotiation of the lease, but interruption of the service would probably be less lengthy than in the previous case.

Pharmacy operated in space leased by a firm or individual for a percentage of gross revenue

In this instance, the hospital would lease the facility to a firm or individual for a minimum rate or a percentage of the gross revenue, whichever was greater. The minimum rate would be set to insure that the hospital would not lose money. The six per cent of gross revenue was established because it was given as the going rate for the area.³⁶ A limited outlay of capital would be required of the pharmacist. This pharmacy was also determined to be self-supporting at all levels of activity (see Appendix H). It provided an expected value to the proprietor of \$35,351.60 per year and to the hospital of \$4,943.90 per year. It provided net revenue to the hospital except at the lower levels of prescription activity. The profit incentive to the proprietor would have a spinoff to the hospital as indicated by the expected value figures. As with the previously mentioned alternatives, the purchasing restrictions on hospitals would have no effect.³⁷ It would be expected to have positive impact on hospital-community pharmacist relations.

Its disadvantages would be similar to those of the other lease agreement. One additional factor should be considered here. Dr. Olsen indicated that some pharmacists felt that this arrangement was a form of fee-splitting and as such would be considered unethical.³⁸ Mr. Moore stated that this was commonly done in chain stores.³⁹ This might have hindered

the leasing of a facility under this arrangement. Control, discounted prescriptions, non-pharmacist ownership, and interruption of service must be considered disadvantages for the same reasons as the previous alternative.

Pharmacy operated by the hospital with the manager paid a percentage of net revenue

The hospital would be responsible for operation of the pharmacy, but a manager would be hired under an incentive reimbursement program. He would be paid either a minimum salary or a percentage of the net revenue, whichever was greater. The minimum rate would be set to protect the individual's income. The rate of 33 per cent of net revenue was provided as the going rate for this arrangement. Since a manager being reimbursed under this system would have normally been responsible for rent as an expense that reduced net revenue, the annual indirect cost of \$6,779 previously mentioned was subtracted from the net revenue shown in Appendix I for the calculation of his salary.⁴⁰ In this case, all levels of activity appeared to be self-supporting (see Appendix I). It provided an expected value to the manager of \$18,154.40 and to the hospital of \$29,422.60. Where the previous alternatives lacked control, control now would have been very good. The incentive to the manager was provided with an emphasis on a high net revenue. All outpatient prescriptions could be moved from the hospital pharmacy to this pharmacy without any problems. This would have freed 30 per cent of a

pharmacist's time to accomplish other duties and \$6,000 capital tied up in hospital drug inventory. Backup service could be provided through employees of the hospital preventing any interruption of service.

Negatively, the manager's incentive might not have proven totally effective since prescription activity must be maintained at a high level to get over the minimum. In the event of very low prescription activity, the hospital would have stood to incur a loss. The hospital would be prevented from purchasing drugs for the pharmacy at favorable hospital prices if the court decisions were upheld.⁴¹ In the event of a law similar to that of North Dakota was passed in Texas, the hospital could be determined to be an illegal owner of the pharmacy.⁴² Community pharmacists might have viewed this operation as an encroachment on their business by the hospital. Hospital-community pharmacist relations would not be expected to be enhanced.⁴³ If the pharmacy was performing poorly, an excess of management time of the hospital administration might be spent trying to solve problems. Additionally, if it performed very well, personnel problems might occur in the hospital pharmacy. This might generate hard feelings if a director of pharmacy discovered that he was making less money than a pharmacy manager that he supervised.

Pharmacy operated by the hospital with a salaried manager

As with the previous alternative, the hospital would

have complete control of the pharmacy. This alternative was self-supporting at all levels and generated expected values of \$15,600 for the manager (his salary) and \$23,301.40 for the hospital annually (see Appendix J). Outpatient prescriptions could be moved from the hospital pharmacy with the same benefits as the previous alternative. No service interruptions would be anticipated because of backup from the hospital pharmacy. Personnel problems should not be encountered because of perceived inequitable pay.

In addition to the other disadvantages mentioned for a hospital operated pharmacy, this alternative had another serious defect. No monetary incentive was offered for good performance by the manager. He could be replaced for poor performance, but this would be considered a negative incentive. A pharmacy operating in this manner might find itself accomplishing a very low workload at considerable expense to the hospital. The disadvantages offered for the other hospital operated alternative, with the exception of the personnel problem, would also be a consideration here for the same reasons.

Footnotes

¹ Francke, et. al., p. 7.

² Donald E. Chandler, Director of Pharmacy, Hendrick Memorial Hospital, Abilene, Texas, Personal Interview, March 6, 1975.

³ John D. Karr, Vice President, Hendrick Memorial Hospital, Abilene, Texas, Personal Interview, March 12, 1975.

⁴ Lamar Moore, Jr., Member, Board of Trustees, Hendrick Memorial Hospital and Businessman, Abilene, Texas, Personal Interview, March 12, 1975.

⁵ Boone Powell, Jr., President, Hendrick Memorial Hospital, Abilene, Texas, Personal Interview, March 12, 1975.

⁶ Frey, Personal Interview, March 6, 1975.

⁷ Powell, Personal Interview, March 13, 1975.

⁸ Frey, Personal Interview, March 6, 1975.

⁹ Olsen, "The Drugstore in a Medical Building," 40.

¹⁰ Paul C. Olsen, Contributing Editor, Drug Topics, Oradell, New Jersey, Telephone Interview, April 25, 1975.

¹¹ Paul C. Olsen, Contributing Editor, Drug Topics, Oradell, New Jersey, Letter, May 9, 1975.

¹² Frey, Personal Interview, March 6, 1975.

¹³ Chandler, Personal Interview, March 6, 1975.

¹⁴ "Courts Urged Not to Hamper Hospital Outpatient Dispensing," American Druggist, CLXXI, March 1, 1975, p. 21.

¹⁵ Martin, p. 1087.

¹⁶ Chandler, Personal Interview, March 6, 1975.

¹⁷ Frey, Personal Interview, March 6, 1975.

¹⁸ Olsen, Telephone Interview, April 25, 1975.

¹⁹ Frey, Personal Interview, March 6, 1975.

- ²⁰Moore, Personal Interview, March 12, 1975.
- ²¹Chandler, Personal Interview, March 6, 1975.
- ²²Turenne, p. 28.
- ²³Moore, Personal Interview, March 12, 1975.
- ²⁴Karr, Personal Interview, March 12, 1975.
- ²⁵Turenne, p. 28.
- ²⁶Jerry Epperson, Accountant, Hendrick Memorial Hospital, Abilene, Texas, Personal Interview, March 12, 1975.
- ²⁷Karr, Personal Interview, March 12, 1975.
- ²⁸Epperson, Personal Interview, March 12, 1975.
- ²⁹Ibid.
- ³⁰Federal Reporter, p. 489.
- ³¹"Should You Rent, Lease, or Buy a Building for Your Drug Store?" American Druggist Merchandising, CLXVIII (September 1, 1973), 69.
- ³²Putzel, p. 156.
- ³³Federal Reporter, p. 489.
- ³⁴"Should You Rent, Lease, or Buy a Building for Your Drug Store?" 69.
- ³⁵Karr, Personal Interview, March 12, 1975.
- ³⁶Moore, Personal Interview, March 12, 1975.
- ³⁷Federal Reporter, p. 489.

³⁸ Olsen, Telephone Interview, April 25, 1975.

³⁹ Moore, Personal Interview, March 12, 1975.

⁴⁰ Ibid.

⁴¹ Federal Reporter, p. 489.

⁴² Putzel, p. 156.

⁴³ Olsen, Telephone Interview, April 25, 1975.

CHAPTER III

CONCLUSION AND RECOMMENDATIONS

Summary and Conclusion

Provision of pharmacy services in the proposed professional office building has shown need for consideration of several factors. The development of new pharmacy business showed the need for additional pharmacy services in the area. The evaluation of the present hospital pharmacy indicated that the capability of providing this service was not present in that facility and that it would not be practical to expand the facility for this service. Five alternatives were proposed that could feasibly furnish this service from a facility located in the proposed building. Analysis of these alternatives indicated that each had merits and drawbacks. Each met the criteria of this study but within varying degrees of performance.

All of the alternatives were determined to be self-supporting at predicted levels of pharmacy business. Both hospital owned alternatives had high expected value figures, but they also had a potential for causing a loss to the hospital if the pharmacy business fell too low. Their values to the hospital were considered to be less than the expected value because of the risk of a loss. The alternative with the manager paid on an incentive basis had an appreciably

higher expected value than the alternative with the salaried manager. The alternative of leasing space for a percentage of gross revenue produced a lower expected value than the two previous alternatives, but it also avoided the risk of operating at a loss to the hospital. The value to the hospital was felt to be similar to the expected value but still of significantly less value than the value of the two previous alternatives. The alternatives of selling space or leasing it for a set fee produced no continued net revenue to the hospital. Although the risk was low for the hospital in these alternatives, no economic profit could be expected.

From the standpoint of legality, each alternative could be operated in accordance with the law. The hospital owned alternatives could be found illegal if Texas passed a law similar to that previously referred to in North Dakota. They might also be required to set up complicated accounting systems to separate inpatient and outpatient dispensing. These were considered potential disadvantages. The other three alternatives encountered no such problems. They would not be affected by the court rulings and were equally acceptable from a legal viewpoint.

The selected alternative should have maintained or enhanced hospital-community pharmacist relations. The hospital owned alternatives might have developed difficulty in meeting this criterion. The community pharmacists would have to be

convinced that the hospital was not infringing on their business. The hospital would be required to mount efforts to insure that this did not occur. The alternative of leasing for a percentage of gross revenue might have encountered difficulty while finding a tenant since some pharmacies did not consider this an ethical arrangement. It was determined to be a frequently used arrangement and should ultimately enhance relationships of the hospital with community pharmacists. The leased for a set fee and the purchased space alternatives were determined to be preferred methods by pharmacists and could have certainly enhanced hospital-community pharmacists' relations.

The financial data favored the hospital owned alternatives, particularly the one with the manager paid on an incentive plan. From the legal point of view, the leased or purchased alternatives were preferred as being less likely to have problems. The leased or purchased alternatives would also have had positive impact on hospital-community pharmacists' relations where the hospital owned alternatives would have been likely to only maintain current relationships. In spite of the fact that the leased and purchased alternatives were preferred over the hospital owned alternatives in meeting two of the criteria, the financial differences were considered to be overriding in importance. The high expected value of the hospital owned alternative with the incentive

paid manager made this an extremely attractive alternative. Based on the comparison of the alternatives, it was determined that the best method of providing pharmacy services for the proposed Professional Office Building, Hendrick Memorial Hospital, Abilene, Texas was for the hospital to operate the pharmacy using a manager paid a minimum salary or a percentage of net revenue, whichever was greater.

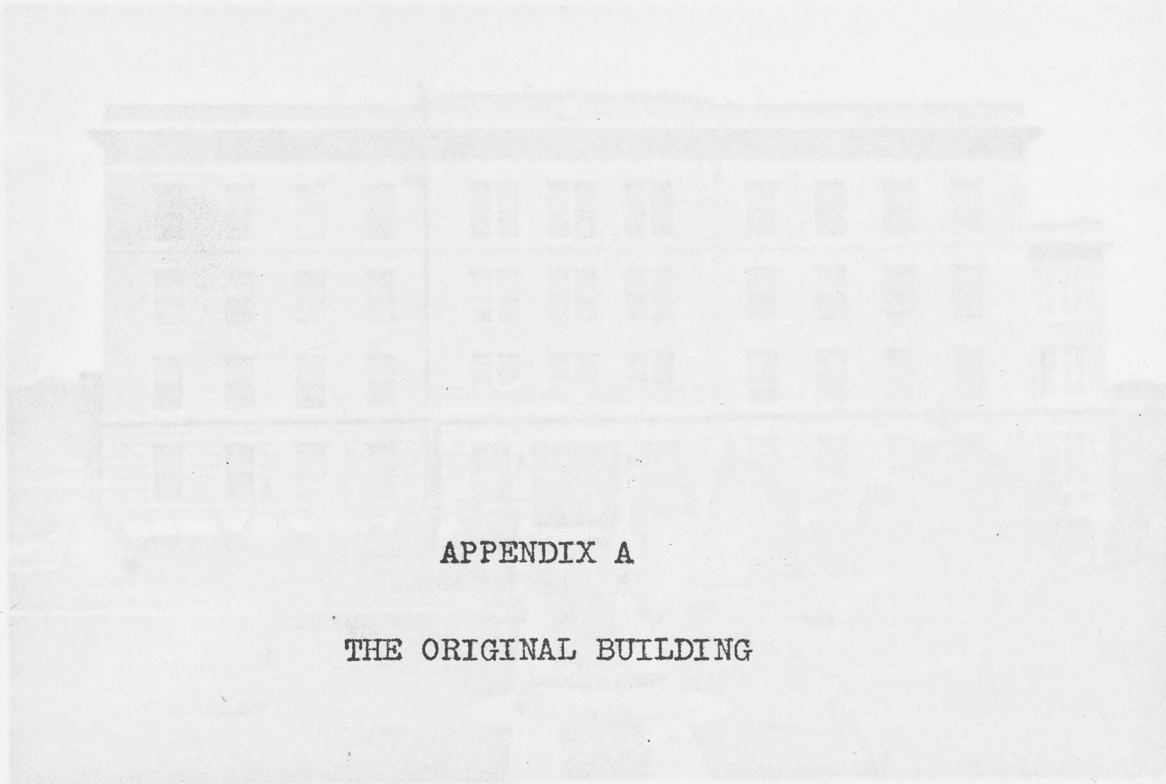
Recommendations

Based on the above conclusion, the following recommendations were made:

1. Steps to implement the above conclusion should be taken to include the identification of a suitable manager and inclusion of definite pharmacy facility planning in the proposed building.
2. Other occupants of the building should be identified and surveyed to determine their prescription writing habits to help determine when to open the pharmacy.
3. Legal advice should be sought to determine tax implications of this alternative.
4. Plans should be initiated to eliminate outpatient prescription service from the hospital pharmacy.
5. Programs should be developed for a more efficient utilization of excess hospital pharmacy capacity created by the elimination of outpatient prescription service.

THE ORIGINAL BUILDING

OUR FIRST FIFTY - - JUST THE BEGINNING I



APPENDIX A

THE ORIGINAL BUILDING

A Christian Hospital, Owned and operated by the Baptists of Texas - -

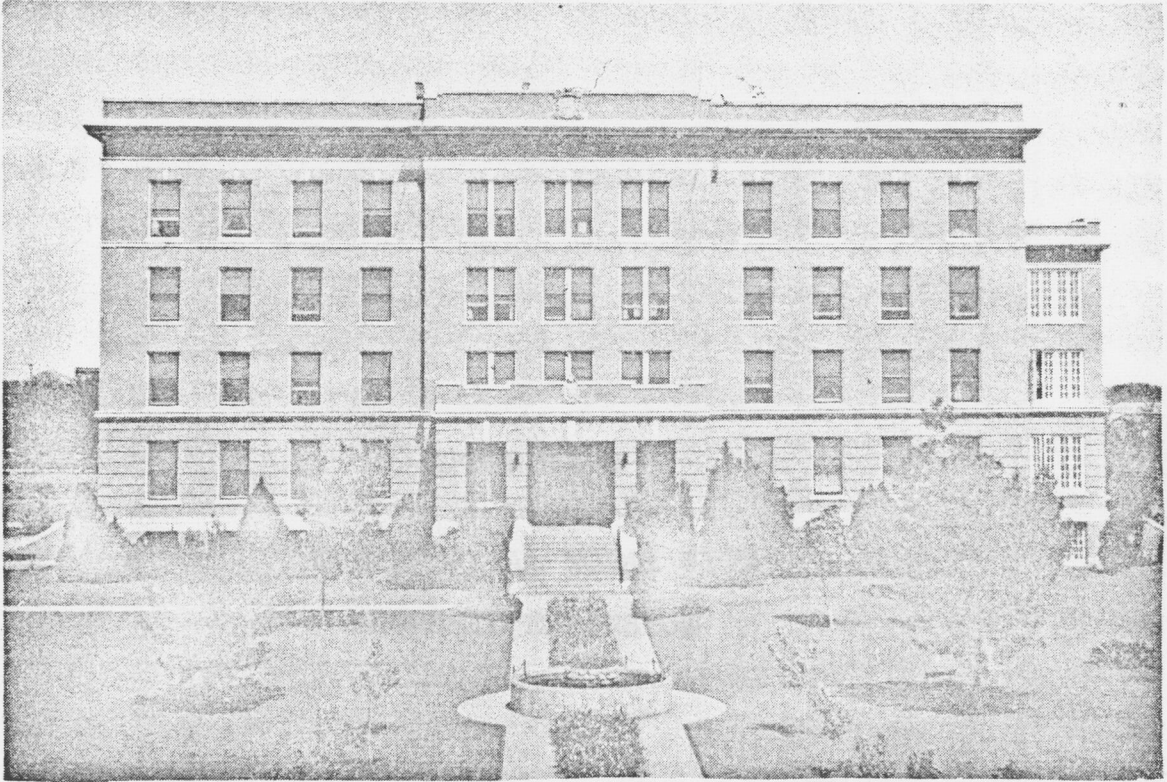
Five stories, 75 beds, fire proof, steam heated, hot and cold running water in each room, three well equipped operating rooms, three modern elevators, excellent nursing service, efficient laboratory service, anesthetic service, well equipped obstetrical department, capable physicians and surgeons.

Our doors are open to you, no matter what your belief or creed.

Source: Hendrick Memorial Hospital, Our First Fifty Years - 1924-1974, Abilene, Texas.

THE ORIGINAL BUILDING

"OUR FIRST FIFTY - - JUST THE BEGINNING !



A Christian Hospital, Owned and operated by the Baptists of Texas - -

Five stories, 75 beds, fire proof, steam heated, hot and cold running water in each room, three well equipped operating rooms, three modern elevators, excellent nursing service, efficient laboratory service, anesthetic service, well equipped obstetrical department, capable physicians and surgeons.

Our doors are open to you, no matter what your belief or creed.

Source: Hendrick Memorial Hospital, Our First Fifty Years - 1924-1974, Abilene, Texas.

THE HOSPITAL TODAY WITH PROPOSED EXPANSION

**Hendrick Memorial Hospital
A Half-Century of Growth**

1. Hendrick Memorial Hospital was founded in 1888 by Dr. J. W. Hendrick, who was the first physician to practice in Abilene, Texas. The hospital was originally a small building on North Street, and it has since grown to its present location on North Street and Hendrick Avenue.

2. The hospital has a long and distinguished history, and it has been a leading institution in the community for many years. It has been a source of pride and inspiration for the people of Abilene, and it has played a vital role in the development of the city.

3. The hospital has a rich tradition of service, and it has always been committed to the highest standards of care. It has been a pioneer in many areas of medicine, and it has been a leader in the development of new techniques and procedures.

4. The hospital has a strong sense of community, and it has always been a part of the life of the city. It has been a place where people have come to seek help and healing, and it has been a place where people have found hope and comfort.

5. The hospital has a proud record of achievement, and it has always been a source of pride for the people of Abilene. It has been a place where people have come to learn and grow, and it has been a place where people have found a better way of life.

6. The hospital has a bright future, and it is always looking for ways to improve and expand. It is always committed to the highest standards of care, and it is always committed to the people of Abilene.

7. The hospital has a strong sense of purpose, and it is always working to make a difference in the lives of the people of Abilene. It is always committed to the highest standards of care, and it is always committed to the people of Abilene.

8. The hospital has a strong sense of community, and it is always a part of the life of the city. It is always a source of pride and inspiration for the people of Abilene, and it is always a place where people have found hope and comfort.

9. The hospital has a rich tradition of service, and it has always been committed to the highest standards of care. It has been a pioneer in many areas of medicine, and it has been a leader in the development of new techniques and procedures.

10. The hospital has a proud record of achievement, and it has always been a source of pride for the people of Abilene. It has been a place where people have come to learn and grow, and it has been a place where people have found a better way of life.

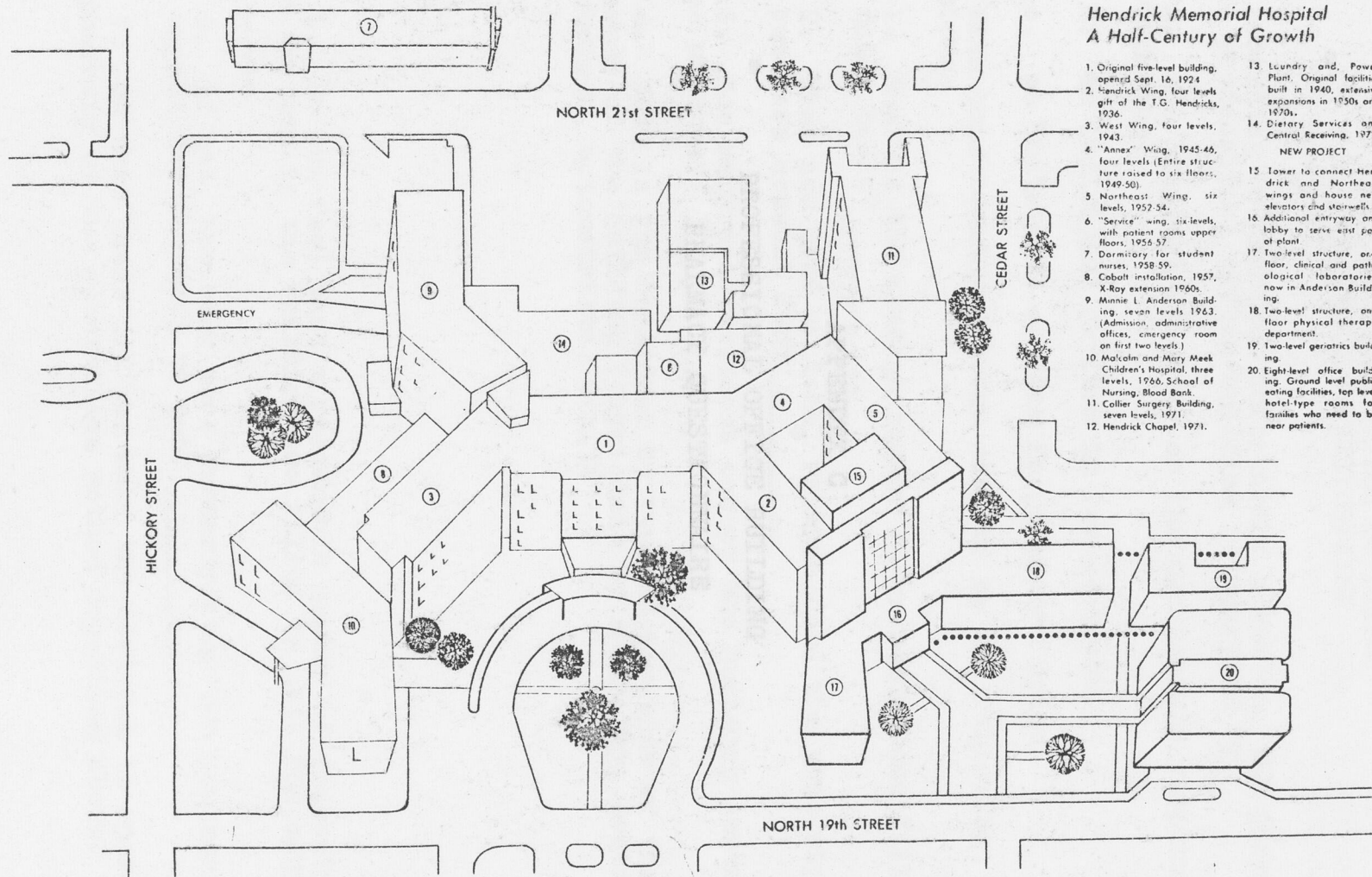
APPENDIX B

THE HOSPITAL TODAY WITH PROPOSED EXPANSION



Source: Hendrick Memorial Hospital, Personnel Handbook, Abilene, Texas.

THE HOSPITAL TODAY WITH PROPOSED EXPANSION



Hendrick Memorial Hospital A Half-Century of Growth

1. Original five-level building, opened Sept. 16, 1924
 2. Hendrick Wing, four levels gift of the T.G. Hendricks, 1936.
 3. West Wing, four levels, 1943.
 4. "Annex" Wing, 1945-46, four levels (Entire structure raised to six floors, 1949-50)
 5. Northeast Wing, six levels, 1952-54.
 6. "Service" wing, six levels, with patient rooms upper floors, 1956-57
 7. Dormitory for student nurses, 1938-39.
 8. Cabott installation, 1957, X-Ray extension 1960s.
 9. Minnie L. Anderson Building, seven levels 1963. (Admission, administrative offices, emergency room on first two levels.)
 10. Malcolm and Mary Meek Children's Hospital, three levels, 1966. School of Nursing, Blood Bank.
 11. Collier Surgery Building, seven levels, 1971.
 12. Hendrick Chapel, 1971.
 13. Laundry and Power Plant. Original facilities built in 1940, extensive expansions in 1950s and 1970s.
 14. Dietary Services and Central Receiving, 1972.
- NEW PROJECT**
15. Tower to connect Hendrick and Northeast wings and house new elevators and stairwells.
 16. Additional entryway and lobby to serve east part of plant.
 17. Two-level structure, one floor clinical and pathological laboratories now in Anderson Building.
 18. Two-level structure, one floor physical therapy department.
 19. Two-level geriatrics building.
 20. Eight-level office building. Ground level public eating facilities, top level hotel-type rooms for families who need to be near patients.

Source: Hendrick Memorial Hospital, Personnel Handbook, Abilene, Texas.

PROFESSIONAL OFFICE BUILDING
PHARMACY QUESTIONNAIRE

According to previous information received, the pharmacy in the professional office building is operated by

- a. the hospital directly or through another corporation or foundation.
- b. an individual or firm in leased space.
- c. an individual or firm in purchased space.

With this in mind, please respond to the following questions:

1. What is the average number of prescriptions filled on a daily basis? _____

APPENDIX C

2. What per cent of total revenue does the prescription business account for? _____

PROFESSIONAL OFFICE BUILDING

3. How many practitioners occupy the building served by the pharmacy? _____
PHARMACY QUESTIONNAIRE

4. What is the breakdown by type of practice of the occupants of the building (physicians by specialty, dentists, podiatrists, optometrists, etc.)? _____

5. Do you feel that a reasonable number of prescriptions written in the building are filled in this pharmacy?

6. If not, how many more prescriptions can you reasonably expect the pharmacy to get? _____

7. On what basis did you make the decision to operate the pharmacy by the alternative method described above?

PROFESSIONAL OFFICE BUILDING
PHARMACY QUESTIONNAIRE

According to previous information received, the pharmacy in the professional office building is operated by

- a. the hospital directly or through another corporation or foundation.
- b. an individual or firm in leased space.
- c. an individual or firm in purchased space.

With this in mind, please respond to the following questions:

1. What is the average number of prescriptions filled on a daily basis? _____

2. What per cent of total revenue does the prescription business account for? _____

3. How many practitioners occupy the building served by the pharmacy? _____

4. What is the breakdown by type of practice of the occupants of the building (physicians by specialty, dentists, podiatrists, optometrists, etc.)? _____

5. Do you feel that a reasonable number of prescriptions written in the building are filled in this pharmacy?

6. If not, how many more prescriptions can you reasonably expect the pharmacy to get? _____

7. On what basis did you make the decision to operate the pharmacy by the alternative method described above?

8. Are you satisfied with the above decision? If so, why? If not, what would you do in a similar future project and why?

9. Remarks if desired.

APPENDIX D

Thank you for your candid answers to the above questions. Any further comments or materials that you might provide will be appreciated. As noted in the cover letter, your answers and comments will be confidential.

ANALYSIS OF PHARMACY QUESTIONNAIRE

Facility	How Operated	Number of Prescriptions Filled Daily	Number Percent of Pre-scriptions Filled Daily	Revenue From Pre-scriptions	Number of Practi- cians	Prescrip- tions Per Day Per Occupant	Medical Special- ties	Surgical Special- ties	Others
1.	Hospital	200	90	90	4	5.98	10	20	4
2.	Hospital	100	95	95	5	1.57	30	40	3
3.	Hospital	70	90	90	7	1.75	24	21	2
4.	Hospital	75	70	70	5	0.98	38	45	4
5.	Hospital	30	55	55	3	0.29	NA	NA	NA
6.	Leased	100	60	60	5	1.06	NA	NA	NA
7.	Purchased	160	30	30	10	8.00	8	8	4

APPENDIX D

ANALYSIS OF PHARMACY QUESTIONNAIRE

included non-clinical physicians, dentists, and optometrists
 NA - Information not provided.

ANALYSIS OF PHARMACY QUESTIONNAIRE

<u>Facility</u>	<u>How Operated</u>	<u>Number of Prescriptions Filled Daily</u>	<u>Percent of Total Revenue From Prescriptions</u>	<u>Number of Practitioners</u>	<u>Prescriptions Per Day Per Occupant</u>	<u>Medical Specialties</u>	<u>Surgical Specialties</u>	<u>Other*</u>
1.	Hospital	200	90	34	5.88	10	20	4
2.	Hospital	100	95	73	1.37	30	40	3
3.	Hospital	70	90	47	1.75	24	21	2
4.	Hospital	75	70	85	0.88	38	43	4
5.	Hospital	30	55	103	0.29	NA	NA	NA
6.	Leased	100	60	95	1.05	NA	NA	NA
7.	Purchased	160	30	20	8.00	8	8	4

*Included non-clinical physicians, dentists, and optometrists

NA - Information not provided.

ESTIMATED PROBABILITIES OF OCCURRENCE
OF A GIVEN LEVEL OF PRESCRIPTION ACTIVITY

<u>Management Alternative</u>	<u>200 Rx/Day</u>	<u>100 Rx/Day</u>	<u>50 Rx/Day</u>
Leased or purchased	.2	.5	.3
Hospital operated			
Manager with per cent of net	.2	.4	.4
Salaried manager	.1	.3	.6

APPENDIX E

ESTIMATED PROBABILITIES OF OCCURRENCE
OF A GIVEN LEVEL OF PRESCRIPTION ACTIVITY

ESTIMATED PROBABILITIES OF OCCURRENCE
OF A GIVEN LEVEL OF PRESCRIPTION ACTIVITY

<u>Management Alternative</u>	<u>200 Rx/Day</u>	<u>100 Rx/Day</u>	<u>50 Rx/Day</u>
Leased or purchased	.2	.5	.3
Hospital operated			
Manager with per cent of net	.2	.4	.4
Salaried manager	.1	.3	.6

APPENDIX F

SOURCES OF INCOME STATEMENT

DATA

SOURCES OF INCOME STATEMENT DATA

<u>Revenue or Expense</u>	<u>Source of Data</u>	<u>Factor Used</u>	<u>Factor Value</u>
Sales			
Prescription	Lilly Digest	Price per prescription adjusted for inflation	\$5.86 per prescription 84.9 per cent of gross sales
Other	Lilly Digest	Per cent of gross sales	15.1 per cent
Total	Lilly Digest	Sum of prescription and other sales	100 per cent of gross sales
Cost of Goods Sold	Lilly Digest	Per cent of gross sales	57.2 per cent
Gross Margin	Lilly Digest	Balance minus cost of goods sold	42.8 per cent of gross sales
Expenses			
Wages and Salaries	Mr. Lamar Hunt,	Salaries of staff retained	Prevailing wages in the Abilene area
Rent or Mortgage Payments			
Set fee	Mr. John Kerr	Fees per square foot	\$7.20
Percentage of Gross Revenue	Mr. Lamar Hunt, Jr.	Per cent of gross revenue	6 per cent
Hospital Owned Alternative	Mr. Jerry Epperson	Original indirect costs incurred in lieu of rent	See Appendix K
Other (Except hospital owned alternative)	Lilly Digest	Per cent of gross revenue	8.6 per cent
Hospital Owned Alternative	Lilly Digest and Mr. Jerry Epperson	Per cent of gross revenue minus per cent of expenses included in indirect costs	6 per cent

APPENDIX F
SOURCES OF INCOME STATEMENT
DATA

SOURCES OF INCOME STATEMENT DATA

<u>Revenue or Expense</u>	<u>Source of Data</u>	<u>Factor Used</u>	<u>Factor Value</u>
Sales			
Prescription	Lilly Digest	Price per prescription adjusted for inflation	\$5.25 per prescription 84.9 per cent of gross sales
Other	Lilly Digest	Per cent of gross sales	15.1 per cent
Total	Lilly Digest	Sum of prescription and other sales	100 per cent of gross sales
Cost of Goods Sold	Lilly Digest	Per cent of gross sales	57.2 per cent
Gross Margin	Lilly Digest	Sales minus cost of goods sold	42.8 per cent of gross sales
Expenses			
Wages and Salaries	Mr. Lamar Hunt, Jr.	Estimates of staff required	Prevailing wages in the Abilene area
Rent or Mortgage Payments			
Set fee	Mr. John Karr	Price per square foot	\$7.20
Percentage of Gross Revenue	Mr. Lamar Hunt, Jr.	Per cent of gross revenue	6 per cent
Hospital Owned Alternative	Mr. Jerry Epperson	Marginal indirect costs incurred in lieu of rent	See Appendix K
Other (Except hospital owned alternative)	Lilly Digest	Per cent of gross revenue	8.6 per cent
Hospital Owned Alternative	Lilly Digest and Mr. Jerry Epperson	Per cent of gross revenue minus per cent of expenses included in indirect costs	6 per cent

ESTIMATED INCOME STATEMENT FOR PHARMACY OPERATED BY A PROPRIETOR IN FACILITIES
PURCHASED OR LEASED FOR A SET FEE

	<u>200 Rx/Day</u>	<u>50 Rx/Day</u>
Sales		
Prescription	\$31,488	\$79,488
Other	5,859	<u>13,669</u>
Total	\$38,347	\$92,447
Cost of Goods Sold	21,511	<u>52,880</u>
Gross Margin	\$16,836	\$39,567
Expenses		
Wages and Salaries	\$5,100	\$15,600
Rent or Mortgage Payments	7,200	7,200
Other Expenses	5,000	<u>7,950</u>
Total	\$20,300	\$30,750
Net Before Taxes	\$6,536	\$8,817
Proprietor's Salary	<u>15,600</u>	<u>15,600</u>
Net to Proprietor Before Taxes	\$5,287	\$24,417
	P (200,100,50)	0.5
	EV (Proprietor) = 16,655.40 +	22917.00 +
		7325.10
	EV (P) = <u>\$46,695.50</u>	
	EV (Hospital) = <u>0</u>	

APPENDIX G

ESTIMATED INCOME STATEMENT FOR PHARMACY
OPERATED BY A PROPRIETOR IN FACILITIES
PURCHASED OR LEASED FOR A SET FEE

ESTIMATED INCOME STATEMENT FOR PHARMACY OPERATED BY A PROPRIETOR IN FACILITIES
PURCHASED OR LEASED FOR A SET FEE

Sales	<u>200 Rx/Day</u>	<u>100 Rx/Day</u>	<u>50 Rx/Day</u>
Prescription	\$313,950	\$156,975	\$78,488
Other	<u>55,838</u>	<u>27,919</u>	<u>13,959</u>
Total	\$369,788	\$184,894	\$92,447
Cost of Goods Sold	<u>211,519</u>	<u>105,759</u>	<u>52,880</u>
Gross Margin	\$158,269	\$79,135	\$39,567
 Expenses			
Wages and Salaries	\$51,600	\$25,800	\$15,600
Rent or Mortgage Payments	7,200	7,200	7,200
Other Expenses	<u>31,802</u>	<u>15,901</u>	<u>7,950</u>
Total	\$90,602	\$48,901	\$30,750
Net Before Taxes	\$67,667	\$30,234	\$8,817
Proprietor's Salary	<u>15,600</u>	<u>15,600</u>	<u>15,600</u>
Net to Proprietor Before Taxes	\$83,267	\$45,834	\$24,417

P (200,100,50) 0.2 0.5 0.3

EV (Proprietor) = 16,653.40 + 22917.00 + 7325.10

EV (P) = \$46,895.50

EV (Hospital) = 0

ESTIMATED INCOME STATEMENT FOR PHARMACY OPERATED BY A PROPRIETOR IN FACILITIES
 LEASED FOR A PERCENTAGE OF GROSS REVENUE

	200 Rx/Day	100 Rx/Day	50 Rx/Day
Sales			
Prescription	\$3,975	\$156,975	\$76,468
Other		<u>27,912</u>	<u>13,959</u>
Total		\$184,887	\$92,447
Cost of Goods Sold		<u>105,759</u>	<u>52,580</u>
Gross Margin		\$79,128	\$39,867
Expenses			
Wages and Salaries Other Than Proprietor		\$18,000	\$9,000
Rent (.06 x gross revenue)		11,093	7,200
Other Expenses		<u>15,901</u>	<u>7,950</u>
Total		\$44,994	\$24,150
Net to Proprietor Before Taxes		\$34,141	\$15,417
Net to Hospital Above Rental Costs (7200)		\$3,893	-0-
		0.5	0.3
P (200,100,50)		17070.50	4625.10
EV (Proprietor) = 13,656			
EV (P) = <u>\$35,551.50</u>			
EV (Hospital) = 2997.40			
EV (H) = <u>\$4,943.90</u>			

APPENDIX H

ESTIMATED INCOME STATEMENT FOR PHARMACY
 OPERATED BY A PROPRIETOR IN FACILITIES
 LEASED FOR A PERCENTAGE OF GROSS REVENUE

ESTIMATED INCOME STATEMENT FOR PHARMACY OPERATED BY A PROPRIETOR IN FACILITIES
LEASED FOR A PERCENTAGE OF GROSS REVENUE

Sales	<u>200 Rx/Day</u>	<u>100 Rx/Day</u>	<u>50 Rx/Day</u>
Prescription	\$313,950	\$156,975	\$78,488
Other	<u>55,838</u>	<u>27,919</u>	<u>13,959</u>
Total	\$369,788	\$184,894	\$92,447
Cost of Goods Sold	<u>211,519</u>	<u>105,759</u>	<u>52,880</u>
Gross Margin	\$158,269	\$79,135	\$39,567
Expenses			
Wages and Salaries Other Than Proprietor	\$36,000	\$18,000	\$9,000
Rent (.06 x gross revenue)	22,187	11,093	7,200
Other Expenses	<u>31,802</u>	<u>15,901</u>	<u>7,950</u>
Total	\$89,989	\$44,994	\$24,150
Net to Proprietor Before Taxes	\$68,280	\$34,141	\$15,417
Net to Hospital Above Rental Costs (7200)	\$14,987	\$3,893	-0-
	P (200,100,50)	0.2	0.5
	EV (Proprietor) = 13,656	+	17070.50
	EV (P) = <u>\$35,351.60</u>	+	4625.10
	EV (Hospital) = 2997.40	+	1946.50
	EV (H) = <u>\$4,943.90</u>		

ESTIMATED INCOME STATEMENT FOR HOSPITAL OPERATED PHARMACY WITH
MANAGER'S SALARY BASED ON NET REVENUE

	200 Rx/Day	100 Rx/Day	50 Rx/Day
Sales	\$313,950	\$156,975	\$78,488
Prescription			
Other	<u>27,819</u>		<u>13,959</u>
Total	\$341,769	\$164,894	\$92,447
Cost of Goods Sold	<u>215,850</u>	<u>105,750</u>	<u>48,860</u>
Gross Margin	\$125,919	\$79,144	\$43,587
Expenses			
Wages and Salaries Other Than Manager	\$16,000	\$6,000	\$6,000
Marginal Indirect Costs Incurred in Area of Rent	3,664	1,832	1,832
Other	<u>21,094</u>	<u>5,947</u>	<u>5,947</u>
Total	\$40,758	\$13,779	\$13,779
Net Before Manager's Salary	\$85,161	\$65,365	\$29,808
Less Manager's Salary (.33 x net)*	<u>28,103</u>	<u>21,570</u>	<u>9,839</u>
Net to Hospital Before Taxes (if any)	\$57,058	\$43,795	\$19,969
P (200,100,50)	0.4	0.4	0.4
EY (Manager) =	\$74.40	\$24.0	\$24.0
EY (H) =	\$18,154.40	\$5,810.80	\$2,955.20
EY (Hospital) =	12,976.60	4,236.20	2,118.10
EY (H) =	\$29,452.60	\$9,047.00	\$4,073.30

APPENDIX I
ESTIMATED INCOME STATEMENT FOR
HOSPITAL OPERATED PHARMACY WITH
MANAGER'S SALARY BASED ON NET REVENUE

*\$6,779 indirect cost for which the pharmacy manager was responsible has been subtracted from the net revenue for the hospital for this computation, i.e. - .33(\$98,755-6,779).

ESTIMATED INCOME STATEMENT FOR HOSPITAL OPERATED PHARMACY WITH
MANAGER'S SALARY BASED ON NET REVENUE

Sales	<u>200 Rx/Day</u>	<u>100 Rx/Day</u>	<u>50 Rx/Day</u>
Prescription	\$313,950	\$156,975	\$78,488
Other	<u>55,838</u>	<u>27,919</u>	<u>13,959</u>
Total	\$369,788	\$184,894	\$92,447
Cost of Goods Sold	<u>211,519</u>	<u>105,759</u>	<u>42,880</u>
Gross Margin	\$158,269	\$79,135	\$39,567
Expenses			
Wages and Salaries Other Than Manager	\$36,000	\$18,000	\$6,000
Marginal Indirect Costs Incurred in Lieu of Rent	7,327	3,664	1,832
Other	<u>22,187</u>	<u>11,094</u>	<u>5,547</u>
Total	\$65,514	\$32,758	\$13,379
Net Before Manager's Salary	\$92,755	\$46,377	\$26,188
Less Manager's Salary (.33 x net)*	<u>28,372</u>	<u>15,600</u>	<u>15,600</u>
Net to Hospital Before Taxes if any	\$74,383	\$30,777	\$10,588
P (200,100,50)	0.2	0.4	0.4
EV (Manager) =	5674.40	+	6,240
EV (M) =	<u>\$18,154.40</u>		
EV (Hospital) =	12,876.60	+	12,310.80
EV (H) =	<u>\$29,422.60</u>	+	4235.20

*\$6,779 indirect cost for which the pharmacy manager was responsible has been subtracted from the net revenue for the hospital for this computation, i.e. - .33(\$92,755-6,779).

ESTIMATED INCOME STATEMENT FOR HOSPITAL OPERATED PHARMACY
WITH SALARIED MANAGER

	<u>200 Rx/Day</u>	<u>100 Rx/Day</u>	<u>50 Rx/Day</u>
Sales			
Prescription	\$313,950	\$156,975	\$78,498
Other	<u>55,838</u>	<u>27,919</u>	<u>13,959</u>
Total	\$369,788	\$184,894	\$92,447
Cost of Goods Sold	<u>111,719</u>	<u>105,759</u>	<u>52,880</u>
Gross Margin	\$258,069	\$79,135	\$39,567
Expenses			
Wages and Salaries	\$33,600	\$33,600	\$21,600
Indirect Costs Incurred in Lieu of Rent	7,277	3,664	1,832
Other	<u>11,094</u>	<u>11,094</u>	<u>5,547</u>
Total	\$51,971	\$48,358	\$28,979
Net to Hospital Before Taxes if any	\$206,098	\$30,777	\$10,588
	0.1	0.3	0.6
F (200,100.50)			
EV (Manager) =	1560	+	4680
EV (M) =	<u>\$15,600.00</u>		+
EV (Hospital) =	<u>7,715.50</u>	+	9233.10
EV (H) =	<u>\$23,301.40</u>		+
			9350
			8352.80

APPENDIX J

ESTIMATED INCOME STATEMENT FOR
HOSPITAL OPERATED PHARMACY WITH
SALARIED MANAGER

ESTIMATED INCOME STATEMENT FOR HOSPITAL OPERATED PHARMACY
WITH SALARIED MANAGER

Sales	<u>200 Rx/Day</u>	<u>100 Rx/Day</u>	<u>50 Rx/Day</u>
Prescription	\$313,950	\$156,975	\$78,488
Other	<u>55,838</u>	<u>27,919</u>	<u>13,959</u>
Total	\$369,788	\$184,894	\$92,447
Cost of Goods Sold	<u>211,519</u>	<u>105,759</u>	<u>52,880</u>
Gross Margin	\$158,269	\$79,135	\$39,567
Expenses			
Wages and Salaries	\$51,600	\$33,600	\$21,600
Indirect Costs Incurred in Lieu of Rent	7,327	3,664	1,832
Other	<u>22,187</u>	<u>11,094</u>	<u>5,547</u>
Total	\$81,114	\$48,358	\$28,979
Net to Hospital Before Taxes if any	\$77,155	\$30,777	\$10,588
	P (200,100,50)	0.1	0.3
	EV (Manager) =	1560	+
	EV (M) =	<u>\$15,600.00</u>	+
	EV (Hospital) =	<u>7,715.50</u>	+
	EV (H) =	<u>\$23,301.40</u>	+

SUMMARY OF EXPECTED VALUES (EV)
FOR MANAGEMENT ALTERNATIVES

<u>Management Alternative</u>	<u>EV to Proprietor/Manager</u>	<u>EV to Hospital</u>
Purchased	\$46,895.80	0
Straight Lease	\$46,895.80	0
Leased for per cent of gross revenue	\$35,351.80	\$4,943.90
Hospital Operated		

APPENDIX K

Manager given per cent of net revenue	\$18,154.40	\$29,422.60
Salaried Manager		\$23,301.40

SUMMARY OF EXPECTED VALUES (EV)

FOR MANAGEMENT ALTERNATIVES

SUMMARY OF EXPECTED VALUES (EV)
FOR MANAGEMENT ALTERNATIVES

<u>Management Alternative</u>	<u>EV to Proprietor/Manager</u>	<u>EV to Hospital</u>
Purchased	\$46,895.50	0
Straight Lease	\$46,895.50	0
Leased for per cent of gross revenue	\$35,351.60	\$4,943.90
Hospital Operated		
Manager given per cent of net revenue	\$18,154.40	\$29,422.60
Salaried Manager	\$15,600.00	\$23,301.40

ANNUAL ALLOCATION OF MARGINAL INDIRECT COSTS

Level of Activity	Type Cost	Allocation Basis	Cost Multiplier	Units	Total
200 prescriptions/ daily	Administrative and general	Number of em- ployees	\$338.22	7	\$6,566
	Materials Man- agement	Price of requi- sitions	.0623	12,183	752
					\$7,327
100 prescriptions/ day	Administrative and general	Number of em- ployees	\$338.22	3.5	\$3,284
	Materials management	Price of requi- sitions	.0623	6,092	382
					\$3,666
50 prescriptions/ day	Administrative and general	Number of em- ployees	\$338.22	1.75	\$1,642
	Materials Management	Price of requi- sitions	.0623	3,046	190
					\$1,832

APPENDIX L

ANNUAL ALLOCATION OF
MARGINAL INDIRECT COSTS

NOTE: While it was recognized that the administrative and general expenses would not vary directly with the level of prescription business, a more precise variation was not desirable.

Source: Mr. Jerry Epperson, Accountant, Hendrick Memorial Hospital, Abilene, Texas.

ANNUAL ALLOCATION OF MARGINAL INDIRECT COSTS

<u>Level of Activity</u>	<u>Type Cost</u>	<u>Allocation Basis</u>	<u>Cost Multiplier</u>	<u>Units</u>	<u>Total</u>
200 prescriptions/ daily	Administrative and general	Number of em- ployees	\$938.22	7	\$6,568
	Materials Man- agement	Price of requi- sitions	.0623	12,183	<u>759</u> \$7,327
100 prescriptions/ day	Administrative and general	Number of em- ployees	938.22	3.5	\$3,284
	Materials management	Price of requi- sitions	.0623	6,092	<u>380</u> \$3,664
50 prescriptions/ day	Administrative and general	Number of em- ployees	938.22	1.75	\$1,642
	Materials Management	Price of requi- sitions	.0623	3,046	<u>190</u> \$1,832

NOTE: While it was recognized that the administrative and general expenses would not vary directly with the level of prescription business, a more precise variation was not definable.

Source: Mr. Jerry Epperson, Accountant, Hendrick Memorial Hospital, Abilene, Texas.

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BIOGRAPHICAL SKETCH

Major James C. Carter [REDACTED]

[REDACTED] He attended Texas A & M University where he received his Bachelor of Science and Doctor of Veterinary Medicine degrees.

He entered the United States Army in 1965, at Fort Sam Houston, Texas. He has served as a station veterinarian at Fort Douglas, Utah; Munich, Germany; and San Diego, California. He also served as Branch Chief and Instructor, Subsistence Branch, Subsistence and Food Service Department, United States Army Quartermaster School, Fort Lee, Virginia.

His military schooling has included the AMEDD Officer Basic and Advance Courses, the Meat and Dairy Products Inspection Course, and the Subsistence Officer Course.

Major Carter is married and the father of two sons.