Mobile PET/CT Pilot Program

Improving Diagnostic Access and Value in Ontario

ADVANCED PET/CT IMAGING INC

The Mobile PET Model

- **Hospital and Mobile PET IHF work in partnership**
  - PET/CT is provided in conjunction with hospital department or in a freestanding IHF center
  - CT services can also be delivered off the same platform to optimize resources
- **Centralized administrative hub for bookings**
  - Verifies and books patients for all of the host sites
  - Allows easy coordination of changes or add-ons with the mobile unit and driver
  - Physicians interact with central hub regarding issues
  - Can be connected to supervising physician or Medical Director as needed
- **Operator compensated through a management services agreement**
  - Reimbursement model determined based upon:
    - Per patient fee
    - Flat monthly cost
- **A trained driver tears down, moves and sets up at each site**
  - Preps the trailer for the next day's operations
  - Technical and operational staff are utilized from each location offering the opportunity to develop local expertise
  - Mobile schedule can be modified on 24 hours notice to accommodate clinical demand

The Mobile PET Model Continued

- **Each site will have standard operating procedures in place**
  - Each mobile location will have procedures in place to coordinate the transfer of patients with mobility challenges
  - Portable oxygen tanks will be provided at each site
  - Unstable patients will be accompanied by a nurse
  - Cardiac PET/CT can be performed as required
- **Each mobile site will be prepared in the case of emergency**
  - Procedures will be developed with each site to determine appropriate response in the event of an emergency
  - Network, PACs and telecommunications will be connected to each host site through pre-installed links allowing direct connection to hospital emergency response
- **Maintenance needs will be managed by Philips Healthcare**
  - Philips maintains a factory trained workforce of field service engineers
  - A schedule of planned preventative maintenance is followed with each system to ensure optimal operating efficiency
  - A remote service engineer will be available at all times to diagnose and/or remedy failures remotely, or dispatch a local service engineer to conduct an onsite visit

Mobile PET Benefits: VALUE

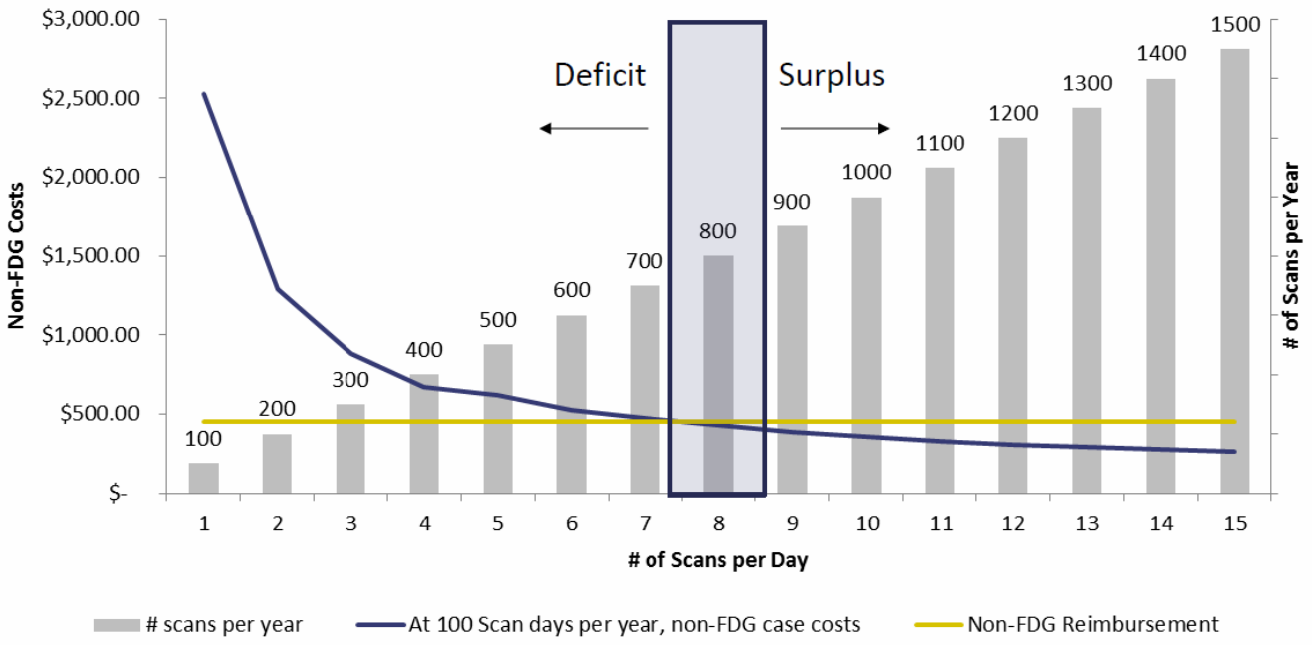
- Mobility allows for economic viability in small and remote communities
- Significantly reduced costs compared to the traditional model

	TRADITIONAL MODEL	MOBILE MODEL
COSTS	Investment in hospital lease hold improvements ($1M-$2M)	Monthly mobile lease
	Capital acquisition of PET/CT terminals, dosing equipment etc. ($2.5M+)	Monthly transportation costs depending on mileage
	Annual service contract with equipment supplier ($250,000+ annually)	Service costs shared by sites
	Reimbursement on a per patient basis	Mentoring/Over-reading
	Potential underutilization of assets based on budget and clinical patient volume	Full utilization by sharing of service
	Staffing	PET/CT technologists can be supplied as needed or shared per site

- Ability to negotiate economies of scale for FDG costs
- More efficient use of financial and human capital
- No travel allowances necessary for out-of-service areas

Economic Viability and Volume Relationship

1. Demand → 2. Capacity → 3. Quality → 4. Cost



Mobile PET Benefits: ACCESS

- Brings services closer to home
- Route flexibility means more Ontarians are served with one machine
- Mobile model will meet or exceed current wait times for fixed PET sites
- PET demand is expected to continue to rise as new indications come online and the mobile model is best able to meet this increased demand without requiring additional capital expenditures

Mobile PET Benefits: QUALITY

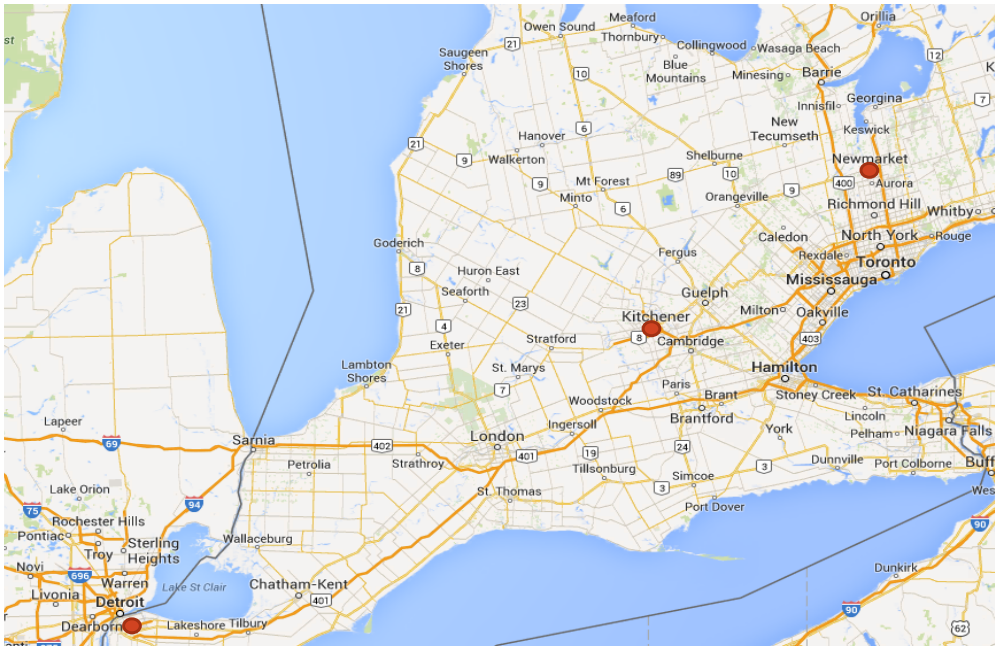
- The mobile units offer PET/CT or CT services and can function as a backup in case a hospital experiences loss of CT service
- This model offers valuable training opportunities for hospital staff in rural and remote communities that they might otherwise not have access to
- PET is the highest standard of diagnostic care for many indications and a mobile model will significantly broaden the reach of this technology across Ontario
- This is a proven delivery mechanism in similar geographical areas such as upper New York State, Northern Michigan and Alaska

Rational for Proposed Pilot Sites

- Two pilot program routes are recommended to afford the most cost-effective use of mobile PET/CT services taking into account patient population, geography, FDG supply and economies of scale
- Adding to the Windsor IHF volume with extension to sites not currently serviced has incremental cost and logistical advantages making this an easy pilot route to quickly implement and assess
- Service needs in northern regions and the ability to evaluate the mobile model in a more challenging and underserviced area led to the identified need for a second route

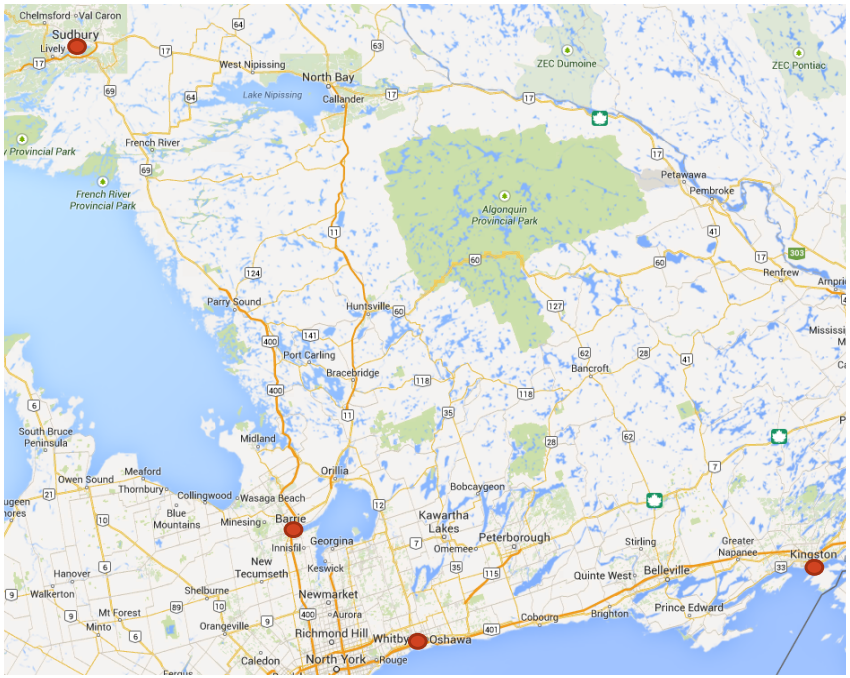
Proposed Mobile PET Pilot Route #1

- SOUTH-WEST ROUTE: Windsor – Kitchener – Newmarket



Proposed Mobile PET Route #2

- NORTH-EAST ROUTE: Sudbury – Lakeridge – Kingston/Barrie



Mobile PET Financials Assumptions

Base Case

2013 total cost of FDG per patient	$400
2013 operating days	250
2013 FDG transportation cost per patient at base	$200
2013 patient volume	500
Price erosion on FDG	5%
Operating days per year	250

Financial Assumptions

Rate to calculate discounted cash flow	6.0%
PET/CT cost for mobile	$2,000,000
Trailer cost	$500,000
Service cost (trailer & PET/CT system)	$200,000
Inflation	2.0%
Lease rate	5.2%
Lease term	60 months
Approximate annual monthly lease amount based on $2,000,000	38,000

Volume

250-500 patients per year to start. Growing at 30% year 1, 12.5% year 2. Maximum of 500 patients per site over six sites

Estimated Patient Volumes											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Windsor	500	500	500	500	500	500	500	500	500	500	500
Kitchener		250	325	406	500	500	500	500	500	500	500
City #3		250	325	406	500	500	500	500	500	500	500
City #4			250	325	406	500	500	500	500	500	500
City #5			250	325	406	500	500	500	500	500	500
City #6			250	325	406	500	500	500	500	500	500
TOTAL	500	1,000	1,900	2,288	2,719	3000	3000	3000	3000	3000	3000

PET Cash Flow

	2013 Base	Plan Yr 1 2014	Plan Yr 2 2015	Plan Yr 3 2016	Plan Yr 4 2017	Plan Yr 5 2018	Plan Yr 6 2019	Plan Yr 7 2020	Plan Yr 8 2021	Plan Yr 9 2022	Plan Yr10 2023
*Tech. Reimburse	$1,050	$1,015	$981	$948	$916	$885	$854	$829	$815	$802	$789
TOTAL ANNUAL MOH REIMBURSE	$525,000	$1,015,000	$1,863,900	$2,168,436	$2,489,838	$2,653,537	$2,562,110	$2,488,005	$2,446,105	$2,406,299	$2,368,484
ANNUAL FDG AND TRANSPORTATION COSTS (Discounted Cash Flow = $16,134,536 total MOH reimbursement & $7,857,476 Total FDG & Transportation Costs)											
# of mobile systems	1	1	2	2	2	2	2	2	2	2	2
Patient volume/yr	500	1,000	1,900	2,288	2,719	3,000	3,000	3,000	3,000	3,000	3,000
Annual FDG costs	$200,000	$380,000	$685,900	$784,498	$885,776	$928,537	$882,110	$838,005	$796,105	$756,229	$718,484
Annual transport costs	$100,000	$185,000	$323,000	$354,563	$380,625	$375,000	$330,000	$300,000	$300,000	$300,000	$300,000
FDG cost per patient	$400	$380	$361	$343	$326	$310	$294	$279	$265	$252	$239
**TOTAL FDG & TRANSPORT COST	$300,000	$565,000	$1,008,900	$1,139,061	$1,266,401	$1,303,537	$1,212,110	$1,138,005	$1,096,105	$1,056,299	$1,018,484
ANNUAL OPERATING SCHEDULE											
Facility Manager	-	$100,000	$102,000	$104,040	$106,121	$108,243	$110,408	$112,616	$114,869	$117,166	$119,509
Technologist	$80,000	$81,600	$166,464	$169,793	$173,189	$176,653	$180,186	$183,790	$187,466	$191,215	$195,039
Administration	$30,000	$30,600	$46,818	$47,754	$48,709	$49,684	$50,677	$51,691	$52,725	$53,779	$54,855
Driver	-	$60,000	$61,200	$62,424	$63,672	$64,946	$66,245	$67,570	$68,921	$70,300	$71,706
Licenses	$20,000	$20,400	$41,616	$42,448	$43,297	$44,163	$45,046	$45,947	$46,866	$47,804	$48,760
Computer/ phone	$20,000	$20,400	$41,616	$42,448	$43,297	$44,163	$45,046	$45,947	$46,866	$47,804	$48,760
Other op costs	$10,000	$10,200	$20,808	$21,224	$21,649	$22,082	$22,523	$22,974	$23,433	$23,902	$24,380
Utilities	$30,000	$61,200	$118,606	$145,651	$176,572	$198,735	$202,709	$206,763	$210,899	$215,117	$219,419
Equipment service	$150,000	-	$200,000	$408,000$	$416,160	$424,483	$432,973	$441,632	$450,465	$459,474	$468,664
TOTAL ANNUAL OPERATING COST	$340,000	$384,400	$799,128	$1,043,783	$1,092,667	$1,133,152	$1,155,815	$1,178,931	$1,202,509	$1,226,560	$1,251,091
ANNUAL OP COST PER PATIENT	$680	$384	$421	$456	$402	$378	$385	$393	$401	$409	$417
NET CASH FLOW PER PATIENT	- $230	$66	$29	-$6	$48	$72	$65	$57	$49	$41	$33
NET CASH FLOW	-$115,000	$65,600	$55,872	-$14,408	$130,771	$216,848	$194,185	$171,069	$147,491	$123,440	$98,909
CAPITAL INVESTMENT											
PET/CT scanner	0	$2,000,000	$2,000,000	0	0	0	0	0	0	0	0
Trailer	0	$500,000	$500,000	0	0	0	0	0	0	0	0
Construction	0	$50,000	$75,000	0	0	0	0	0	0	0	0
CAPITAL COST	0	$2,550,000	$2,575,000	0	0	0	0	0	0	0	0

*($450+cost of FDG +shipping)

**Net FDG + transportation reimbursement should be 0

Our Unique Expertise

- Owner of sole existing IHF license with Mobile PET/CT
- Experienced in operating mobile PET/CT services since 2011
- Standard operating procedures and policies already established and proven
- Existing relationships with suppliers resulting in cost savings
- Ability to offer route flexibility and work with the Steering Committee to ensure viability of the pilots

Addressing your Earlier Questions and Concerns

- Who would be responsible for making sure that the cases meet the indication requirements for reimbursement?
- Who would be medically and legally responsible for the PET patient while in the mobile PET?
- Are host sites going to pay for the connection capital costs (pad, powerlines, infrastructure, etc…)? Roughly how much would it cost?
- If local physicians read and local techs do the PET scans, is there oversight for the local physicians and techs from a training perspective and will there be sufficient volume at those sites to meet any QA requirements (min # of studies for physicians and techs to maintain their expertise)?
- How would the technical fees be divided between the local site (providing technologists, bookings staff etc.) and the Mobile PET?
- The chosen route should include remote sites that do not have nearby existing PET centres (such as Sudbury), rather than sites around the GTA/Greater Hamilton region.

Addressing your Earlier Questions and Concerns

- Who would be responsible for making sure that the cases meet the indication requirements for reimbursement?

- As is currently the case the medical director and PET physicians review and OK each indication to ensure it meets the indication requirements for reimbursement and if not educates the referring physician if they should apply for PET ACCESS where appropriate

Addressing your Earlier Questions and Concerns

- Who would be medically and legally responsible for the PET patient while in the mobile PET?

- As an extension of the Windsor IHF, the medical director of Advanced would be ultimately medically and legally responsible with some shared medical supervisory responsibilities of the on site PET/CT certified physicians at each location.
- Separate standard insurance held by Advanced for the mobile while on site for fire, theft or damages at or to the host site

Addressing your Earlier Questions and Concerns

- Are host sites going to pay for the connection capital costs (pad, powerlines, infrastructure, etc…)? Roughly how much would it cost?

- Siting costs at each location are approximately $25,000 dollars and include:

  Concrete pad: $5,000-10,000 (if needed depending on the hospital location)

  Electrical/ IT/Telecom hookup : 10,000

  Docking Awning: $7000

  These can be shared by the parties or paid for by Advanced based on each operating agreement

Addressing your Earlier Questions and Concerns

- If local physicians read and local techs do the PET scans, is there oversight for the local physicians and techs from a training perspective and will there be sufficient volume at those sites to meet any QA requirements (min # of studies for physicians and techs to maintain their expertise)?

- Our model proposes mentoring, oversight and training for both physicians and technologists depending on their local expertise. We are prepared to work closely with the colleges and the steering committee to ensure all sites and techs/physicians meet QA requirements.
- Our cloud based reporting system allows easy over-read and transfer of studies as needed to allow maintenance of minimum reading numbers. Mentoring and training for technologists at partner locations can supplement training volumes when needed early in each pilot start up

Addressing your Earlier Questions and Concerns

- How would the technical fees be divided between the local site (providing technologists, bookings staff etc.) and the Mobile PET?

- Based on the operating agreement negotiated at each site, sites would be reimbursed for providing their technologists when trained- which is the ultimate goal as each site gains expertise and experience in the process towards full autonomous operation. This has the added ultimate benefit of preparing the site for a stand alone permanent PET/CT service in the future when numbers dictate it.

Addressing your Earlier Questions and Concerns

- The chosen route should include remote sites that do not have nearby existing PET centres (such as Sudbury), rather than sites around the GTA/Greater Hamilton region.

- The Pilot routes suggested are based on ultimate sustainability of the program coupled with evolving need identified by CCO and the principle of closer to home service. We are prepared to work closely with the steering committee and the Ministry of Health and CCO to adjust routes as needed. This flexibility in the model is an added feature we believe.
- A staggered rollout addressing the need in Sudbury will be presented. This can be instituted quickly first

Questions?

Thank you

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