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Inside This Issue

1	President's Message
2	Upfront Editor's letter – Welcome Spring!
3-4	Tax Update for Exempt Organizations
5-6	Accountants and Collecting of Accounts
7	New Member Welcome
8	New Member Profile
9	Member-Get-A-Member Program
10-12	Are We Running Out of Doctors?
13-16	Sponsor Advertising
16	Annual Chapter Sponsors
17	Officer, Board & Committee Listing

STEP Up

President's Message

By: Maria Abrahamsen, JD

FIRST EVER WINE TASTING!

Dear Chapter Members:

Come to the May 25 Meeting

- We're trying something new! On the afternoon of May 25 the Chapter will hold its first ever **wine tasting**. Come to the MSU Conference Center in Troy where a sommelier will provide comments on a variety of wines he has selected for us to sample. Whether or not wine is your thing it will be a great networking opportunity.

- The May 25 wine tasting will be held right after our **final member meeting** of the program year. The Program Committee has lined up a great panel of speakers who are on the front lines of Accountable Care Organizations. Participants will include a national consultant and representatives of Eastern Michigan ACOs.

- We also will present **member awards** at the meeting.

Please join us for education and fun on May 25.

Passing the Gavel

This is my last President's letter. On May 25 Mark McIntosh will be sworn in as Chapter President. I cannot tell you what a pleasure it has been to serve as a Chapter officer. The Eastern Michigan HFMA Chapter is filled with members who have great ideas and are enthusiastic about HFMA. Special thanks to the 2010-11 Directors, officers and committee chairs, all of whom have worked very hard. Also, my great appreciation to Susan Stokes, the Chapter's Administrative Assistant, who is the "glue" that keeps the Chapter running effectively.

Regards,

Maria

Welcome Spring!

By: Jo Ann Roberts
Co-Editor
JRoberts@beaumonthospitals.com

"Spring is nature's way of saying, 'Let's party'." Robin Williams

We have survived another long cold Michigan winter. Now it's time to renew your spirit. In order to maintain balance, we should look for ways to accomplish this in all aspects of our lives.

Some suggestions to consider:
Professional renewal:

- Attend HFMA member and committee sponsored meetings
- Register for spring and summer conferences
- Read HFMA publications

Spiritual renewal:

- Meditation
- Attend religious services
- Volunteer your services

Personal renewal:

- Spend quality time with family and friends
- Indulge in your favorite treat
- Walk outside
- Read a fiction book
- People-watch at the park
- Fly a kite
- Organize your closet, downsize, donate to charity

Health:

- Schedule your annual health screenings
- Eat more fruits and vegetables
- Join a gym or exercise class

Spring and its Rebirth! It reminds us to take the necessary steps to re-energize and the time is now.

CALL FOR ARTICLES

Do you have a best practice in your field? Have you overcome a challenging business issue? Share your knowledge with your fellow HFMA members. Please submit articles to Maryanne VanHaitsma mvanhait@dmc.org or Jo Ann Roberts JRoberts@beaumonthospitals.com. Next HealthCents deadline May 20, 2011.

Tax Update for Exempt Organizations

By: Kathrin E. Kudner
Dykema
kkudner@dykema.com

The Internal Revenue Service (IRS) has increasingly focused attention on exempt organizations in an effort to increase (1) the transparency of exempt organization operations and (2) their accountability for furthering the charitable purposes for which they received exempt status. Recent IRS initiatives, including revisions to the Form 990 and increased audits, illustrate the scrutiny of the IRS on all exempt organizations and particularly hospitals. The Patient Protection and Affordable Care Act (Affordable Care Act), enacted on March 23, 2010, also imposed additional requirements on exempt hospitals.

The following is a summary of recent activities by the IRS relating to exempt organizations.

Revised Schedule H. On February 24, 2011, the IRS posted revised Form 990 Schedule H and Instructions, modified to reflect the new requirements of Internal Revenue Code Section 501(r). Section 501(r) was enacted as part of the Affordable Care Act and imposes requirements on exempt hospitals related to community health needs assessments, financial assistance policies, limits on charges, and limits on collection practices. These new requirements are in effect for tax years beginning after March 23, 2010, except for the provisions relating to community health needs assessment which take effect for tax years beginning after March 23, 2012.

Community Needs Assessment. The Affordable Care Act requires each hospital to conduct a community health needs assessment at least once every three years. The hospital is required to implement an assessment process that includes input from individuals who represent the interests of the community served by the hospital and who have specific health expertise. The hospital must disclose in its Form 990 how the hospital is addressing the needs identified in the assessment and, if a particular need is not being addressed, must include an explanation of its failure to address the need.

Financial Assistance Policies Under the Affordable Care Act, each hospital is required to adopt, implement and publicize a written financial assistance policy and a policy for emergency medical treatment. The policies must define the eligibility criteria, whether the financial assistance is in the form of free care or a sliding fee scale, the application process and the billing and collection process. The Instructions to Schedule H clarify various terms used in Schedule H and provide guidance to multi-hospital systems. For example, the Instructions provide that the questions relating to “eligibility criteria” should be answered based on the largest number of the organization’s patients, based on patient contacts or encounters. The Instructions also provide guidance on calculating community benefit costs and provide worksheets for use by hospitals.

Limit on Charges. The Affordable Care Act limits the amount hospitals may charge patients for emergency or other medically necessary care under the hospital’s financial assistance policy – the limit is the amount that is “generally billed” to insured patients. The Act further provides that a hospital may not use gross charges, and must base charges under its assistance policy on the best rate or an average of different rates. This provision, and the use of gross charges in particular, are likely to continue to generate controversy.

Please see **Update for Tax Exempt Organizations** on Page 4

Update for Tax Exempt Organizations from Page 3

Collection Practices. Hospitals are now required to follow current Medicare law regarding the collection of debts and may not use "extraordinary collection actions" unless the hospital makes a "reasonable attempt" to inform the patient of the hospital's financial assistance policy.

Delayed Filing of Form 990. On February 23, 2011, the IRS issued Announcement 2011-20 granting an automatic three-month extension of the deadline for hospital organizations to file Form 990. The IRS is granting the extension to enable the IRS to complete changes to its forms and systems to implement the Affordable Care Act. The extension applies only to hospital organizations which are required to file Schedule H with the 2010 Form 990 and which otherwise would have had 2010 tax year filing due dates before August 15, 2011 – any hospital organization whose 2010 tax year started between January 1, 2010 and March 23, 2010. A "hospital organization" is defined as an exempt organization that operates one or more hospitals.

Medical Resident FICA Refund Claims. On March 2, 2010, the IRS issued a News Release announcing an administrative determination to accept the position that medical residents are excepted from FICA taxes under the student exemption for tax periods ending before April 1, 2005. This determination follows the United States Supreme Court decision on January 11, 2011 in *May Foundation for Medical Education and Research v. United States*, upholding a Treasury Regulation making medical residents ineligible for the student FICA tax exemption.

2011 EO Initiatives. In 2011, the IRS plans to do the following:

Examine the activities of 501(c)(4), (c)(5) and (c)(6) organizations, reviewing inurement, compliance and political activities, continuing to focus on governance, following-up on the governance check sheets completed in 2010.

Focus on exempt organizations that conduct international activities and transactions relying, in part, on the Form 990 for information.

In March 2007, the IRS published its report on the *Executive Compensation Compliance Initiative: Loans Project*. The report raised concerns about loans to officers, directors and key employees, including reporting and excess benefit transactions. In 2011, the IRS intends to continue to assess compensation using the data collected.

The IRS will conduct full examinations of exempt organizations to evaluate their compliance with employment tax rules, including employee expense reimbursement, employee/independent contractor classification, and fringe benefits. Hospitals should review their personal service contracts, including those with physicians, to determine whether the individuals have been properly classified (employee or independent contractor) in accordance with IRS criteria.

Finally, the IRS will be drafting regulations to implement the tax provisions of the Affordable Care Act.

Accountants and Collecting of Accounts

Note: Below is copy of a presentation made at an annual Indiana Hospital Association meeting in 1930 about the difficulties hospitals have in collecting payment for their services. As the proverb says, “the more things change, the more they remain the same.” Article submitted by Chapter member Hugh Deery.

The old saying, “A man without tools is nothing, with tools he is all.” might be amended and applied to read, “A hospital without operating funds is nothing, with funds it may be all.” Money is the “tools” that make a hospital of efficiency and service possible. A building, equipment and a staff are powerless to function without an income from service to furnish the motive power.

Very few hospitals, if any, have sufficient financial receipts from their pay, or part pay, cases to do more than meet current bills, and often a deficit for this charge must be met from other sources. Various ways, means, plans and schemes have been advanced and tried, yet, when a patient either cannot, or will not, pay his obligation to a hospital there is very little that can consistently be done to force a settlement.

Law suits are seldom advisable and collecting agencies will most likely make enemies of the people most needed as friends. The most satisfactory method is a personal interview, either before or soon after, the patient leaves the hospital. Paying at the end of each week is a method which is often successful, and deposits or advance payments have been tried with a varying degree of satisfaction to the institution. Yet, with all the above mentioned methods there are still unpaid bills, the payment of which is badly needed in order to meet charges and maintain credit with business concerns that deal with the hospital in an open account.

The yearly deficit of most hospitals is met in numerous ways, some from community funds, county or individual subscription. The taking care of these annual deficits is most necessary, but general knowledge that at the end of each year such deficits will be taken care of through public generosity in some cases has the effect of making patients lax about meeting their obligations. A certain percentage of patients meet all payments to the best of their ability, but there is a class, living on practically a fixed income, and living up the full amount each month, that, when an unanticipated hospital expense comes, finds the monthly budget entirely absorbed by current living bills, payments on the car and radio and other fixed demands of living. These, having made no provision for an emergency, feel forced to meet the foregoing listed expenses and have nothing left for the hospital obligation. They honestly intend to pay something next month, but the condition of the family purse is not changed and the hospital bill remains at its original figure. The months elapse, and before long the hospital obligation becomes not even a dim memory and is forever lost. This class could, by personal sacrifice, meet this obligation, but too few here have the will power to forego the automobile for even a limited time. The hospital will wait, or forget. I do not believe that the real charity cases in a majority of the hospitals today are as real a financial detriment as the class I have just attempted to describe.

The class of patients who could pay if they exercised some little sacrifice should be made to pay. Could these people be made to realize the cost and necessity of having and maintaining a hospital ready for their services they might feel more compunction in the matter of settling their

Please see **Collecting of Accounts** on Page 6

Collecting of Accounts from Page 5

accounts. These are the people who should most heartedly co-operate to maintain the institution. Wealthy people can go elsewhere if necessary.

In some hospitals there is a custom to have patients make notes, before leaving the house. These usually do not bear interest, and more often are not worth the paper on which they are written. There are some, too, who are under the hallucination that signing the note squares the obligation. Occasionally a patient leaves the hospital with an air of having done the institution an honor by his visitation, and one of this class always forgets the account. Former patients, still indebted, frequently move and rarely ever are thoughtful enough to notify the business department of the hospital that a new address has been acquired. This means that such an account might as well be charged off the books.

When patients enter the hospital they are admitted in a most informal manner. The patient is sick or injured and those who come with him are both anxious and excited. This is not a proper time to talk dollar and cents, and it is not done in the average hospital. There is not even time, usually, to make inquiry as to the financial status, nor time to secure anyone who will vouch for the charges. After the hospital care has been rendered is a poor time to bargain for the financial phase of the patient's experience. The regular charges are made, and getting payment is another element in conducting a hospital successfully.

Just where the trouble lies, and why a greater number of bills are not collected is a vital question confronting all hospital authorities, and much too large a question to be answered by one individual. An article in the "Modern Hospital" says, "education work among the public and laymen is needed," and I, too, think this is essential. People should be made to realize, in some way, the necessity for paying for hospital service, particularly since no hospital is operated for private gain.

The doctors making up the staff sell the hospital to their patients, and it would be a great help if they would sell to them the class of service best adapted to their financial means. This does not mean every patient is not to have all necessary service, but there are extras such as private rooms, special nurses and attentions that their cases as patients do not require. The patient will be none the worse, and when the hospital bills are presented they can be better met.

The time is going to come when people will have accident and sick insurance. There is scarcely a family of small means that does not carry small industrial insurance policies for the sole reason of being able, in emergency, to secure a decent burial. Why shouldn't insurance be carried to insure ability to meet the normal hospital bill in case of sickness and accident? Educate the people to this plan and the major portion of the collection problem will be solved.

Membership Committee News

Welcome New Members

New members of the Eastern Michigan Chapter are an important part of the Chapter's continued success. Please take a moment to contact our new members and share your experiences about our Chapter. We value their membership and encourage them to become active on Chapter committees.

Candace Lewis
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- Operations
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Nationally recognized as an expert in healthcare financial and administrative executive search, Managing Partner, Mrs. Michelle Whittaker-McCracken, CPC, SPHR, CIR is an Advanced HFMA Member, has served two terms on the Eastern Michigan Board of Directors and served on numerous committees. We are proud to be a Silver Sponsor for HFMA this year.

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New Member Profile – Philip Carey

Organization: **William Beaumont Hospital for 15 years**.

Title: **Sr. Financial Analyst**

HFMA Member Since: **New Member**

Years in current position: **4**

Joined HFMA : **To network with other Financial Professionals and to expand my knowledge and experience.**

“Get to Know You” questions:

1. Favorite soft drink? **Coke Zero**
2. Top 3 songs on your iPod? **I still have to get one of those**
3. Greatest indulgence? **Cheese Cake**
4. If I had time, I would like to learn: **Another Language**
5. If I had time, I would like to travel to: **Alaska**
6. Favorite midnight snack: **Ice Cream**
7. Three things you’ll always find in my fridge: **Milk, eggs, and beer**
8. What is in your briefcase? **I don’t use one - but it would make a nice lunch box**
9. You would be surprised to know**: I have a twin brother.**
10. Greatest career achievement: **Still waiting**
11. In case of fire, I would grab my**: My dog Boomer, assuming the rest of the family is safe.**
12. Proudest moment: **When my Daughters were born (Elena 5 and Julia 2)**
13. Favorite breakfast: **Spinach and Mushroom Omelet with pepper jack cheese**
14. Restaurant we might bump into you: **Shields or Kerby’s**
15. Favorite saying: **If at first you don’t succeed, try, try again**. *Arnold Palmer*
16. Person I would like to meet: **Actor - Anthony Hopkins**
17. Last book read: **“If you Throw a Pig a Party” to my 2 year old**
18. Dream automobile: **2012 Camaro ZL1**
19. Someday I hope to: **Travel more than I do now**

HERE'S HOW THE 2010-2011 MEMBER-GET-A-MEMBER PROGRAM WORKS:

- Recruit one or two new members who begin their membership between June 1, 2010, and April 30, 2011, or former* HFMA members who reactivate their membership between August 1, 2010, and April 30, 2011, and you will win your choice of an HFMA apparel item (approximate retail value of $25) or a $25 Visa® Fuel Card.** Fuel cards can be used at the gas station of your choice or anywhere Visa debit cards are accepted worldwide.
- Recruit three or four new and/or former* HFMA members and you will receive a $100 Visa prepaid card good anywhere Visa debit cards are accepted worldwide. You will also be entered into a drawing among all those recruiting three or four to receive a $1,000 cash prize.
- Recruit five or more new and/or former* members and you will receive a $150 Visa prepaid card. You will also be entered into a drawing among all those recruiting five or more to receive a $2,500 cash prize.

MEMBER-GET-A-MEMBER MAKE A DIFFERENCE GRAND PRIZE

For every new or former* member you recruit, you will receive one entry into the drawing for the Member-Get-A-Member Make A Difference Grand Prize worth $5,000. The winner will receive $3,000 in cash and a $2,000 donation in their name to the charity organization of their choice.

You will receive one entry in the drawing for each new member or former* HFMA member you bring in (or bring back).

*Sponsors will receive credit in the Member-Get-A-Member campaign for former members who reinstate (reactivate) their memberships between August 1, 2010, and April 30, 2011. Sponsors will also continue to receive credit in the Member-Get-A-Member campaign for new members who join (or have joined) between June 1, 2010 and April 30, 2011.

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Are We Running Out of Doctors?

By: Steven Fehlinger, FHFMA
HFMA-EMC Program Committee Member
Steve.fehlinger@lubawaymasten.com

Measuring Physician Availability

Before we address the question of whether we have enough physicians, it is important to understand the measurement criteria. A recent article in *24/7 Wall Street* highlighted that there are several ways to measure what many experts describe as a shortage of physicians in many parts of the United States. The most common measure is the ratio of physicians per thousand people. In the U.S., this ratio is 3.12. The article pointed out that in some countries, such as Israel, Belgium, Greece and Italy, the ratios is 50% higher than the U.S.[1]

A second measure is the ratio of doctors by region. The Department of Health and Human Services provides criteria for the designation of Health Professional Shortage Areas (HPSA) and Medically Underserved Area/Populations (MUA/P). In Michigan, for a primary medical care HPSA, the ratio must be at least 3,500:1. For a geographical HPSA designation the ratio is 3,000:1. (See the Michigan Department of Community Health and the U.S. Department for Health and Human Resources websites for more information on the types of medical shortage designations.) [2]

Approximately 30 percent of the U.S population lives in areas designated as medically underserved. An interesting aspect of the 24/7 article was the variability ratios in some states. Oklahoma for example, had the lowest ratio at 2.03 physicians per thousand. This was followed by Idaho, Mississippi and Iowa at 2.2 per thousand.

A third measure identified by *24/7 Wall Street* is the rate at which the doctor to population ratio has grown during the last 15 years. The national average between 1995 and 2009 was 15.6%. Based on AMA data, States with the lowest growth rates were Arizona, 4.6%; Georgia, 9.4%; Utah at 10.1%; and Mississippi at 10.2%. Arizona and Utah both reduced Medicaid enrollment due to state budget cuts. Georgia has not raised Medicaid payments to physicians in more than a decade. Mississippi has the third lowest ratio of physicians to residents at 2.06 per 1,000. Mississippi is also expected to add more than half a million to the insurance rolls under the Affordable Care Act (ACA). The backdrop to this is that “experts” believe that the ACA will further strain the availability physicians across the country. [3]

Michigan Physicians

The total number of physicians providing patient care in Michigan, including graduate medical training programs, as of January 2008 was 29,302. This is a physician to population ratio of per thousand of 2.89. In a 2008 study by the Center for Health Professionals at the Michigan Health Council, approximately 34 percent of active physicians identified themselves as primary care doctors (family practice, general medicine, internal medicine, and pediatrics).

- 39 percent of the active physicians attended Michigan medical school
- 61 percent completed a residency program in Michigan
- 15 percent had a post-residency fellowship in Michigan
- 28 percent of the physicians were categorized as an international medial graduate (IMG). (26 percent of physicians in the U.S are IMG’s.)
- In the 2007-2008 academic year, Michigan had 3,208 medical students (2.461 allopathic and 747 osteopathic medicine).

Please see **Running Out of Doctors** on Page 11

Running Out of Doctors from Page 10

- Michigan ranked ninth in the nation for the number of residents and fellows trained in the state during the 2007-2008 academic year.

A Blue Ribbon Physician Workforce Committee in 2005 commissioned a study to forecast the physician supply and demand through the year 2020. That study projected a 5% increase in physicians per 100,000 population with a 10 percent increase in the number of physicians and a population growth of five percent over the 2005 to 2020 period. However, due to demographic shifts such as an aging population, the study predicted a physician shortage between 1 and 12 percent. More critical was the predicted shortage of specialists by 2020 in the following areas:

- Family physicians: 4 to 10%
- General surgeons: 11 to 22%
- Cardiologists: 23 to 33%
- Orthopedic surgeons: 19 to 36%
- Psychiatrists: 19 to 36%
- Internists: 1 to 5%
- Radiologists: 1 to 16%

Interestingly, the report predicted a surplus of emergency medicine of 10 to 25%.

Forty seven percent of the physicians surveyed in 2008 were 55 years of age or older and are expected to reach retirement age (65 to70) during the next 10 to 15 years. While 34 percent of active fully licensed physicians surveyed in 2008 were in primary care specialties, a recent study of medical students indicated only two percent of fourth-year students planned to work in internal medicine. Observers suggested that this is due to decreased career satisfaction of primary care physicians, declining income, and a widening difference between specialists and primary care. The National Health Policy Forum suggests the income disparity is due to the higher dollar value placed on services provided (e.g. radiology, cardiology) and the additional ancillary revenues afford specialists. [4]

National Physician Shortage Predictions

On a national level, at least one estimate predicts that there will be a shortage in the order of 200,000 by 2020. This is almost a quarter of the 850,000 physicians practicing today. From a historical perspective it is interesting to note that in 1980 the Graduate Medical Education National Advisory Committee (GMENAC) predicted the U.S would have 145,000 more physicians that it needed by the turn of the century. Subsequent studies predicted even greater excess. In 1997 Congress limited the number of residencies Medicare would fund to 80,000 each year. Although another 20,000 are financed elsewhere, this effectively limited enrollment. Now there are fewer physicians each year relative to the growth in population.

The year 2000 came and passed and a surplus of physicians never materialized. Where were the studies wrong? The studies failed to anticipate changes in medical practice that affected the specialties doctors choose. For example, lucrative specialties such as cosmetic surgery and sports medicine attracted large numbers of physicians. The explosion of new imaging technologies also contributed to a growth in radiologists.

However, this is no guarantee that an increase in residency programs will put more physicians in specialties that are needed or in the service areas where they are most needed. At the same time, adding training slots in specialty areas begs the question as to where the money will come from. There has been much discussion

Please see **Running Out of Doctors** on Page 12

Running Out of Doctors from Page 11

of late concerning the looming federal deficit and federal debt. As a consequence, Congress is under pressure to cut Medicare spending.

Not everyone shares the belief that a physician shortage is inevitable. David C. Goodman, M.D., of the Center for Health Policy Research at the Dartmouth Institute, contends that anecdotal reports of shortages in some geographical areas and specialties are due to inefficient health care systems and recruiting problems. He notes a 2006 survey by the U.S. Government Accountability Office that from 2000 through 2004 no more than seven percent of Medicare patients nationwide reported a problem finding a doctor. "It's what physicians do that's important, not how many there are," says Goodman. Some systems are more efficient that others and require fewer physicians to serve a population. [5]

Adding additional uncertainty to the mix is the role of foreign medical school graduates. Today, foreign students fill one in four residency slots. Can the U.S. continue to import such a large percentage of its doctors? Many nations have their own issues. Canada for example has a doctor shortage that is expected to worsen. Canada has 2.6 physicians per 1,000, a ratio that ranks Canada 26th of 28 developed countries that have public funded health care. Further, 38% of Canada's physicians are age 55 or older in 2010. [6]

A third of the physicians practicing in the U.S. are older than 55 and likely to retire during the next 20 years. This exodus will be taken up in part by Generation Xers who place a higher value on lifestyle and family than their predecessors. Many new doctors are women. In 1980, 10% of practicing physicians were women. Today they comprise half of the medial student enrollment. Women, more so than their male colleagues, place a value on career balance and family life.

Doing More With Less

Most estimates of future healthcare expenditures assume that growth will exceed that of the overall economy. Such continued growth is not sustainable. Dr. Goodman believes that is not necessary to produce additional doctors who will order more services for their patients. He states, "Rather than spend resources on training more physicians, we should focus on building more efficient delivery systems." [7]

Maybe Dr. Goodman's position has merit. In addition, the increased use of electronic medical records and telemedicine over time may help stem the growth by adding further efficiencies to the costly current system.

There has also been discussion about the need to pay primary care physicians more and change the reimbursement model. Perhaps more needs to be said about how to redesign the delivery system that remains safe but adds significantly greater efficiency to the healthcare delivery process. Counting on increased professional payments and/or funding to support a growth in medical education is probably wishful thinking.

1 States Running Out Of Doctors - 24/7 Wall St.

2 MDCH - HPSA and MUA/P Program Overview

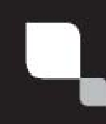
3 States Running Out Of Doctors - 24/7 Wall St.

4 http://www.michigan.gov/documents/healthcareworkforcecenter/Physician_Profile_MHC_FINAL__FEB09_267821_7.pdf

5 Are We Running Out of Doctors? - Proto Magazine - Massachusetts General Hospital

6 Canada's MD shortage will worsen, Fraser Institute predicts

7 Are We Running Out of Doctors? - Proto Magazine - Massachusetts General Hospital



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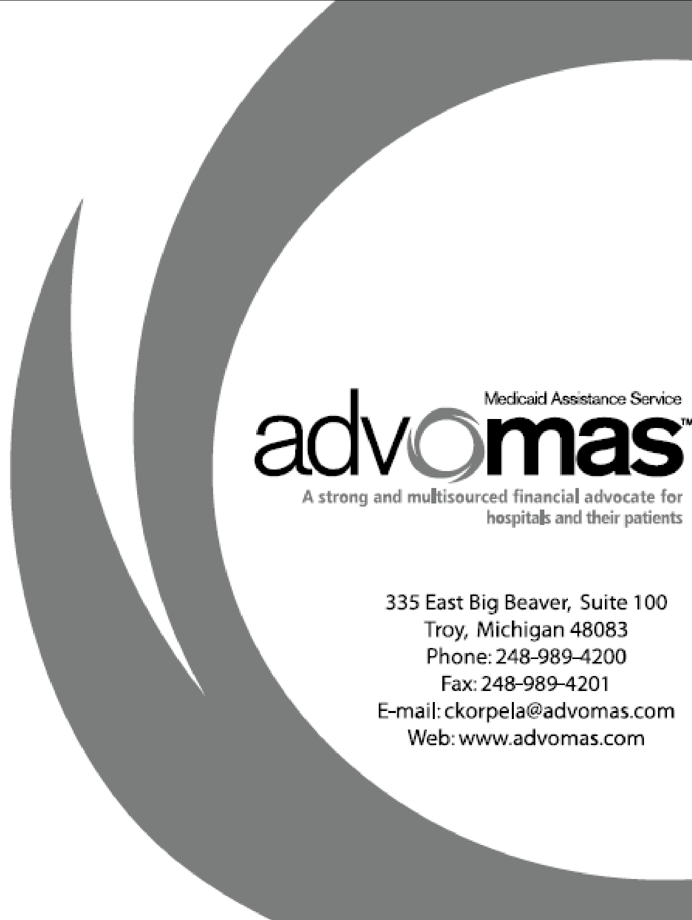

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